

## **2019 – 2023 HAWAII STATE PLAN ON AGING**

For Older Americans Act  
Title III and Title VII Programs

For the period:  
October 1, 2019 – September 30, 2023

Department of Health  
Executive Office on Aging



*"E Loa Ke Ola"  
May Life Be Long*

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*Mission Statement:*

*Optimize the health, safety and independence of Hawaii's older persons.  
We support Kupuna<sup>1</sup> and their caregivers through advocacy, planning  
development, and coordination of policies, programs and services.*

## **EXECUTIVE SUMMARY**

The Hawaii State Department of Health, Executive Office on Aging (EOA) is submitting the 2019 - 2023 Hawaii State Plan on Aging, covering the period from October 1, 2019 to September 30, 2023 to the U.S. Department of Health and Human Services, Administration for Community Living (ACL). This plan describes the goals, strategies, and objectives that will be accomplished in 2019-2023 to ensure a comprehensive and coordinated system of long-term services and supports for Hawaii's older adults and individuals with disabilities and their caregivers. The plan complies with the Older Americans Act (OAA) of 1965, as amended in 2016 through Public Law (P.L.) 114-144, and the Administration on Aging (AoA) Program Instruction (PI), AoA-PI-14-01, which outlines the criteria set forth by the Assistant Secretary for Aging.

Hawaii's older adult population (60+) continues to increase. By 2020, 1 in 4 residents of Hawaii will be 60 years or older. It is expected that between 2020 to 2030 the growth in the number of older adults 60 years of age and older in the State of Hawaii will increase by 17% and represent 28% of the State's total population. In addition, there will be a 31.7% increase in older adults 85 years of age and older over the next 10 years between 2020 to 2030.

As Hawaii's aging population increases, the need for a comprehensive and coordinated system of long term, home and community-based services and supports to address their current and anticipated needs will continue to rise. To address and respond to the current and anticipated needs of Hawaii's growing aging population, the EOA has been working closely with the county Area Agencies on Aging (AAAs), the Administration for Community Living (ACL) discretionary grant programs (namely the Hawaii Senior Medicare Patrol (SMP) and the Hawaii State Health Insurance Assistance Program (SHIP)), and members of the Policy Advisory Board of Elder Affairs (PABEA) to discuss the areas of concern and needs of Hawaii's older adults and persons with disabilities. As a result, the Executive Office on Aging and Hawaii's four Area Agencies on Aging (AAA) will pursue the following five (5) statewide goals to address the current and anticipated needs of Hawaii's older adults and persons with disabilities:

1. Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities;
2. Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population;

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<sup>1</sup> Kupuna is the Hawaiian word meaning ancestor, grandparent, or older adult.

3. Strengthen the statewide Aging and Disability Resource Center (ADRC) system for persons with disabilities, older adults and their families;
4. Enable older adults to live in their communities through the availability of and access to high quality, long term services and supports (LTSS), including supports for their families and caregivers; and
5. Optimize the health, safety, and independence of Hawaii's older adults.

All goals, objectives, and strategies outlined in this plan will be carried out through partnerships and collaboration with public, private sector, community organizations, volunteers, and Hawaii's older adults and persons with disabilities. The 2019 - 2023 Hawaii State Plan on Aging implements a comprehensive and coordinated support system of LTSS that is needed by Hawaii's older adults and individuals with disabilities, along with their caregivers.

EOA will continually work and partner with the county AAAs, their providers, and community organizations to ensure that LTSS are provided to Hawaii's older adults and persons with disabilities. It is only through collaboration and working together will the State be able to successfully navigate through the challenges that our older adult population and persons with disabilities face. It is through the goals, strategies and objectives in this plan that will set the State on a course to achieve a comprehensive and coordinated support system of care for Hawaii's older adults and persons with disabilities.

## **I. INTRODUCTION**

The Executive Office on Aging (EOA) of the Hawaii State Department of Health (DOH) is submitting this 2019 - 2023 Hawaii State Plan on Aging for Older Americans Act (OAA) Title III and Title VII funds for the period of October 1, 2019 - September 30, 2023 to the U.S. Administration on Aging, Department of Health and Human Services for approval.<sup>2</sup> This plan complies with the requirements of the OAA, as amended in 2016 through P.L. 114-144 and the Administration on Aging (AoA) Program Instruction (PI) 14-01 which outlines criteria by the Assistant Secretary for Aging.

### **A. Organizational Structure of the National Aging Network**

The OAA passed by Congress in 1965 established a social services and nutrition services program for America's older adults. State and area offices were established and a nationwide "Aging Network" was created to assist older adults in meeting their physical, social, mental health, and other needs, and maintain their well-being and independence.

On April 18, 2012, the Administration for Community Living (ACL) was created and is organizationally part of United States Department of Health and Human Services (HHS). ACL brings together the efforts and achievements of the Administration for Aging (AoA), the Administration on Intellectual and Developmental Disabilities (AIDD) and the HHS Office on Disability and serves as the Federal Agency responsible for increasing access to community supports, while focusing attention and resources on the needs of older Americans and people with disabilities across their lifespan. ACL is committed to the fundamental principle that people with disabilities and older adults should be able to live where they choose, with the people they choose and fully participate in their communities. Inherent in this principle is the core belief that everyone can contribute, throughout their lives. ACL is structured to provide general policy coordination while retaining unique programmatic operations specific to the needs of each population they serve.

The ACL administers programs and awards OAA Title III, IV and VII federal funding for nutrition and supportive in-home and community-based services for disease prevention and health promotion, elder rights, and monitors and assesses State Offices on Aging that administer these funds. ACL also develops, coordinates and administers programs nationwide; provides leadership, direction, technical assistance and advocacy; and develops policy to meet the needs of elderly individuals.

### **B. Organizational Structure of Hawaii's Aging Network**

The Hawaii State Aging Network is comprised of the EOA, four county AAAs (Area Agencies on Aging) and their community contracted providers. The EOA is the designated lead agency or State Unit on Aging in the Hawaii State Aging network

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<sup>2</sup>Title III funds are for nutrition and supportive home and community-based services and Title VII funds are for vulnerable elderly rights activities

responsible for the administration, oversight, and monitoring of all the county AAAs programs and services that receive funding from the Older Americans Act Title III, IV and VII programs. The EOA is required to plan and lead the coordination of access to home and community-based services to the older adult population at both the State and local levels, which involves:

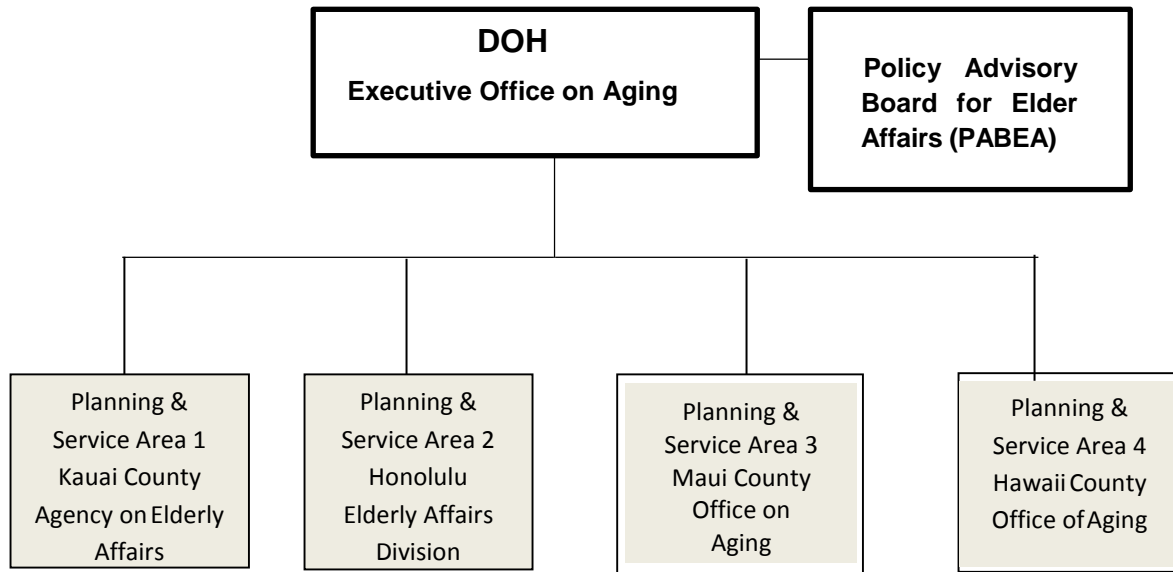
- Planning
- Policy and program development
- Advocacy
- Research
- Information and referral
- Coordination of services provided by public and private agencies for our elders and their families

The mission of the EOA is to promote and assure opportunities for Hawaii's older adults to achieve dignified, self-sufficient and satisfactory lives. EOA pursues its mission by advocating, developing, and coordinating federal, State, and local resources for adults 60 years and older and their caregivers.

Chapter 349-4 of the Hawaii Revised Statutes (HRS), defines the purpose and functions of the EOA and establishes a Policy Advisory Board for Elder Affairs (PABEA) to assist and advise the EOA Director on the development and administration of the Hawaii State Plan on Aging by representing the interests of older adults (includes grandparents raising grandchildren), persons with disabilities, and their caregivers. That same statute also allows the PABEA Board to review and provide comments on any county plans, State plans, budgets and policies that affect older persons and persons with disabilities.

The EOA delineated the State into distinct planning and service areas for purposes of planning, developing, delivering, and the overall administering of services (See Chart 1: State Network on Aging). These four Planning and Services Areas include the counties of Hawaii, Honolulu, Kauai, and Maui. Kalawao County on the island of Molokai is included in the Maui Planning and Service Area.

**Chart 1  
State Network  
on Aging**



The following agencies have been designated the county AAAs by the EOA:

**Kauai Agency on Elderly Affairs (KAEA)**

County of Kauai  
4444 Rice Street, Suite 330  
Lihue, HI 96766  
  
Kealoha Takahashi, County Executive  
Telephone: (808) 241-4470

**Elderly Affairs Division (EAD)  
Department of Community Services**

City and County of Honolulu  
715 South King Street, Suite 200  
Honolulu, HI 96813  
  
Derrick Ariyoshi, County Executive  
Telephone: (808) 768-7705

**Maui County Office on Aging (MCOA)**

County of Maui  
95 Mahalani Street, Room 20  
Wailuku, HI 96793  
  
Deborah Stone-Walls,  
County Executive  
Telephone: (808) 270-7755

**Hawaii County Office of Aging (HCOA)**

County of Hawaii  
1055 Kino`ole Street, Suite 101  
Hilo, HI 96720  
  
Christian Alameda, County Executive  
Telephone: (808) 961-8600

The county AAAs are responsible for developing 4-year plans to implement the OAA in their respective counties. Each AAA has an advisory council that oversees the development and implementation of their plan to ensure a comprehensive, coordinated community-based system of services for older adults and persons with disabilities. The county AAAs perform a wide range of functions including advocacy, planning, coordination, inter-agency linkages, information sharing, monitoring and evaluation to enable older persons to lead independent, meaningful and dignified lives in their homes and communities for as long as possible.

The EOA receives formula funds from the ACL, AoA under Title III and VII, and Title IV discretionary funds of the OAA, based upon the population of the State. Based upon the State's Intrastate Funding Formula, Title III and VII funds are allocated to the four county AAAs. A portion of the OAA Title VII funds received from EOA and other federal grants are also provided to carry out elder rights and benefits programming. Additional funds from the State Legislature for aging services (Kupuna Care, Kupuna Caregivers, and other programs) are also appropriated to the EOA each year which are allocated to the county AAAs.

The county AAAs, in turn, utilize their federal and State funds from the EOA to contract with organizations, agencies, and educational institutions that provide direct services under the Aging Network to deliver services to Hawaii's older adults, aged 60 years old and older, their caregivers and persons with disabilities at the local county level, in their geographical area. Services contracted include: personal care, homemaker services, chore services, home delivered meals, adult day care/health, case management, congregate meals, nutrition counseling, assisted transportation, transportation, legal assistance, nutrition education, information and assistance, outreach, and caregiver support services (counseling, respite, supplemental services, access assistance, and information services).

In addition, EOA and the county AAAs also coordinate Title III services and programs with Title VI grantees in Hawaii by referring Native Hawaiians using the Hawaii State Aging and Disability Resource Center (ADRC), to Title VI grantee provider, Alu Like, Inc., for the full range of services if they meet qualifications.

### **C. State Plan Purpose**

Under the requirements of the OAA (Section 307(a)), the State of Hawaii is required to submit a State Plan on Aging that meets the criteria outlined by the Assistant Secretary for Aging to be eligible for grants under Title III. This 2019-2023 Hawaii State Plan on Aging ("State Plan") complies with the requirements of the OAA, as amended in 2016 through P.L. 114-144 and AoA-PI-14-01 and covers a four-year period beginning October 1, 2019 and concluding on September 30, 2023.

The purpose of the State Plan is to set the direction for the period, October 1, 2019 through September 30, 2023, for the development of a comprehensive, coordinated statewide system of LTSS in accordance with all federal requirements, to serve Hawaii's older adults, persons with disabilities and their caregivers.



As the State of Hawaii's designated State Unit on Aging, the EOA prepared the State Plan with a focus on person centered planning that encourages the independence and well-being of older adults and adults with disabilities to make informed decisions on the long terms services and community supports needed to remain in their communities. As a result, the State Plan incorporated in its strategies, the needs, expectations, and choices of Hawaii's older individuals as determined by the county AAAs in the development of their county area plans and describes how Hawaii's system of services and access to these services will meet the challenges of Hawaii aging population.

The strategies of the State Plan on Aging are based on principles in the OAA, which form the direction over the next four years. These principal areas are:

- Activities for disease prevention and social engagement;
- Support for caregivers;
- In-home and community-based programs and services;
- Access to information and care options;
- Person centered approaches for at-risk older adults; and
- Elder rights and benefits.

With the reauthorization of the OAA in 2016, the AoA, outlined additional strategic principles and objectives in Choices for Independence, enabling the Aging Network to be more participant-directed. Consequently, additional strategic principles incorporated into the State Plan on Aging strategies are:

- Empower participants to make informed decisions about their care options;
- Help older adults at risk of nursing home placement to remain in their own homes and communities through flexible financing and service models (including consumer-directed models); and
- Build evidence-based prevention into community-based systems of services, enabling older people to make behavioral changes that reduce risk of disease, disability and injury.

Activities relating to four federal, AoA goals, were also included in the strategies:

- Empower older people, their families, and other consumers to make informed decisions and to be able to easily access, existing health and long-term supports and service options;
- Enable seniors to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
- Empower older people to stay active and healthy through OAA services and the new prevention benefits under Medicare; and
- Ensure the rights of older people and prevent abuse, neglect and exploitation.

The fiscal year 2015 AoA Program Instruction requirements further listed the following focus area activities:

- Coordinating, strengthening, and expanding the Title III and VII programs and integrating them with Title VI (Native Hawaiian Programs), the health care and social services systems, and the ACL discretionary program;
- Developing measurable objectives and identifying partners for the ACL discretionary programs integration with the OAA core programs;
- Giving older adults in Hawaii the option to direct their own care; and
- Working with elderly justice stakeholders to prevent, detect, assess, intervene, and/or investigate elderly abuse, neglect, and financial exploitation.

#### **D. Planning Process and Community Input**

Development of the State Plan includes the collaboration and input of all four county AAAs, who have developed their own 2019-2023 County Area Plans on Aging. To assess the needs of older adults and persons with disabilities within their county, the county AAAs collected input from community senior groups, older adults, persons with disabilities, Aging Network partners, service providers, organizations working with older adults, and AAA staff and volunteers utilizing community meetings, surveys, focus groups, key informant interviews, and public hearings. As a result, the county AAAs reported that some of the major concerns that older adults and persons with disabilities expressed in all the counties are:

- Health Care (access, affordability, managing medications, preventive care, screenings, etc.)
- Transportation (availability, accessible, etc.)
- Chore services (grocery shopping, cleaning the yard, etc.)
- Affordable, accessible & low-income senior housing
- Access to in-home services (bathing, grooming, etc.)
- Work force capacity
- Legal assistance
- Chronic disease management programs and services
- Loneliness and social isolation

Starting from July 2018, the EOA held three WebEx planning meetings with the county AAAs to begin to collaboratively plan and develop the State Plan as well as provide any technical assistance needed by the AAAs in developing their 2019 - 2023 County Area Plans on Aging. (**SEE APPENDIX I**)

The first EOA WebEx meeting held on July 9, 2018 with the AAAs concentrated on developing timelines for the completion of the State Plan on Aging and the 2019-2023 County Area Plans on Aging. This initial meeting also included a brainstorming exercise to develop draft goals that were broad in scope that would be used as the driving force in both the State Plan on Aging and the 2019-2023 County Area Plans on Aging to meet the comprehensive needs of older adults living in the State of Hawaii. As a result, the

EOA and the AAAs agreed upon the following five (5) overarching Goals to be included in the 2019-2023 State Plan:

1. Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.
2. Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.
3. Strengthen the statewide ADRC system for person with disabilities, older adults, and their families.
4. Enable older adults to live in their communities through the availability of and access to high quality, long term services and supports (LTSS) including supports for their families and caregivers.
5. Optimize the health, safety, and independence of Hawaii's older adults.

Upon the development of the five (5) overarching goals for the 2019-2023 State Plan on Aging, the AAAs proceeded to develop and implement their county needs assessment of older adults in their communities through community surveys, community meetings, focus groups, and interviews. A second WebEx meeting with the AAAs was held on August 2018 with EOA providing county specific health surveillance data and resources needed by the AAAs for completing their county needs assessments and developing draft strategies and objectives for their own 2019-2023 County Area Plans on Aging.

In November 2018, EOA held a final WebEx meeting with the AAAs to provide input and suggestions on Statewide Strategies and Objectives that should be included in the State Plan to be reflective and responsive to the community needs of all the AAAs. These strategies and objectives will be accomplished collaboratively by the EOA, AAAs, Hawaii's State Aging Network, and other community-based partners to achieve the overarching goals of the 2019-20213 State Plan on Aging

In addition, individual meetings were also held with each of the EOA program staff supervisors to provide input on any additional strategies and objectives that should be included and worked on to by their section staff and the AAAs to achieve the above mentioned five (5) overarching Goals of the 2019-2023 State Plan on Aging.

The initial Draft of the State Plan was then developed and distributed to various public and government officials. A draft of the plan was posted on the Hawaii ADRC website for public review. Notice of the plan's posting and the schedule of the three (3) public informational meetings were posted on the ADRC and EOA websites, and distributed by email to advocates, legislators, community organizations, and service providers for older adults and persons with disabilities. Of the three public meetings held, one community meeting was held in person at the Hawaii State Capitol in Honolulu, Hawaii on May 23, 2019 for all interested individuals and two (2) community meetings were held via WebEx (with captioning available to persons with disabilities) in all four counties

throughout the State of Hawaii (City and County of Honolulu, Maui County, Hawaii County, Kauai County) on May 24, 2019 and May 29, 2019. The plan was also presented to the PABEA Board on May 3, 2019 for comments. More than seventy-six (76) individuals attended these public meetings and offered comments and input (**SEE APPENDIX J**).

All comments on the State Plan that was received from the public and community meetings, PABEA Board Meeting, and by the AAAs, EOA staff, State Aging Network, community partners, and interested individuals were incorporated in the Final Draft of the State Plan and then submitted to the Hawaii State Department of Health Director and the Governor’s Office for review and approval. Upon approval by the Governor, the Final 2019-2023 Hawaii State Plan was then submitted to ACL for final approval.

The next chapter describes Hawaii’s older adult population and their use of Title III services. Chapter III presents Hawaii’s goals and the strategies and objectives for achieving each goal and the potential barriers and the proposed strategies for addressing those barriers. The plan concludes with a presentation of outcomes and performance measures and EOA’s approach to quality management.

## II. PROFILE OF HAWAII’S AGING POPULATION

A majority of Hawai`i’s population of baby boomers have reached the age of 60 and over resulting in the rapid growth of Hawaii’s aging population. With a population of a little over 1.4 million residents living in Hawai`i in 2017, 341,760 (24%) of these residents were over the age of 60. By 2020, one out of every four people in Hawai`i will be 60 years or older. The rapid growth of Hawaii’s aging population Hawai`i’s will greatly impact Hawai`i’s economic structure and increase the need and demand for health and social services to meet the needs of Hawai`i’s older adults.

**Table 1.** Population Distribution Projections of Older Adults for the Hawai`i and the United States by Age Groups, 2020 to 2045. (In percent)

AGE GROUPS	2020	2025	2030	2035	2040	2045
<b>Hawaii<sup>1</sup></b>						
Total Population	1,466,632	1,514,723	1,556,843	1,592,684	1,622,480	1,648,609
55 – 59 years old	6.2%	5.6%	5.2%	5.3%	5.7%	5.7%
60 years and older	25.3%	27.0%	27.9%	28.4%	28.8%	29.3%
60 – 64 years old	6.2%	5.9%	5.3%	4.9%	5.1%	5.5%
65 – 74 years old	10.7%	10.9%	10.7%	10.0%	9.2%	9.1%
75 – 84 years old	5.5%	7.2%	8.3%	8.6%	8.6%	8.1%
85 years and older	2.9%	3.0%	3.6%	4.8%	5.8%	6.5%

<sup>1</sup>Source: State of Hawaii Department of Business, Economic Development and Tourism

## Hawai`i's Distribution of Persons 60 Years of Age and Older by Gender

In Hawai`i, the proportion of females over 60 years old is greater than males (Table 2). In 2017, 46.2% (157,893) of Hawai`i's population were men over the age of 60 years old while 53.8% (183,867) were women over 60 years of age. Hawai`i's population distribution based on gender seems to widen as one ages as demonstrated with Hawai`i's population of women 75 years of age and older, far surpassing the number of their male counterparts by nearly 20% in 2016 and 2017.

**Table 2.** Sex Distribution of Persons 60 Years and Older in the United States and Hawai`i for 2013 – 2017. (In Percent)

SEX AND AGE GROUP	HAWAI`I					UNITED STATES				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
<i>Male</i>										
60 years and older	46.1	46.3	45.7	46.3	46.2	45.0	45.1	45.2	45.2	45.4
60 – 64 years old	50.0	50.7	47.6	49.3	49.8	47.9	47.9	47.9	47.8	48.0
65 – 74 years old	48.3	48.1	48.4	48.6	48.1	46.8	46.8	46.7	46.8	46.7
75 years and older	39.9	40.1	40.7	40.6	40.8	40.0	40.2	40.5	40.7	40.9
<i>Female</i>										
60 years and older	53.9	53.7	54.3	53.7	53.8	55.0	54.9	54.8	54.8	54.6
60 – 64 years old	50.0	49.3	52.4	50.7	50.2	52.1	52.1	52.1	52.2	52.0
65 – 74 years old	51.7	51.9	51.6	51.4	51.9	53.2	53.2	53.3	53.2	53.3
75 years and older	60.1	59.9	59.3	59.4	59.2	60.0	59.8	59.5	59.3	59.1

Source: U.S. Census Bureau, 2013 to 2017 American Community Survey, Table B01001, Male vs Female Population.

## Hawai`i's Social Demographics of Older Adults

Social characteristics of Hawai`i's older adults over the last five years have been relatively consistent (Table 3). Hawai`i has a smaller proportion of older adults living alone as compared to the U.S. In Hawai`i, only 32.7% of its older adult population live alone whereas, 40% of older adults live alone in the U.S. In 2015 approximately 36,203 Hawai`i households (11.6%) are multigenerational, defined as households with more than two generations living under the same roof. Many households in Hawai`i are multigenerational for various reasons. Culturally in Hawai`i, many families believe that living with their families and extended families are very important. A typical family household in Hawai`i is defined as consisting of individuals who identify as being related to one another by birth, marriage, or adoption. Another reason why fewer older adults in Hawai`i live alone than their national counterpart may be due to the high cost of living and housing in Hawai`i. Extended multigenerational family members often choose to live together in one home to share the cost of housing.

Hawai`i also has fewer disabled older adults compared to its national counterpart. However, a large proportion of Hawai`i's older adults speak English less than "very well". This is a result of the racial and ethnic diversity of Hawai`i's population with a

majority of Hawai'i's population being of Asian, Native Hawaiian, or Pacific Islander descent. In addition, Hawai'i has slightly more military veterans than the United States.

**Table 3.** Social Demographic Characteristics of Person 60 Years and Older in the United States and Hawai'i for the Years 2013 – 2017. (In Percent)

SOCIAL DEMOGRAPHIC CHARACTERISTICS	HAWAII					UNITED STATES				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Householder living alone	31.9	31.8	31.7	33.8	32.7	40.0	40.0	39.9	39.8	39.4
Responsible for grandchildren	1.9	2.4	1.6	2.0	1.7	1.6	1.6	1.5	1.5	1.5
Civilian veteran	18.8	17.3	17.9	16.7	16.8	18.4	17.5	16.6	15.8	15.1
With a disability	29.5	30.4	28.3	29.3	27.8	31.8	31.5	31.0	30.9	30.4
Speak English less than "very well"	18.3	17.5	18.5	17.4	16.2	8.5	8.7	8.9	8.9	8.8
Live below 100% of the poverty level	7.6	9.0	8.3	9.6	9.6	9.9	9.9	9.5	9.7	9.7

Source: U.S. Census Bureau, 2013 to 2017 American Community Survey, Table S0102.

### Hawai'i's Racial Diversity

Hawai'i has a racially diverse population. The racial distribution of persons over 60 years old has been relatively stable over the past 5 years. Table 4 indicates the proportion of whites and African-Americans is much lower in Hawai'i than the U.S. However, the proportion of Asians, Native Hawaiians, and Pacific Islanders in Hawai'i is much larger than the U.S. In 2017, Hawai'i's State population of persons over 60 years old consisted of 52.7% Asians, 28.6% Caucasians, 6.8% Native Hawaiians or other Pacific Islanders with 11.1% reported being of mixed race, not uncommon within the State of Hawai'i.

**Table 4.** Race Distribution of Persons 60 Years and Older in the United States and Hawai'i for the Years 2013 to 2017. (In Percent)

RACE/ETHNICITY	HAWAII					UNITED STATES				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
<b>One Race</b>	89.0	88.6	88.5	89.1	88.9	98.9	98.9	98.9	98.8	98.8
White	28.1	28.0	27.9	28.5	28.6	83.2	82.8	82.4	82.0	81.6
African American	0.7	0.7	0.7	0.5	0.7	9.3	9.4	9.5	9.7	9.8
American Indian / Alaska Native	0.1	0.2	0.2	0.2	0.1	0.5	0.6	0.6	0.6	0.6
Asian	53.4	53.2	52.8	52.8	52.7	4.0	4.2	4.3	4.4	4.6
Native Hawaiian / Other Pacific Islander	5.9	6.1	6.4	6.8	6.8	0.1	0.1	0.1	0.1	0.1
Some other race	0.8	0.5	0.6	0.3	0.3	1.8	1.8	1.9	2.1	2.2
Two or more races	11.0	11.4	11.5	10.9	11.1	1.1	1.1	1.1	1.2	1.2
White Alone, not Hispanic or Latino	27.0	27.1	26.9	27.3	27.3	77.5	76.9	76.4	75.9	75.4

Source: U.S. Census Bureau, 2013 to 2017 American Community Survey, Table S0102.

## Hawai`i's Life Expectancy, Health, And Disabilities Among Older Adults

According to a recent study published in the JAMA journal, Hawai`i has the longest life expectancy (81.3 years of age) of any State in United States.<sup>3</sup> Hawai`i was considered one of the healthiest states in the U.S. for several years with only 19% of its population being obese which is the lowest in the nation. In addition, only about 17% of the population smokes.

While Hawai`i's older adults enjoy long lives, 87% of older adults have one or more chronic conditions. Chronic disease prevalence of Hawai`i's older adults differs by ethnicity. Native Hawaiians and Filipinos have higher prevalence of diabetes, while Caucasians have higher incidences of cancers, and the Japanese have higher prevalence of hypertension. Because of the high prevalence of multiple chronic conditions, 27% of older adults have at least one disability and about 38% of them report poor physical and mental well-being.

**Table 5.** Persons with Disabilities in Hawai`i and the United States for the years 2013 to 2017 by Age Group (in percent)

AGE GROUP AND DISABILITY	HAWAII					UNITED STATES				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
65 years and older										
Hearing	15.2	16.4	15.4	14.5	13.7	15.2	15	14.8	14.6	14.4
Vision	5.8	5.3	4.7	5.1	4.8	6.8	6.7	6.5	6.5	6.3
Cognitive	12.7	12.2	10.3	11	9.1	9.2	9.1	9	8.9	8.6
Ambulatory	22	22.9	20.4	22.3	20.1	23.3	23	22.6	22.5	22.5
Self-Care <sup>1</sup>	7.8	9.3	8.5	8.9	6.8	8.5	8.4	8.2	8.1	7.8
Independent Living <sup>2</sup>	17	17.5	15.7	16.3	13.4	15.4	15.4	14.9	14.6	14.2

Source: U.S. Census Bureau, 2013 to 2017 American Community Survey, Table S1810.

<sup>1</sup> Self-care difficulty is having difficulty bathing or dressing.

<sup>2</sup> Independent living difficulty is having difficulty doing errands alone because of a physical, mental, or emotional condition.

The proportion of persons ages 65 and older with disabilities in Hawai`i and the U.S. has been slightly decreasing. As reflected in Table 5, hearing, vision, cognitive, and independent living disabilities have decreased. This trend may be due to the baby boomers, who are younger and healthier, making up a larger portion of the 65 and older population.

While there may be a slight downward trend of persons with disabilities, in 2017, 9.1% (31,100) of those 65 years of age and older had a cognitive disability and 20.1% (68,694) have an ambulatory disability. Currently, the Alzheimer's Association, Aloha Chapter reports more than 28,000 people in Hawaii are living with Alzheimer's disease with this number expected to increase as the baby boomers population cohort ages.

<sup>3</sup> The US Burden of Disease Collaborators. The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. *JAMA*. 2018;319(14):1444–1472. doi:10.1001/jama.2018.0158

In summary, older adults in Hawai'i have a higher life expectancy, the baby boomers have had an impact of the number of individuals with disabilities however, those who age into the higher age groups, that is those 85 years of age and older, have multiple chronic conditions and may have increased long-term services and support needs. Understanding this growing population will assist the EOA in the development of a more comprehensive set of services and supports.

Profile of Hawai'i's Older Adults Receiving State and/or Older Americans Act, Title III Funded Services

The Executive Office on Aging is currently serving older adults with Title III Older Americans Act funding and State funds to provide a comprehensive array of services and supports to meet the needs of Hawaii's older adults.

Tables 6, 7, and 8 indicate that Hawai'i's Title III programs are serving the needs of Hawai'i's disparate population of older adults in Hawai'i. In 2017 9.6% of older adults in the State of Hawai'i was living in poverty. Of those receiving the OAA, Title III services, 22.2% are below poverty, a higher percentage than their proportion in the State. In addition, more than 1 in 3 Title III participants were at high nutrition risk and about 6 out 10 lived in rural areas of the state. A comparison of Table 3 to Table 7 denotes a much larger portion of Title III participants had at least one disability.<sup>4</sup>

**Table 6:** Characteristics of Title III Participants, Federal Fiscal Years 2014 to 2018

CHARACTERISTICS	FEDERAL FISCAL YEAR				
	2014	2015	2016	2017	2018
Percent minority participants	72.9%	74.7%	74.9%	75.3%	71.8%
Percent rural participants	61.7%	61.4%	61.1%	62.7%	58.2%
Percent below poverty	26.2%	26.5%	24.3%	22.2%	19.3%
Percent living alone	35.1%	36.2%	35.7%	37.0%	34.0%
Percent of persons at high nutrition risk	34.3%	35.3%	38.3%	37.3%	29.3%
Number of Cluster 1 and 2 participants	7,509	7,176	7,555	7,716	8,788

**Table 7.** Number of Activities of Daily Living Disabilities (ADLs) Reported by Cluster 1 Clients, Federal Fiscal Years 2014 to 2018

Number of ADLs	FEDERAL FISCAL YEAR				
	2014	2015	2016	2017	2018
0 ADL	15.6%	15.2%	14.1%	15.3%	22.4%
1 ADL	7.6%	8.6%	8.0%	8.7%	9.8%
2 ADL	20.0%	20.4%	15.6%	12.1%	11.7%
3 or more ADLs	53.8%	52.7%	58.7%	59.9%	43.9%
ADL missing	3.0%	3.0%	3.6%	4.0%	12.2%
Number of Cluster 1 Clients (All Ages)	4,215	4,207	4,600	4,917	6,361

Source: Hawai'i State Performance Reports for Title III Services.

<sup>4</sup> The fact that ACS considers only 6 types of disabilities may also have contributed to explain some of the differences.



**Table 8.** Age Distribution of Participants Receiving Title III Cluster 1 and 2 Services, Federal Fiscal Years 2014 to 2018

Age Group	FEDERAL FISCAL YEAR				
	2014	2015	2016	2017	2018
60 to 74 years old	27.5%	26.9%	27.0%	27.4%	27.1%
75 to 84 years old	31.0%	31.1%	30.6%	30.3%	29.8%
85 years or older	40.0%	40.2%	40.4%	40.6%	39.3%
Missing	1.5%	1.7%	2.0%	1.7%	2.2%
Number	7,509	7,176	7,555	7,716	8,788

Column percentages do not sum to 100.0%.

Source: Hawai'i State Performance Reports for Title III Services.

For the most part, the proportion of Title III participants has remained relatively stable between FFYs 2014 and 2018. There are two exceptions to this. One is the slight drop in the number of participants receiving Title III Cluster 1 and 2 services percentages in FFY 2018 as indicated in for the characteristics listed in Table 6. Some of this decrease may be a consequence of the implementation of the newly created Kupuna Caregiver (KCG) Program and the increased public interest it generated. While the KCG program, which was enacted by the Hawai'i State Legislature in July 2017 and launched in January 2018, it served 159 caregivers in the first year, but it generated inquiries from approximately 1,700 caregivers, some of whom may have enrolled their care recipient in other Title III programs. If they resembled those who enrolled in the KCG program, most of them would be living with the care recipient, thereby reducing the percentage of participants living alone. These participants would also then be less likely to be at high nutrition risk and, since the caregiver needed to be employed at least 30 hours a week, less likely to living in poverty.

### III. HAWAI'I'S PROGRAMS AND SPECIAL INITIATIVES

Programs for Hawai'i's older adults are available through statewide and local agencies, including OAA funded services, grant funded, and State and local initiatives. Each of the following programs aim to assist older individuals while maintaining their independence and avoiding institutionalization:

In SFY 2018, the EOA received a total of \$19,269,823 in appropriations resulting in 12,100,000 (63%) in appropriations from State funds and \$7,169,823 (37%) in appropriations from federal funds for services enabling older adults to remain in their homes and communities. These funds were used to support the following Kupuna Care (KC) core services: adult day care, attendant care, case management, chore, homemaker, personal care, assisted transportation, and home-delivered meals. In addition, some of these funds were used to provide home and community-based services for older adults and their caregivers. Upon receipt of these funds, the EOA then contracts with each of the county AAAs to procure, manage, and coordinate the delivery of these services in their respective counties.

The State and federally funded services reached an estimated 7,129 older adults in SFY2018. The funds provided 175 older adults with 7,366 one-way trips of assisted transportation; 969 older adults with 46,847 hours of personal care; 285 older adults with 81,499 hours of adult day care; 3,288 older adults with 386,089 home delivered meals; and 268 caregivers with 32,062 hours of respite care for family members of older adults.

### Kupuna Care Program

The Kupuna Care Program assists older adults to remain in their homes and communities by providing a variety of different long-term caregiving and support services, such as adult day care, attendant care, case management, chore, homemaker/housekeeping, personal care, assisted transportation, transportation, and home delivered meals. In addition, other home and community-based services for older adults and their caregivers are also provided. The Kupuna Care Program is available Statewide, in all the counties.

### Aging and Disability Resource Center (ADRC)

For the past six years, the EOA has been implementing and strengthening the Statewide ADRC. The ADRC assists older adults, individuals with disabilities, and family caregivers find options for long term supports and services that fit their needs and are available to them in the State of Hawaii. ADRC staff provides consumers assistance by first assessing the consumer's service needs and then enrolling them in the appropriate Kupuna Care and/or Title III funded services that will best meet their needs. In addition, the ADRC staff provides consumers with information on options for other services that the ADRC may not directly provide.

In SFY 2018, the ADRC received 60,281 contacts or calls, of which 5,172 received an initial assessment. Consumers who responded to the ADRC satisfaction survey were generally quite satisfied with the ADRC's performance. In three of the counties, 97% of consumers were satisfied with the ADRC and, in one county, 85% of consumers in that county was satisfied.

### Long Term Care Ombudsman Program (LTCOP)

This LTCOP provides information, outreach, and advocacy for residents of long-term care facilities. To ensure all residents are aware of the services provided by the Long Term Care Ombudsman, volunteers are trained and certified by the Long Term Care (LTC) Ombudsman Volunteer Program to regularly visit licensed LTC sites.

In SFY 2018, the LTCOP filled its Volunteer Coordinator position, certified four new volunteers who will serve as Ombudsman representatives, updated the LTCOP Policies and Procedure and updated the LTCOP brochure and logo.

The LTCOP also initiated procurement to contract services on the islands of Maui, Kauai, and Hawai'i. An ombudsman volunteer in Maui was awarded the Maui contract and began in June 2017. Contractors for Kauai County and Hawai'i County have also been selected and will begin providing services in SFY 2019.

### Hawai'i State Health Insurance Assistance Program (SHIP)

The Hawaii State Health Insurance Assistance Program (SHIP) counsels and educates Medicare beneficiaries, their families, and soon-to-be beneficiaries on their Medicare options. In SFY 2018, the SHIP program reached over 1,000,000 individuals through digital and print media, responded to over 3,000 calls on their helpline, and counseled over 3,000 beneficiaries. The program recruited and trained over 40 new counselors in all four counties and partnered with the University of Hawaii to conduct Medicare training statewide.

### Hawai'i Senior Medicare Patrol (SMP) Program

The Hawai'i Senior Medicare Patrol (SMP) Program educates beneficiaries on ways to avoid Medicare scams, fraud, waste, and abuse. The SMP Program is a volunteer-based program to ensure Medicare is not billed for health care services, medical supplies, and equipment not received by Medicare clients. In SFY 2018 the SMP Program participated in 139 community group outreach and educational events that reached nearly 10,000 people statewide. The SMP Program broadcasted 179 public service announcements between July and December 2017 on local NBC and CBS affiliates and trained seven new SMP Program volunteers. The volunteers dedicated over 6,000 hours of services to the SMP program.

### **Special Initiatives**

The following are several special initiatives that are also administered by the EOA that improves the accessibility of services, well-being, independence, and safety of Hawai'i's Kupuna:

#### Kupuna Caregiver Program

In SFY 2018, the Hawai'i State Legislature passed Act 102, which appropriated \$600,000 to the EOA to implement the Kupuna Caregiver (KCG) Program to provide support to employed caregivers caring for an older adult family member or loved one. As a result, the EOA designed and developed the KCG Program with the assistance and input of the county AAAs, legislators, community advocates, and service providers. In January 2018 the ADRC officially launched the KCG Program in all the counties. The ADRC received a total of 2,707 inquiries from the public, enrolled 159 caregivers into the program and provided services to 101 care recipients before the close of the State fiscal year. The ADRC used a majority of the initial appropriation to provide adult day care services for the KCG care recipients.

#### The Hawai'i Healthy Aging Partnership (HHAP) Initiative

The EOA is one of the founding partners of the HHAP Initiative and continues to offer the Chronic Disease Self-Management Education and EnhanceFitness workshops.

In SFY2018, HHAP offered 10 workshops on chronic disease self-management, diabetes and cancer. These workshops were attended by a total of 92 individuals, of which 88% completed the workshops. The EnhanceFitness workshops served a total of 575 individuals, an increase of 21% over SFY 2017.

### Community Living/ Participant Direction and Veterans Directed Care

Participant Direction (PD) is another initiative that was started by EOA in SFY 2018. PD is a service model in which participants are their own case managers and are responsible for self-directing their Long Term Services and Supports (LTSS). The EOA offered the following two types of PD: 1) Participant direction for persons eligible for publicly funded LTSS; and 2) Veterans Directed Choice (VTC) for veterans eligible for nursing home placement.

In SFY 2018, 49 individuals were enrolled in the participant direction care and the EOA anticipates enrolling 24 additional individuals in SFY 2019. The EOA received 37 referrals in SFY 2018 for the VDC program, an increase of 37% over the previous State fiscal year. The EOA accomplished these enrollments despite the retirement of the program manager for PD,

### No Wrong Door (NWD)

The NWD is an ACL initiative to improve the public's access to Long Term Services and Supports (LTSS). In SFY 2018, the NWD network piloted and refined an automated referral tool, trained NWD agency staff, reviewed draft documents for Medicaid Federal Financial Participation (FFP) administrative claims to secure Medicaid reimbursement for the Door agencies, and worked on a plan to sustain the NWD initiative over the next three years.

### Alzheimer's Disease and Related Dementia

In SFY 2017 EOA was awarded a three year grant from the ACL for the Hawai'i Alzheimer's Disease Supportive Services Program (HADSSP): Creating and sustaining Dementia-Capable Service System. The goals of the project are to: 1) Build and sustain dementia-capability within the NWD Network; and 2) Provide better access to services for persons with dementia and their caregivers.

### The EOA Language Access Plan

In SFY 2018, the EOA continues to refine its efforts to make LTSS services more accessible to older adults with limited English proficiencies (LEP). The EOA reviewed its Language Access Plan after participating in two statewide trainings sponsored by the Affirmative Action Office.

## **IV. HAWAII'S GOALS, STRATEGIES, OBJECTIVES, PERFORMANCE MEASURES, AND TIMELINES**

All goals, strategies and objectives outlined in the State Plan on Aging will be carried out through partnerships and collaboration with public agencies, private sector, community organizations, and volunteers for Hawaii's older adults and persons with disabilities.

Over the next four years from 2019-2023, the EOA will be working on completing the Goals, Strategies and Objectives as identified below.

**Goal 1: Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.**

**Strategy 1.1: Implement and expand wellness and health maintenance evidence-based interventions for all generations and persons with disabilities throughout the State of Hawaii.**

Keeping older adults physically active and healthy can prevent chronic diseases and disabilities and reduce health care costs. Studies show that physical inactivity increases health care costs. CDC estimates that non-institutionalized adults 50 years or older spend about \$860 billion annually on health care.<sup>5</sup> It is estimated that 4 out of 5 of the costliest chronic conditions among older adults 50 years or older can be prevented or managed with physical activity. Other studies have also found that social activity also helps in reducing and delaying the onset of cognitive and physical limitations.

**Objective 1.1:1:** Expand the number of older adults, caregivers, and persons with disabilities, who participate in evidence-based interventions that manage chronic conditions.

**Objective 1.1:2:** Provide support to the Healthy Aging Partnership through training of lay leaders, master trainers, and enhanced fitness instructors.

**Objective 1.1:3:** Increase the number of older adults, caregivers and persons with disabilities who participate in fall prevention and other evidenced-based physical fitness programs.

**Objective 1.1:4:** Increase public awareness of fall prevention, evidence-based interventions that manage chronic conditions, and other evidence-based physical fitness programs.

**Strategy 1.2: Engage older adults through civic engagement, community partnerships, and learning opportunities to improve their quality of life and be valuable members of society.**

Loneliness and social isolation have been linked to poor health outcomes in seniors and can lead to numerous detrimental health effects in older adults such as increased risk of falls, mortality, dementia and rehospitalization.<sup>6</sup>

Older adults can also contribute their vast skills, knowledge, and experiences to their community in a meaningful way by choosing to volunteer within their communities. Studies have shown that older adults that do volunteer work have better physical and mental health, higher levels of happiness, reduced stress, and reduced risks of disease and lower health care costs. Hence, older adults who engage in community

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<sup>5</sup> Center for Disease Control Prevention (CDC), “Adults Need More Physical Activity”. Website: <https://www.cdc.gov/physicalactivity/inactivity-among-adults-50plus/index.html#Problem>

<sup>6</sup> Nicholson, Nicholas R. A Review of Social Isolation: An Important but Underassessed Condition in Older Adults. *Journal of Primary Prevention*. 212 Jun;33(2-3):137-52. doi: 10.1007/s10935-012-0271-2.

initiatives and programs are often healthier than adults who are not as socially engaged in their communities.

Research has shown that learning new things throughout your life has many benefits. Many older adults choose to go back to school to learn a new skill or study a subject area that they are interested in that they may not have had the opportunity to learn before. Choosing to go back to school can combat loneliness through social engagement with other peers in class, improve your cognitive skills, and may even prevent the early onset of Alzheimer’s disease and other related dementias.

**Objective 1.2:1:** Provide statewide support to volunteer, faith based, and social engagement groups that focus on aging well programs and services that increase civic engagement opportunities, and volunteerism for older adults within their communities to stay healthy and socially engaged.

**Objective 1.2:2:** Develop innovative partnerships and models to address volunteer programs.

**Objective 1.2:3:** Explore innovative strategies and models to maintain and/or increase senior participation in the congregate meal sites.

**Objective 1.2:4:** Explore new models and programs to engage older adults in lifelong learning opportunities and encore careers.

**Performance Measures and Timelines for Goal One**

<b>Performance Measure(s)</b>	<b>Timeline</b>
Increase the number of older adults, caregivers, and persons with disabilities, who participate in evidence-based interventions that manage chronic conditions.	Ongoing
Provide support and training to the Healthy Aging Partnership through training of lay leaders, master trainers, and enhanced fitness instructors from communities and volunteers.	Ongoing
Increase the number of fall prevention and other evidenced-based physical fitness programs and evidence based interventions that manage chronic conditions that are offered by the county AAAs throughout the State.	Ongoing
Track the number of ADRC referrals who manage a chronic disease to CDSMP.	Ongoing
Increase collaborative partnerships between the county AAAs and volunteer, faith based, and social groups that focus on aging well programs and services to increase civil engagement opportunities, volunteerism, companionship program, etc. for older adults within their communities.	Ongoing
Develop incentives and activities to increase participation of older adults to congregate sites.	Ongoing
Conduct analysis of satisfaction survey of participants in congregate eating sites.	Ongoing
Develop partnerships with the community colleges, the University of Hawaii, and community groups to explore and develop lifelong learning opportunities for older adults.	Ongoing
Number of public awareness of fall prevention, evidence-based interventions offered by the county AAA that manage chronic conditions, and other evidence-based physical fitness programs.	Ongoing

**Goal 2: Forge partnerships and alliances that will give impetus to meeting Hawai`i's greatest challenges of the aging population.**

Developing and fostering existing and new innovative strategic partnerships that leverage existing resources and services to address the needs of Hawai`i's older adults is a priority of the State of Hawai`i. The EOA will work with and utilize the expertise from government agencies, health care organizations, community-based organizations, county agencies on aging and their clients, and other organizations serving older adults to better streamline referrals, coordinate services and improve service efficiency and quality of services being provided to Hawai`i's older adults. These partnerships and alliances will ensure a coordinated system and target services to meet the diverse needs of Hawai`i's aging population, including individuals with Alzheimer's disease and other related dementia, thereby using limited resources more efficiently and effectively to meet the needs of Hawai`i's older adults.

**Strategy 2.1: Collaborate and strengthen the Aging Network's statewide workforce to enhance and improve service efficiency and quality of services being provided to Hawai`i's older adults and their caregivers.**

**Objective 2.1:1:** Survey the Aging Network to identify workforce barriers faced by service providers and others who serve older adults and their caregivers.

**Objective 2.1.2:** Develop workgroups to look at changes to the Aging Network that will address workforce barriers (i.e. staff shortages, staff fatigue and trauma, etc.) and enhance the capacity, and competencies (trainings (dementia care guidelines, fall prevention, etc.), certification, etc.) of providers and stakeholders to provide a more coordinated system of supports statewide.

**Strategy 2.2: Explore innovative partnerships and alliances, leveraging resources to address the needs of older adults and/or their caregivers.**

**Objective 2.2:1:** Collaborate, develop partnerships, and leverage resources to develop more age friendly communities that promote promising practices for aging in place and active aging.

**Objective 2.2:2:** Collaborate and educate agencies and service providers in the community to increase the number of Dementia-Friendly (Dementia-Capable) agencies and services providers.

**Objective 2.2:3:** Maintain, enhance, and leverage resources for No Wrong Door (NWD) efforts with NWD agencies and partners to continue seamless access and referrals, information sharing, cross trainings, and person centered trainings.

**Objective 2.2:4:** Collaborate with partners in the community to update the Alzheimer's Disease and Related Dementias (ADRD) State Plan to address the needs of individuals with ADRD.

**Strategy 2.3: Collaborate with partners and alliances in the community to address the needs of the at-risk and homeless older adults.**

Hawai`i's population of older adults and persons with disabilities continues to rapidly increase. Hawai`i's cost of living remains one of the highest in the nation due to the need to import everything to the islands either by sea or plane. The cost of food and housing keeps rising. As a result, homelessness has been a growing issue in Hawai`i. Hundreds of Hawai`i's older adults and persons with disabilities receive shelter and outreach services from various State homeless programs each year. Many of Hawai`i's older adults and persons with disabilities live on fixed incomes and rely upon subsidized housing. However, the supply of subsidized housing units is dwindling, forcing many of Hawai`i's seniors and persons with disabilities to live in homeless shelters or on the streets. Innovative initiatives, creative partnerships and leveraging of resources are desperately needed to address the problem of Hawai`i's growing homeless population of older adults and persons with disabilities.

**Objective 2.3:1:** Develop partnerships with organizations serving the aged homeless and at risk of homelessness population to advocate for specific needs of the older adult population.

**Objective 2.3:2:** Work with partners and the Aging Network to develop strategies and action steps to address housing concerns.

**Performance Measures and Timelines for Goal Two**

<b>Performance Measure(s)</b>	<b>Timeline</b>
Development of a survey to identify workforce barriers faced by service providers and others who serve older adults and caregivers.	2020
Distribute and collect the survey to Hawai`i's aging network of service providers and others who serve older adults and their caregivers to identify workforce barriers.	2021-2022
Convene workgroups to recommend changes needed to the Aging Network that will address workforce barriers (i.e. staff shortages, staff fatigues, trauma, etc.) to services and enhance the capacity and competencies (trainings, (dementia care guidelines, fall prevention, etc.), certification, etc.) of the providers and stakeholders to provide a more coordinated statewide system of supports.	On-going
Develop partnerships to discuss leveraging resources to develop more age friendly communities that promote promising practices for aging in place and active aging.	On-going
Collaborate and educate agencies and service providers in the community to become Dementia-Friendly (Dementia-Capable) agencies and service providers.	On-going
Number of Dementia-Friendly (Dementia-Capable) agencies and service providers.	On-going
Maintain, enhance, and leverage resources for No Wrong Door (NWD) efforts with NWD agencies and partners to continue seamless access and referrals, information sharing, cross trainings, and person centered trainings.	On-going
Partner with individuals with ADRD as well as community agencies, organizations, and professionals working with ADRD individuals to conduct a needs assessment of individuals with ADRD in Hawai`i.	Feb 2020
Development of an updated ADRD State Plan that addresses the needs of individuals with ADRD.	Feb 2023



<b>Performance Measure(s)</b>	<b>Timeline</b>
Development of partnerships with organizations serving the aged homeless and at risk of homelessness population to advocate for specific needs of the older adult population.	On-going
Development of strategies and action steps with partners and the Aging Network to address housing concerns in Hawaii.	2023

**Goal 3: Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.**

The Hawai'i Aging and Disability Resource Center (ADRC) assists Hawai'i's older adults, individuals with disabilities, and family caregivers to find options for long term supports and services available to them in the State of Hawai'i. The ADRC is a highly visible and trusted source of information that people of all incomes and ages can access at home, electronically on the computer or via their phone for information and resources that are available to assist the needs of Hawai'i's older adults and persons with disabilities. The ADRC staff determines eligibility of the older adult consumer for government paid programs, finds providers of long-term support and services (LTSS) that the consumer can pay for themselves, and works with the consumer to develop their own individual plan for meeting their future long-term care needs. The consumer is not charged any fee for services offered. All long-term services and supports provided by the ADRC are all paid for by the State and counties.

**Strategy 3.1: Assist the county AAAs to ensure that services and supports are culturally competent and linguistically appropriate for a diverse community.**

**Objective 3.1:1:** Provide technical assistance which may include training on cultural competencies.

**Objective 3.1:2:** Provide technical assistance to ensure that the Language Access Plan is being implemented at the AAA and provider level.

**Objective 3.1:3:** Incorporate the referral process between Alu Like and the ADRC operation model.

**Strategy 3.2: Promote community awareness and accessibility of the ADRC to older adults, persons with disabilities, and their families.**

**Objective 3.2:1:** Coordinate marketing activities with the county AAAs to increase the visibility and accessibility of the ADRC to older adults, persons with disabilities, and their families.

**Objective 3.2:2:** Educate county and State elected officials on the ADRC.

**Objective 3.2:3:** Participate in opportunities in the community to promote awareness of the ADRC as the No Wrong Door to address the need for long term services and supports.

**Strategy 3.3: Maintain, expand and update the resources and information available through the ADRC to address the needs of the communities.**

**Objective 3.3:1:** Partner and work with various agencies to provide input to annually update the resource database to ensure that the ADRC website and services are updated, the ADRC information is correct, relevant, and accessible to persons with disabilities.

**Objective 3.3:2:** Has an updated ADRC website that is comprehensive, accessible, integrated and interactive responding to the needs of families, older adults, caregivers, persons with disabilities, and the public.

**Objective 3.3:3:** Annually update and post a list of interpreters with their contact information and culturally competent informational documents of available services that are offered with captions, videos and/or recordings in different languages on their ADRC website to meet the needs of older adults and persons with disabilities and special needs.

**Strategy 3.4: Strengthen the statewide ADRC processes, accountability and sustainability.**

**Objective 3.4:1:** Evaluate the effectiveness of the ADRC process to ensure that it provides streamlined information that is person centered and accessible to persons with disabilities.

**Objective 3.4:2:** Re-evaluate the four (4) ADRC sites for compliance with national standards to ensure compliance with the five (5) components of the fully functional ADRC criteria.

**Objective 3.4:3:** Work with the county AAAs to evaluate the quality assurance measures to ensure timeliness and consumer satisfaction of the ADRC.

**Performance Measures and Timelines for Goal Three**

<b>Performance Measure(s)</b>	<b>Timeline</b>
Review the language access plans of all the AAAs and annually update the plan as needed.	Annual as needed
Partner with community-based organizations that work with and provide services to the LEP population.	On-going
Ensure EOA staff receive annual training on language access policies and procedures, including cultural competencies that should be followed statewide.	Annual
Ensure that staff of all the AAA's and ADRC receive annual training on language access policies and cultural competencies that are meet the needs of the population(s) they serve.	Annual
Percent of participants served who are LEP.	Annual
Implementation of marketing strategies to increase public awareness and accessibility of the ADRC in their counties to older adults, persons with disabilities, and their families.	On-going
Number of visitors who visited the ADRC site.	Annual
Education of county and State elected officials of the ADRC.	Annual
Promote awareness of the ADRC as the No Wrong Door to address the need for long term services and supports for older adults and persons with disabilities.	

<b>Performance Measure(s)</b>	<b>Timeline</b>
Percent of consumers who visited the ADRC site and were satisfied with the ADRC.	Annual
Percent of consumers who visited the site more than one time within the year.	Annual
Percent of consumers to the ADRC site who needs were met.	Annual
Percent of ADRC staff who received training and education on person centered training, benefits enrollment training, and other annual trainings as needed.	Annual
Ensure adoption, implementation and compliance of state and national standards, using needs based and person centered options counseling in providing home and community-based services and complies with the five (5) components of the fully functional ADRC criteria .	Semiannual
Update the ADRC resources database annually by partnering with public, private, and not profit agencies to provide input to ensure that the resources are updated, comprehensive, correct and relevant, integrative, accessible to persons with disabilities and interactive responding to the needs of older adults, person with disabilities, caregivers, and their families.	Annual
Ensure that there is an updated ADRC website that is comprehensive, accessible, integrated, and interactive responding to the needs of the public, families, older adults, caregivers, and persons with disabilities.	
Ensure ADRC website contains an annually updated current list of interpreters with their contact information, documents, videos, and/or recordings on the ADRC website that are culturally competent with captions in different languages for the public to use to meet the needs of older adults and persons with disabilities that have hearing, vision, and other impairments.	On-going updates as needed.
The ADRC process provides streamlined information that is person centered and accessible to persons with disabilities.	Annual
Evaluate the timeliness and consumer satisfaction of the ADRC.	Annual

Incorporate referral processes between Alu Like and the ADRC operational model.

**Goal 4: Enable older adults and persons with disabilities to live in their communities through the availability of and access to high quality, long term services and supports (LTSS), including supports for their families and caregivers.**

For many older adults and persons with disabilities, maintaining a sense of independence is important and many prefer to receive care in the comfort of their homes rather than receiving institutional care. Aging in place allows older adults and persons with disabilities to retain control over their lives and continue to live in their community where they are familiar with their surroundings. To continue to live in their communities it is important that older adults and persons with disabilities have access to high quality, long term services and supports (LTSS) such as adult day care, assisted transportation, attendant care, case management, chore and homemaker services, home-delivered meals, transportation services, and personal care. It is also important that the caregivers of older adults and persons with disabilities be provided the same support that older adults are provided as most caregivers have assumed their caregiving responsibilities with very little or no training.

**Strategy 4.1: Collaborate with the Aging Network statewide and other public and private agencies to enhance access to quality long term services and supports (LTSS) that is innovative, culturally competent, and person centered.**

**Objective 4.1:1:** Ensure the delivery of LTSS is person centered, comprehensive and takes into consideration various public and private resources and natural supports to address the participant’s goals and meets their needs.

**Objective 4.1:2:** Develop policies and procedures for the inclusion of private pay options for older adults who have the financial means to pay for services.

**Objective 4.1:3:** Increase and strengthen the participant directed services as a LTSS option for participants.

**Objective 4.1:4:** Continue collaboration with the Veterans Administration to strengthen the delivery of services to veterans through the Veterans Directed Care statewide.

**Strategy 4.2: Ensure statewide consistency and compliance for long-term services and supports for Kupuna Care.**

**Objective 4.2:1:** Develop and finalize Kupuna Care Administrative Rules in accordance with the federal and state law (Hawaii Revised Statutes).

**Objective 4.2:2:** Develop an integrative monitoring schedule to ensure compliance with administrative rules for Kupuna Care.

**Strategy 4.3: Provide person centered support and services for family caregivers, including grandparents raising grandchildren, through training, education, counseling, respite and referrals.**

**Objective 4.3:1:** Expand outreach and provide support, training, and assistance for family caregivers through the National Family Caregiver Support Program, including grandparents raising grandchildren and other relative caregivers, through person centered approaches (e.g. trainings, conferences, educational opportunities, respite, counseling, direct services, and informational materials).

**Objective 4.3:2:** Develop and implement a plan to maximize the number of working caregivers served through the Kupuna Caregiver Program.

**Objective 4.3:3:** Monitor, assess, and evaluate the effectiveness of the Kupuna Caregiver program.

**Performance Measures and Timelines for Goal Four**

<b>Performance Measure(s)</b>	<b>Timeline</b>
Delivery of LTSS that is comprehensive and utilizes public funds and natural supports to address the participants goals and meets their needs.	On-going
Development of policies and procedures for the inclusion of private pay options for older adults who have the financial means of paying for services.	2020
Increase and strengthen the participant directed services as a LTSS option for participants.	On-going

<b>Performance Measure(s)</b>	<b>Timeline</b>
Collaborate with the Veterans Administration to strengthen the delivery of services to veterans through the Veterans Directed Care statewide.	On-going
Develop Kupuna Care Administrative Rules in accordance with the federal and State laws.	2019 - 2021
Develop an integrative monitoring schedule to ensure compliance with the administrative rules for Kupuna Care.	2021
Expand outreach and provide support, person centered services, training, and assistance for family caregivers through the National Family Caregiver Support (NFCSP).	On-going
Develop a plan to maximize the number of working caregivers served through the Kupuna Caregiver Program.	2021
Implement the plan to maximize the number of working caregivers served through the Kupuna Caregiver Program.	2022-2023
Monitor and evaluate the effectiveness of the Kupuna Caregiver program.	2019-2023

**Goal 5: Optimize the health, safety, and independence of Hawaii’s older adults and persons with disabilities.**

Many older adults and persons with disabilities within Hawaii chose to receive care in the home rather than in an institutional care facility. Frail and more vulnerable older adults may seek higher levels of care in institutional settings. Regardless of the setting, the State has responsibility to ensure the health, safety, and independence of Hawaii’s older adults. Safety includes protecting older individuals at risk of abuse, neglect, and exploitation. In addition, the environment needs to meet the needs of older adults. The State needs to be mindful of universal design of homes and buildings that meet the needs of all families and individuals throughout their life span, thereby allowing everyone the opportunity to age safely in their own home and community. Goal 5 seeks to increase the likelihood that no matter where older adults and people with disabilities choose to live, whether it be in the care of their homes, in the care of their families or in an institutional care facility their health, safety, and independence will not be compromised.

**Strategy 5.1: Expand and foster collaboration with the Aging Network to enable older adults and persons with disabilities to receive the care that they need in their homes or in the care of their families to live safely and independently in their community.**

**Objective 5.1:1:** Ensure and monitor the AAAs efforts to address safety in the home and community.

**Objective 5.1:2:** Ensure that older adults are provided long term case management which will better allow older adults to remain in their home longer.

**Strategy 5.2: Foster collaboration with the Aging Network and other partners working with the aging population and persons with disabilities to ensure older adults, and persons with disabilities, are safe from abuse, neglect and fraud.**

**Objective 5.2:1:** Collaborate with the Aging Network, State agencies, federal agencies, non-profits, county mental health agencies, and other community organizations to develop a multidisciplinary team on elder abuse to increase awareness and education, and advocacy on elder abuse, neglect and exploitation.

**Objective 5.2:2:** Develop a partnership with the State Department of Human Services, Adult Protective and Community Services Branch and the Aging Network to develop resources and services to deal with individuals who self-neglect.

**Objective 5.2:3:** Collaborate with the Aging Network, State agencies, federal agencies, non-profits, and other community organizations to develop a standard referral process and eligibility criteria across county AAAs for referrals involving abuse, or to prevent abuse from occurring.

**Strategy 5.3: Develop and strengthen the Statewide Legal Services Program to address the provisions of the Older American Act of 1965<sup>7</sup>, Title VII, Chapter 4, by strengthening partnerships, offering legal services, information, and assistance to older adults in the State of Hawaii.**

On June 2018 the Executive Office on Aging hired a Legal Services Developer to build partnerships to develop and strengthen the capacity of a Hawaii Statewide Legal Services Program to offer legal services, information and assistance to assist Hawaii's older adults under the provisions of Title VII of the Older American's Act of 1965<sup>8</sup>. The role of the Legal Services Developer is to improve the quality and quantity of legal assistance to vulnerable older adults to protect their autonomy, dignity, an independence.

**Objective 5.3:1:** Provide State leadership in developing and strengthening partnerships with all the Area Agencies on Aging in the State of Hawaii to ensure the provision of legal assistance services to their consumers.

**Objective 5.3:2:** Develop and strengthen partnerships with other state agencies, non-profit organizations, service providers and community organizations that provide services to older adults to increase access to and awareness of legal assistance services.

**Objective 5.3:3:** Assist older adults in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older adults at risk of guardianship.

**Objective 5.3:4:** Build state capacity and monitor the improvement of the quality and quantity of legal services provided to Hawaii's older adults.

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<sup>7</sup> As amended through P.L. 114-144, enacted April 19, 2016.

<sup>8</sup> Ibid.

**Strategy 5.4: Advocate for the rights of older adults living in long term care facilities.**

The Long Term Care Ombudsman Program (LTCOP) advocates, provides information and assistance, makes referrals, counsels, responds to complaints and problems on behalf of residents of nursing homes, adult residential care homes, expanded adult residential care homes, assisted living facilities and community care family foster homes. The LTCOP coordinates with residents and their families, facility staff, various advocacy organizations, provider groups, the media, legislators, family members and facility staff to improve the quality of care and life for Hawaii's 12,661 long term care residents residing in 1,700 facilities spread over six islands.

The LTCOP also works with national senior advocacy organizations, the federal government, state licensing and certification agencies and other State/county agencies to improve the quality of care in long term care facilities.

**Objective 5.4:1:** Develop agreements with the county AAAs to provide LTCOP services statewide.

**Objective 5.4:2:** Create and hire two (2) LTCOP Specialist positions for Oahu to provide services on Oahu and provide technical support in the other counties.

**Objective 5.4:3:** Track and manage data for reporting purposes.

**Objective 5.4:4:** Participate in advocacy groups to raise awareness and promote system change to improve the quality of care in long term care facilities.

**Strategy 5.5: Recruit, train, and support volunteers, statewide, to provide information, education, referrals, advocacy, and one-on-one assistance to Medicare beneficiaries, their families, and caregivers.**

The Long-Term Care Ombudsman Volunteer Program (LTCOVP) assists the Long-Term Care Ombudsman Program in meeting the requirements stated in HRS 349, Section 21-25, and the Older American Act, as amended in 2016. Trained and certified volunteers are designated as representatives to support, educate and empower the residents in a long-term care setting with information and assistance to protect themselves from abuse, neglect, exploitation and to advocate for their rights and quality of life.

The Senior Medicare Patrol (SMP) Program provides outreach, education and counseling to Medicare beneficiaries to detect, protect, and report healthcare fraud, abuse and billing errors in accordance with grant requirements as set forth by ACL. Trained volunteers conduct presentations and participate at exhibits statewide to promote awareness of scams, fraudulent activities, and potential risks for financial exploitation.

The State Health Insurance Assistance Program (SHIP) provides information, education, referrals, and one-on-one assistance to Medicare beneficiaries, their families, caregivers, and soon-to-be retirees to enable them to make informed and

cost-effective health care decisions that best fit their individual needs. Trained volunteers conduct presentations and participate at exhibits statewide to promote Medicare, Medicaid, Medigap, prescription drug coverage, health care plan options and selection, benefit coordination, and eligibility and enrollment for low-income subsidy program assistance.

**Objective 5.5:1:** Establish and strengthen relationships with public and private sector partners to raise awareness and promote volunteer recruitment.

**Objective 5.5:2:** Enhance volunteer roles and recruitment to build a larger, more diverse cohort of volunteers to provide outreach to Hawaii’s multi-ethnic communities.

**Objective 5.5:3:** Support volunteer professional development and advocacy skills-building through ongoing training.

**Objective 5.5:4:** Explore opportunities to increase volunteer retention through collaborative partnerships, program collaboration and sharing of resources to recognize volunteer’s contributions.

**Objective 5.5:5:** Develop tools and processes to collect, assess, and evaluate data to identify areas for quality improvement and assurance.

**Strategy 5.6: Develop partnerships and alliances to ensure that disaster preparedness planning address the needs of older adults and persons with disabilities.**

**Objective 5.6:1:** Review the emergency disaster plans of the AAAs to ensure that protocols and procedures are in place for older adults and persons with disabilities following the event of a disaster.

**Objective 5.6:2:** Annually monitor the AAAs on the emergency disaster plans.

**Performance Measures and Timelines for Goal Five**

<b>Performance Measure(s)</b>	<b>Timeline</b>
Monitor the AAAs efforts to address safety in the home and community.	Annual
Increase the number of service providers to provide the care needed by Hawaii’s older adults and persons with disabilities to live safely and independently in their community.	Annual
Develop a multidisciplinary team (consisting of representatives form community organizations, non-profits and government agencies) on elder abuse to increase awareness, education, and advocacy on elder abuse, neglect, and exploitation.	2019-2020
Increase awareness, education, and advocacy on elder abuse, neglect, and exploitation.	Annually
Increase access and awareness of legal assistance services to older adults and persons with disabilities.	On-going
Percent of EOA and AAA staff trained on how to prevent, recognize, report, and deal with Elder Abuse and Neglect and Adult Financial Abuse.	Annual
Number of older adults (including older adults at risk of guardianship) assisted in understanding their rights to make their own choices.	On-going
Build State capacity to work with the AAAs in improving the quality and quantity of legal services provided to Hawaii’s older adults.	On-going



<b>Performance Measure(s)</b>	<b>Timeline</b>
Number of legal services provided to Hawaii's older adults.	Annually
Level of consumer satisfaction with legal services provided by the AAAs	On-going
Development of agreements with the county AAAs to provide LTCOP services statewide.	SFY 2023
Hire and train two LTCOP specialist positions for Oahu to provide services on Oahu and oversight to the neighbor islands.	SFY2023
Develop an electronic data tracking reporting system for the LTCOP.	Ongoing
LTCOP participation in advocacy groups to raise awareness and promote system change to improve the quality of care in long term care facilities.	On-going
Increase awareness and promote volunteer recruitment for the Long-Term Care Volunteer Ombudsman Program, SMP, and SHIP.	Annual
Increase volunteer outreach to Hawaii's multi-ethnic communities.	Annual
Increase volunteer professional development and advocacy skill-building through ongoing training.	On-going
Increase volunteer participation and retention.	Annually
Development of tools and processes to collect, assess, and evaluate data to make improvements to increase the overall effectiveness of volunteer programs.	SFY 2021
Number of AAA staff trained to assist older adults in preparing their personal disaster preparedness plan.	Annually
Number of county AAAs collaborating with appropriate government agencies and other organizations to update their emergency disaster plans to address the needs of older adults and persons with disabilities.	On-going
Number of county AAAs working with appropriate government agencies and other organizations to develop protocols that older adults and persons with disabilities should follow to be better prepared in the event of a disaster.	On-going
Partner with the State Department of Human Services, Adult Protective and Community Services Branch and the Aging Network to develop resources and services for individuals who self-neglect.	On-going

## **V. Potential Barriers to the Proposed Strategies**

The following are potential barriers that may make it difficult for the timely accomplishment of some of the goals in the 2019 - 2023 Hawaii State Plan:

**Lack of Funding:** Goal 1 (expanding wellness and health maintenance interventions) will need additional funding to implement these goals successfully. EOA will continue to seek grants, contributions, and state legislative support for these activities.

During the 2019 Hawaii State Legislative Session, the EOA actively sought support from the Legislature to provide funds for the Healthy Aging Partnership. HB468, which appropriates \$550,000 for the Healthy Aging was successfully passed by the Senate and House and is currently awaiting approval from the Governor. The State Base Budget measure is also awaiting approval from the Governor which appropriated \$3.1 million to support the ADRC for the State fiscal biennium.

In addition, in January 2019, the EOA submitted a fall prevention grant application to ACL for \$600,000 and is currently awaiting approval from ACL.

**Shortage of Service Providers to provide services needed by Hawaii’s older adults and persons with disabilities:**

Hawaii is experiencing an acute shortages of home health aides, nursing assistants, and other paraprofessionals that are needed to provide the support services that are needed by Hawaii older adults and persons with disabilities.

**Breakdown in Communication:** Goal 2 involves developing some partnerships and alliances with entities EOA has not worked with before. As with any new partnerships, there is the possibility of miscommunication or misunderstandings. To build trust and improve collaboration and communication between new partnerships, it is very important for all parties in the partnership to build trust, clearly define goals and objectives, and delineate the roles and responsibilities of each organization.

**Compliance with State and Federal Requirements:** Organizations have their own State and Federal compliance requirements that may or may not align with other partner organizations. This may make it difficult for some organizations to link with, share certain information and collaborate fully with other organizations participating in the ADRC. To maintain and strengthen partnerships with other organizations, it is important that all parties are sensitive to these restrictions, focus upon collaborating with information they can share and look for other ways to be able to make smooth referrals and share information between organizations.

## **VII. QUALITY MANAGEMENT**

The EOA will ensure that quality management of service programs encompass the following functions:

- EOA will utilize the consolidated data base for desk top review of program implementation by reviewing service utilization data on a quarterly basis to ensure that services are delivered timely to clients at high risk of potential institutionalization.
- EOA will perform annual monitoring of service programs to ensure that the programs are being implemented and following service standards.

*Continuous Improvement:* Currently all the county AAAs are a fully functioning ADRC and the EOA maintains the statewide ADRC consolidated database. The State and the county AAAs will collaboratively develop quality and performance measures using the consolidated ADRC database to enable county and Statewide program reports and performance reports to be generated for the State and the county AAAs. These reports will be reviewed to identify potential statewide and local problem areas.

*Remediation of problem areas:* EOA will perform the following steps to ensure remediation of any problem areas of the county AAAs:

- Identify problem areas and discuss these problems and issues with the county AAAs.
- Review any federal and State statutory rules that may have been violated.
- Complete a thorough review of problem areas and provide findings and recommendations to the AAAs in a timely manner.
- Require the county AAAs to submit a Corrective Action Plan to EOA with an agreed upon time frame. EOA will provide any necessary technical assistance needed by the AAAs.
- Monitor the Corrective Action Plan (CAP) to ensure that the CAP has been implemented by looking at program data before and after implementation of the CAP.
- If problem areas in the CAP has been resolved, submit a close out report to the county AAAs.

# **APPENDICES**

# **APPENDIX A**

## References

## REFERENCES

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# **APPENDIX B**

## Attachment A: State Plan Assurances and Required Activities

**State Plan Guidance  
Attachment A**

**STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES  
Older Americans Act, As Amended in 2016**

*By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2016.*

**ASSURANCES**

**Sec. 305, ORGANIZATION**

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title--

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

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

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

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

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

(c) An area agency on aging designated under subsection (a) shall be--...

(5) in the case of a State specified in subsection (b) (5), the State agency; and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other



arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

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

**Sec. 306(a), AREA PLANS**

(a) Each area agency on aging... Each such plan shall--

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services--

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and  
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and  
(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared,  
(I) identify the number of low-income minority older individuals in the planning and service area;  
(II) describe the methods used to satisfy the service needs of such minority older individuals; and  
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

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

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

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

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship;

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

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

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

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

### **Sec. 307, STATE PLANS**

(a) Each such plans shall comply with all of the following requirements: ...

(3) The plan shall...

- (B) with respect to services for older individuals residing in rural areas—
  - (i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000...

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

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

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

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

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

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on

individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals --

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

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

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

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

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

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

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

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

- (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
- (B) are patients in hospitals and are at risk of prolonged institutionalization; or
- (C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall--

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

(23) The plan shall provide assurances that demonstrable efforts will be made--

- (A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

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

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

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

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

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

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

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307--

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

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

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

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

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

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

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

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

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

(iii) upon court order...



**State Plan Guidance  
Attachment A (Continued)**

**REQUIRED ACTIVITIES**

**Sec. 305 ORGANIZATION**

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title— . . .

(2) the State agency shall—

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas; . . .

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals; and

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

**Sec. 306 – AREA PLANS**

(a) Each area agency will:

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

(6)(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate;”

**Sec. 307(a) STATE PLANS**

(1) The plan shall—

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

(B) be based on such area plans.

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

(2) The plan shall provide that the State agency will --

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; ...

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

(5) The plan shall provide that the State agency will:

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

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

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*Signature and Title of Authorized Official*

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*Date*

# **APPENDIX C**

## **Attachment B: Information Requirements**

## State Plan Guidance Attachment B

### INFORMATION REQUIREMENTS

**IMPORTANT:** States must provide all applicable information following each OAA citation listed below. Please note that italics indicate emphasis added to highlight specific information to include. The completed attachment must be included with your State Plan submission.

#### **Section 305(a)(2)(E)**

*Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;*

#### **Section 306(a)(17)**

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.*

#### **Section 307(a)(2)**

The plan shall provide that the State agency will --...

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

#### **Section 307(a)(3)**

The plan shall--

...

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

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

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

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

### **Section 307(a)(10)**

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

### **Section 307(a)(14)**

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and*

(B) *describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.*

### **Section 307(a)(21)**

The plan shall --

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

### **Section 307(a)(28)**

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive

### **Section 307(a)(29)**

*The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for*

emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

**Section 307(a)(30)**

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

**Section 705(a) ELIGIBILITY --**

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

*(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).*

*(Note: Paragraphs (1) of through (6) of this section are listed below)*

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

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

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

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

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

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

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

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

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

*(ii) receipt of reports of elder abuse;*

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

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

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

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

- (i) if all parties to such complaint consent in writing to the release of such information;*
- (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*
- (iii) upon court order.*

# **APPENDIX D**

## Intrastate (IFF) Funding Formula



**INTRASTATE FUNDING FORMULA  
(No Changes Since the Last Plan)**

**The State of Hawaii will use the same Intrastate Funding Formula it used in the previous plan.**

**Intrastate Funding Formula (IFF)**

The Executive Office on Aging is the designated State Agency responsible for developing an Intrastate Funding Formula (IFF) to distribute Older Americans Act(OAA) Title III funds to its planning and service areas (PSAs). The IFF reflects the best available data on the geographic distribution of the characteristics of individuals aged 60 and older in the State of Hawaii.

Under the OAA, older adults with the “greatest economic need” or “greatest social need” are given preference. The “greatest economic need” is defined as the need resulting from an income at or below the poverty line as defined by the Office of Management and Budget and adjusted by the Secretary for the U.S. Department of Health and Human Services (DHHS). The “greatest social need” is defined as the need caused by non-economic factors which include: physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks or threatens the capacity of the individual to live independently.

**I. Goals for Hawaii’s IFF**

The following goals were developed for Hawaii’s IFF:

1. Follow OAA provisions and program instructions concerning intrastate funding formula development.
2. Distribute funds in a fair and equitable manner.
3. Consider the following distribution among planning and service areas (PSAs):
  - a) Adults age 60 and older

- b) Adults age 60 and older with greatest economic need
  - c) Adults age 60 and older with greatest social need
  - d) Adults age 60 and older who are low income minorities
  - e) Adults age 60 and older living in rural areas
4. Ensure open, adequate, and inclusive discussion on factors and their definitions, base amounts, and weights.

## **II. Assumptions for Hawaii's IFF**

In selecting factors for the IFF, the EOA made the following assumptions:

Low Income: Older persons with income at or below poverty will have difficulty meeting the costs of daily life and health care.

Low Income Minority: Many low income minority persons disproportionately experience social and economic hardship or challenges.

Disabilities: Older persons with physical and mental disabilities, whatever the causes, require a variety of support services to remain independent in their own home or in the community.

Language Barriers: Many older persons who are unable to speak English or speak English "not well" may have limited access to information and services and may require additional support services.

Geographic Isolation: Many older persons who live in rural areas are often isolated from family and friends and formal support services. In addition, isolated areas may not have the service infrastructure to provide needed support services.

## **III. IFF Factors and Their Definitions**

Section 305(a)(2)(c) of the Older Americans Act (as amended in 2006) stipulates that the state agency (EOA) shall use "best available data" in developing the IFF. The IFF factors and their definitions are shown below.

IFF Factors and Their Definitions

<b>Factor</b>	<b>Definition and source</b>
Age 60 years and over	American Community Survey, (ACS) Three Year Estimates (2005-2007)
Greatest Economic Need (125% FPL)	Defined as Age 65 and over, and income below 125% FPL. Source: American Community Survey, Three year estimates (2005-2007)
Low income minority (100% FPL)	Defined as 65 yrs and over and non-white (total minus whites only), and income below FPL. Source: American Community Survey, Three Year Estimates (2005-2007)
Unable to perform 2 ADL; using census data 65 or older	Defined as: 65 yrs and over, and having "two or more types of disabilities". Source: American Community Survey, Three years Estimate (2005-2007), Table: B18001
Speak English not well and not at all; 65 or older from census data	U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.
Older population in <u>rural</u> areas	U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.
Density of older population in the PSA	American Community Survey, Three Year Estimates (2005-2007)
Living alone in Poverty	Aged 60 years and over, below poverty level, and living alone. Source: Census 2000

OAA Funding Category Federal FY 2010 Award

Title III-B Supportive Services \$

Title III-D Preventive Health \$

Title III-C1 Home Delivered Meals \$ Title

III-C2 Home Delivered Meals \$ Title III-E

Family Caregiver Services \$

Title VII Elder Abuse Services \$

Title VII LTC Ombudsman Services \$

Nutrition Services Incentive Program \$

Based on the data definitions, the following data was used in deriving Hawaii's

IFF: A Listing of Population, Economic, and Social Data Used

		PSA 1	PSA 2	PSA 3	PSA 4	Total
		KAEA Kauai	EAD Honolulu	MCOA Maui	HCOA Hawaii	
<b>Factors</b>						
Older adults (OA) <sup>/1</sup>		12159	175197	24299	31623	243278
Greatest Economic Need <sup>(GEN)/2</sup>		1007	14660	1752	3128	20547
Low-Income Minority <sup>/3</sup>		633	9784	695	1327	12439
Disabilities (DA) <sup>/4</sup>		1711	28237	3165	5333	38446
Language barrier (LB) <sup>/5</sup>		934	19414	2355	1765	24468
Geographic Isolation (GI) <sup>/5, 6</sup>		10992	5920	16227	18363	51502
IPD						
	Total older population <sup>/1</sup>	12159	175197	24299	31623	243278
	Land area (square mile)	622.44	599.77	1172.41	4028.02	6422.64
	Population density	19.53441	292.107	20.72568	7.85075	37.87819
	Inverse ranking	0.401894	0.026876	0.378794	1	0.207263
Living Alone in Poverty <sup>/7</sup>		275	4110	580	980	5945

/1 American Community Survey, Three Year Estimates (2005-2007), Table B01001

/2 Defined as Age 65 and over, and income below 125% FPL. Source: American Community Survey, Three year estimates (2005-2007), Table B17024

/3 Defined as: 65 yrs and over, non-white (includes Hispanic), income below FPL. Source: American Community Survey, Three Year Estimates (2005-2007), Table B17001

/4 Defined as: 65 yrs and over and having "two or more types of disabilities". Source: American Community Survey, three years Estimate (2005-2007), Table: B18001

/5 U.S. Census Bureau, Census 2000 Special Tabulation, updated with 2002 60+ estimates.

/6 A rural area is: any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

/7 Census 2000 Special Tabulation on Aging (STA), 2004. Table P087\_HI.

#### IV. Numerical Statement of Hawaii's IFF

The detailed IFF formula for each category is shown below.

	Part B	Part C1	Part C2	Part D	Part E
<b>Base Amount</b>	\$128,758	\$75,600	\$12,375	--	--
<b>Factors</b>					
Older adults (OA)	0.25	0.25	0.25		0.25
Greatest Economic Need (GEN)	0.20	0.20	0.20	0.40	0.20
Low-Income Minority (LIM)	0.10	0.10	0.10	0.20	0.10
Disabilities (DA)	0.19	0.19	0.19	0.10	0.19
Language barrier (LB)	0.07	0.07	0.07	0.08	0.07
Geographic Isolation (GI)	0.10	0.10	0.10	0.14	0.10
Living alone in poverty (LAP)	0.03	0.03	0.03	0.08	0.03
Inverse Population Density (IPD)	0.06	0.06	0.06		0.06

#### Weighted Proportions Formulas

After the base amounts are granted, the following formula is used to calculate the proportion of the remaining funds each PSA will receive.

Formula #1: Part B, C1, C2, E:

$$.25(pOA) + .20(pGEN) + .10(pLIM) + .19(pDA) + .07(pLB) + .10(pGI) + .03(pLAP) + .06(pIPD)$$

Formula #2: Part D

$$.40(pGEN) + .20(pLIM) + .10(pDA) + .08(pLB) + .14(pGI) + .08(pLAP)$$

*p is the proportion a PSA has of a specific factor.*

Based on the weights and the data above, the summary weighted proportions of each is shown below:

		<b>PSA 1 KAEA Kauai</b>	<b>PSA 2 EAD Honolulu</b>	<b>PSA 3 MCOA Maui</b>	<b>PSA 4 HCOA Hawaii</b>
Part B	Supportive Services*	7.458%	62.961%	11.700%	17.881%
Part C1	Congregate Meals	7.458%	62.961%	11.700%	17.881%
Part C2	Home-Delivered Meals	7.458%	62.961%	11.700%	17.881%
Part D	Preventive Health	7.087%	65.103%	11.313%	16.498%
Part E	Family Caregiver Support	7.458%	62.961%	11.700%	17.881%

**\*Note: Includes at least 1% for access in-home, and legal assistance services.**

**V. Descriptive Statement of Hawaii’s IFF**

Part B

Each PSA will receive a base amount of \$128,758. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part C1

Each PSA will receive a base amount of \$75,600. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part C2

Each PSA will receive a base amount of \$12,375. The remainder of the funds will be distributed using the weighted proportion formula #1.

Part D

No base amount. Funds will be distributed using the weighted proportion formula #2.

Part E

No base amount. Funds will be distributed using the weighted proportion formula #1.

**VI. Demonstration of Allocations of Title III Funds to PSAs**

Based on the weighted proportions formulas and assuming funding at 2008 level, the allocations for the PSAs are as follows:

	PSA 1	PSA 2	PSA 3	PSA 4
	KAEA (Kauai)	EAD (Honolulu)	MCOA (Maui)	HCOA (Hawaii)
Part B	\$216,703.51	\$871,151.16	\$266,714.91	\$339,601.42
Part C1	\$167,387.06	\$850,421.66	\$219,583.01	\$295,653.27
Part C2	\$80,254.22	\$585,378.29	\$118,854.65	\$175,110.84
Part D	\$7,375.69	\$67,758.25	\$11,774.38	\$17,170.67
Part E	\$56,648.50	\$478,199.09	\$88,862.44	\$135,810.96
<b>Total</b>	<b>\$528,368.98</b>	<b>\$2,852,908.45</b>	<b>\$705,789.40</b>	<b>\$963,347.17</b>

**VII. Additional Notes**

State Administrative and Title VII Allocations

The amount available for IFF allocation is calculated by subtracting from the State’s total Title III grant \$500,000 for the State to carry out the purposes of Title III (OAA Section 308(b)) and \$45,000 to conduct an effective Ombudsman program under OAA Section 703(a)(9) and OAA Section 304(d)(1)(B)). Administrative funds for EOA will be taken from Part C1. Ombudsman funds will be taken from the Part B.

Services for older adults residing in rural areas

Pursuant to OAA Section 307(a)(3)(B)(i), with respect to the services for older individuals residing in rural areas, the State will spend, for each fiscal year, not less than the amount expended for such services for fiscal year 2000.

# **APPENDIX E**

## EOA Language Access Plan



# **EXECUTIVE OFFICE ON AGING**

## **Department of Health**



# **LANGUAGE ACCESS PLAN**

## **2019**

as amended June 2019



*"E Loa Ke Ola"  
May Life Be Long*

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# LANGUAGE ACCESS PLAN

## EXECUTIVE OFFICE ON AGING

### I. INTRODUCTION

For persons with limited English proficiency (LEP), language can be a barrier to accessing important benefits or services, understanding and exercising important rights, complying with applicable responsibilities, understanding information provided by federal or state-funded programs and services, and participating in federal or state-funded programs and activities. Hence, it is important for government and government-funded entities to have policies, plans and procedures that would enable individuals with LEP to meaningfully and equally access programs and services provided by governmental entities and their sub-contractors without unreasonable delay.

The purpose of this Language Access Plan is to implement the requirements of both federal and state laws, including federal regulations and guidelines, related to language access. It is patterned after the U.S. Department of Health and Human Services (HHS) Language Access Plan of 2013, as well as the Administration for Community Living (ACL) Language Access Plan of 2014.

Language access may be defined as the use and provision of language services to individuals with LEP to enable them to meaningfully access programs, services and activities provided by government and covered entities. Language services refer to interpretation (spoken) and translation (written) services. Individuals with LEP are those whose primary language is not English and who have a limited ability to speak, read, write or understand the English language; under the U.S. Census, they are categorized as individuals who speak English less than “very well.” By “meaningful access” is meant “to be informed of, participate in, and benefit from” government programs, services and activities. Government refers to both federal and state, while “covered entities” means all agencies receiving federal or state funds, including counties, non-profit agencies and other organizations.

### II. THE EXECUTIVE OFFICE ON AGING

Hawaii’s Executive Office on Aging (EOA) is the designated lead agency at the State level that is required to plan for and offer leadership at the State and local levels in the coordination of access to home and community-based services to the older adult population. Responsibilities include planning, policy and program development, advocacy, research, information and referral, and coordination of services provided by public and private agencies for the elderly and their families.

The Older Americans Act (OAA) established a social services and nutrition services program for America’s older adults. State and area offices were established, and a nationwide “Aging Network” was created to assist older adults in meeting their physical, social, mental health, and other needs, and also to maintain their well-being and independence. The ACL heads the Aging Network at the federal level.

A. Mission

The mission of the EOA is to promote and assure opportunities for Hawaii’s older adults to achieve dignified, self-sufficient and satisfactory lives. The office pursues its mission by advocating, developing, and coordinating federal, state, and local resources for adults 60 years and older, and their caregivers.

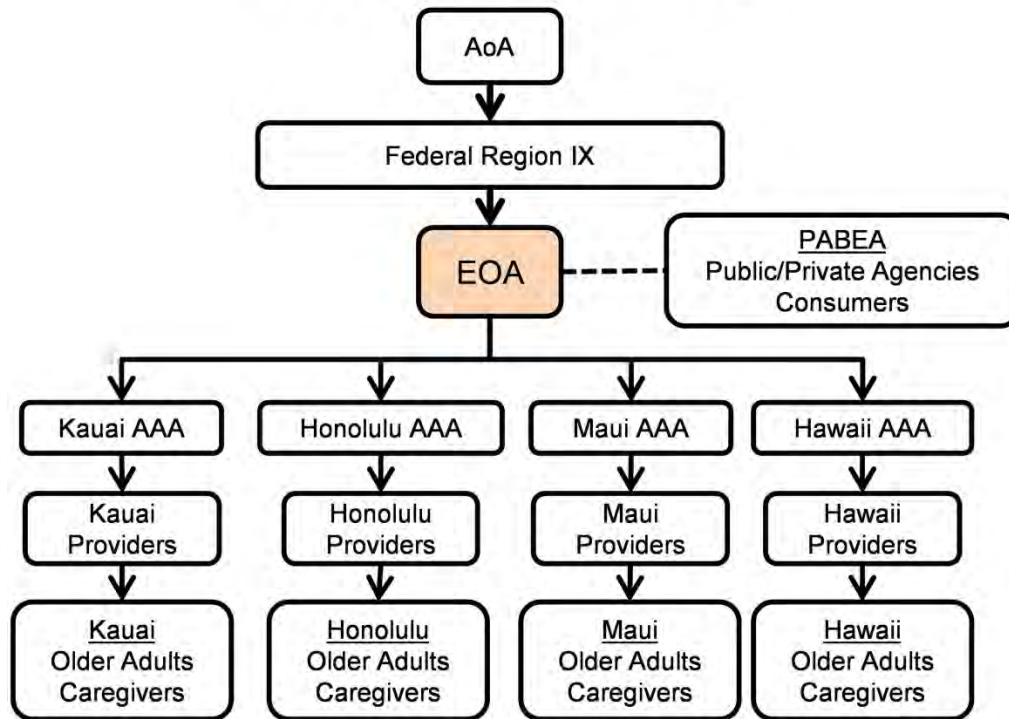
B. Areas of Coverage

The EOA has delineated the State into distinct planning and service areas for purposes of planning, development, delivery, and the overall administration of services. These four Planning and Services Areas (PSAs) include the counties of Hawaii, Honolulu, Kauai, and Maui. The following agencies have been designated by the EOA as Area Agencies on Aging:

1. Kauai Agency on Elderly Affairs (KAEA)
2. Honolulu Elderly Affairs Division (HEAD)
3. Maui County Office on Aging (MCOA)
4. Hawaii County Office of Aging (HCOA)

The Area Agencies on Aging are responsible for implementing the Older Americans Act at the local level.

**HAWAII’S AGING NETWORK**



Under the Aging Network are other organizations that provide direct services to older adults, and higher education institutions that are contracted for services. Recipients for these services in the Aging Network are adults 60 years of age and older, and their caregivers, including grandparents raising grandchildren.

#### C. Funding

The EOA is a recipient of federal and State funds. It receives formula funds based on population from the ACL under Title III and VII, and discretionary funds under Title IV, of the Older Americans Act. It also receives Title VII funds from the OAA and other federal grants to carry out elder rights and benefits programming. EOA likewise receives funds from the State Legislature for aging services (Kupuna Care and other programs).

#### D. Services, Programs, and Special Initiatives

EOA currently offers the following services, programs, and special initiatives:

1. Kupuna Care Services: These services are intended to assist older adults in remaining independent and active. Kupuna Care funds the following nine core home and community-based services: adult day care; attendant care; case management; chore; homemaker/housekeeper; personal care; assisted transportation; KC transportation; and nutrition/home delivered meals.

2. Title III OAA Services: OAA funds support the following services: family caregiver support services; access services; home and community-based services; and nutrition services.

3. Aging and Disability Resource Center: The ADRC serves as the highly visible and trusted source for people of all incomes and ages to get information on the full range of long-term services and supports, based on a “no wrong door” approach for access to public long-term support programs and benefits.

4. The Long-Term Care Ombudsman Program (LTCOP): This program provides information, outreach, and advocacy for residents of long-term care facilities. To ensure that all long-term care residents are aware of the services provided by the Long-Term Care Ombudsman, volunteers are trained and certified by the LTC Ombudsman Volunteer Program to regularly visit licensed LTC settings.

5. Hawaii SHIP (State Health Insurance Program): This program provides free health insurance information, education, counseling, and a referral service for people with Medicare. Volunteers are trained and certified to assist members and their families with questions about Medicare benefits, Medicare Advantage Program, Long-Term Care financing, and Medicare Part D – the prescription drug benefit.

6. Senior Medicare Patrol Hawaii (SMP Hawaii): The program recruits, trains, and certifies volunteers to educate seniors to prevent Medicare and Medicaid fraud,

waste, and abuse. SMP Hawaii also provides one-on-one counseling with Medicare billing errors and refers potential fraud cases to the appropriate authorities for investigation.

7. Alzheimer's Disease and Related Dementias (ADRD): This special initiative aims at developing the infrastructure necessary to build dementia-capable programs and services for the growing number of people in Hawaii with the disease and their family members and caregivers.

8. Healthy Aging Partnership: A statewide public-private partnership committed to improving the health and well-being of residents. The partnership offers evidence-based health promotion and disease prevention programs: the EnhanceFitness (EF) Program on Kauai and the Ke Ola Pono Disease Self-Management Programs-Chronic Disease Self-Management (CDSMP), Arthritis Self-Management (ASMP) and Diabetes Self-Management (DSMP) on Maui. Ke Ola Pono classes are open to adults 18 and older.

9. Participant Direction and Veteran Directed Care: This is a service model that empowers public program participants and their families by expanding their degree of choice and control over the long-term services and supports they need to live at home. Presently, EOA is using this service model in two programs: the Community Living Program (CLP) and the Veteran-Directed Care (VDC).

### **III. BACKGROUND AND LEGAL HISTORY**

#### **A. Demographic Profile**

Hawaii is one of, if not the most, diverse state in the nation. U.S. Census figures show that out of Hawaii's total population of about 1.3 million, 24.4% or approximately 311,000 people speak a language other than English at home. About 45% or approximately 141,000 people speak English less than very well (11% of total population). In this LEP population, 35% or approximately 49,350 people are age 60 years and older.

### Top Languages spoken by Older Adults in Hawaii

Language 65+	Number	Percentage
Japanese	17,290	27.2%
Ilocano	13,746	21.6%
Tagalog	10,672	16.8%
Chinese	6,926	10.9%
Korean	3,916	6.2%
Hawaiian	1,674	2.6%
Spanish	1,546	2.4%
Samoan	1,119	1.8%
Vietnamese	1,109	1.7%
German	1,053	1.7%
Other	4,620	7.3%

DBEDT report

U.S. Census Bureau. 2010-2014 American Community Survey 5-year Estimates

The above figures illustrate that Hawaii has a sizable elderly LEP population and that most of Hawaii's elderly LEP population speak Asian and Pacific Island languages.

#### B. Statutory Basis: Federal and State

##### 1. Federal Law

Language access is based on both federal and State laws. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Enforcement of Title VI necessitates that federal funding sources have policies and practices in place that ensure persons with limited English proficiency are not prohibited from having full access to all opportunities and benefits of federally-funded programs and services.

To ensure this, on August 11, 2000, former President Clinton signed Executive Order 13166, "*Improving Access to Services for Persons with Limited English Proficiency*." The Order set two overarching goals for all federal agencies: 1) improve access to federally-funded programs and activities by persons with LEP; and, 2) implement a system by which individuals with LEP can meaningfully access the agency's services.

To address the first goal, HHS issued its "*Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*" (2000; updated in 2003). HHS addressed the second goal by submitting to the Department of Justice (DOJ) its "*Strategic Plan for Improving Access to HHS Programs and Activities by Limited English Proficient (LEP) Persons*" (2000).

On February 17, 2011, U.S. Attorney General Eric Holder issued the memorandum, “*Federal Government’s Renewed Commitment to Language Access Obligations Under Executive Order 13166*” which directed agency heads, general counsels, and civil rights heads to develop a plan to ensure full compliance with Executive Order 13166. In response to this memorandum, HHS developed and published its Language Access Plan in 2013. The Plan requires each department agency (including the Administration for Community Living) to produce and submit a language access plan to be made available to the general public.

In January 2014, ACL issued its Language Access Plan. Among others, the ACL Language Access Plan provides that it will “*ensure that grantees...have programs in place that assure LEP persons have equal access and opportunities to all ACL-funded services and activities.*”

It is to be noted that ACL’s language access plan aligns with Section 305 (a) (2) (E) of the Older Americans Act, as amended in 2006, which requires that state agencies shall “*provide assurances that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, **older individuals with limited English proficiency**, and older individuals residing in rural areas)...*” Section 307 (14) of the Act also mentions that the state plan on aging (as well as the area plans on aging) shall “*include in its annual evaluation the identification of and methods used to provide services to these populations.*” Hawaii’s state and area plans on aging include these assurances.

## 2. State Law

Hawaii’s Language Access Law was passed in 2006 and amended in 2012 (Chapter 321c, HRS). Modeled after federal laws and regulations, Hawaii’s law requires all State agencies and State-funded agencies, including county and nonprofit agencies, to take reasonable steps to ensure meaningful access to services, programs, and activities by persons with LEP.

State agencies and State-funded agencies are mandated to:

- a. Assess LEP population and needs.
- b. Inform LEP population or individuals of the availability of free language services.
- a. Provide free oral and written language services, including the translation of vital documents.
  - Establish a language access plan, to be reviewed every two years and revised if necessary.
  - Designate a language access coordinator.
  - Hire bilingual personnel for existing, vacant, and budgeted public contact positions, if necessary.



#### **IV. EOA LANGUAGE ACCESS POLICY**

EOA is committed to eliminating barriers that block access to federal and State-funded services and activities by persons with low English proficiency. EOA is further committed to promote policies and procedures to enhance the availability of such services and activities.

EOA's goal for its Language Access Plan is to ensure that LEP customers receive free language and culturally-appropriate assistance. A customer is considered LEP when his/her primary language is not English and has a limited ability to speak, read, write or understand the English language.

EOA's plan will ensure that the agency is in compliance with federal and State laws on language access. In line with this, EOA will promote the linguistic and cultural competency of its contracted agencies providing EOA-funded services.

To ensure success of plan implementation, EOA will designate a Language Access Coordinator from among its staff who will implement the plan, working internally with agency staff to ensure language access requirements are met in a timely manner. The Language Access Coordinator, working with staff, grantees and stakeholders, will review/update the plan every two years to ensure that the agency's response to the linguistic needs of its customers and its outreach strategies to under-served linguistic groups remains effective.

#### **V. LANGUAGE ACCESS IMPLEMENTATION PLAN: ELEMENTS**

##### **A. Implementation**

EOA's language access policy consists of several elements that are essential for an effective language access plan. EOA's language access plan also identifies specific steps that EOA must take to implement the policy at the program level. These elements, patterned after HHS' and ACL's language access plans, are:

- Element 1: Assessment: Needs and Capacity
- Element 2: Oral Language Assistance Services
- Element 3: Written Translations
- Element 4: Policies and Procedures
- Element 5: Notification of the Availability of Language Assistance at No Cost
- Element 6: Staff Training
- Element 7: Assessment: Access and Quality
- Element 8: Stakeholder Consultation
- Element 9: Digital Information
- Element 10: Grant Assurance and Compliance
- Element 11: Language Access Plan Coordination and Implementation

## 1. Element 1 – Assessment: Needs and Capacity

EOA shall have processes in place to regularly identify and assess the language assistance needs of its current and potential customers. Additional processes shall be in place to assess the office's capacity to meet these needs according to the elements of this Plan.

### a. Four Factors

This assessment will use the four factors identified in federal regulations and State law, namely:

- (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
- (2) The frequency with which LEP individuals come in contact with the program;
- (3) The nature and importance of the program, activity or service determined by the program on people's lives; and
- (4) The resources available to the grantee/recipients and associated costs.

The purpose of this analysis is to arrive at a balance that ensures meaningful access by LEP persons to critical services without imposing undue burdens on small agencies.

### b. Description:

EOA shall assess the language assistance needs of its current and potential customers to identify policy and processes necessary to implement language assistance services that increase access to its programs and services. This assessment may include identifying non-English languages spoken by the agency's target population and whether barriers exist that hinder effective oral and written communications by individuals with LEP. Language data may be collected from various sources, including data from the U.S. Census, customer files, schools, and other agencies. EOA shall also assess its capacity to meet the needs of its current and potential customers to fulfill its commitment to provide free competent language assistance in a timely manner to LEP individuals. This assessment will also help ensure meaningful access to and provide an equal opportunity for LEP persons to participate fully in the services, programs and activities administered by the agency. This includes ensuring effective communication between individuals with LEP, agency staff, and contractors.

### c. Action Steps:

- (1) Consult staff, advocacy organizations, LEP individuals, the Office of Language Access (OLA), other experts and access applicable research to determine best practices for assessing and implementing language assistance needs.
- (2) Conduct an initial EOA language access needs assessment.
- (3) Consult with management and staff to identify existing capacity to provide language assistance services, such as identifying bilingual staff qualified to serve as interpreters, providing access to contract interpretation and

- translation services, and exploring the hiring of bilingual personnel for existing, vacant and budgeted public contact positions, if necessary.
- (4) Identify gaps where language assistance services are inadequate to meet LEP needs and to take specific steps to enhance language assistance services.
  - (5) Use data resources, such as U.S. Census data, when program-specific data is unavailable to evaluate the extent of need for language assistance services in particular languages.
  - (6) Create or modify satisfaction and other surveys for beneficiaries or customers and other means of obtaining feedback on services delivered. Collection of data identified at point of entry on preferred languages, English proficiency, and immigration trends shall be gathered in the surveys.
  - (7) Research best practices and procedures to enhance the provision of more efficient language assistance services.

## 2. Element 2 – Oral Language Assistance Services

EOA shall provide oral language assistance services (e.g., qualified interpreters or qualified bilingual staff) in both face-to-face and telephone encounters that address the needs identified in Element 1.

### a. Description:

EOA shall provide oral language assistance services to ensure that individuals with LEP will have meaningful access and an equal opportunity to participate fully in the services, programs and activities administered by the agency. Oral language assistance may be provided through a variety of means, e.g., qualified bilingual staff, contract of interpreters to include telephonic and video interpretations, interpreters from community organizations or volunteer interpreter programs. EOA shall ensure that the interpreters used are qualified to provide the service and understand ethics in client confidentiality needs. The use of family members as interpreters is not encouraged.

### b. Action Steps:

- (1) Devise criteria for assessing bilingual staff to provide services in languages other than English and to provide competent interpreter services.
- (2) Maintain a list of qualified bilingual staff capable of providing competent interpreter services in languages other than English.
- (3) Establish a list of other available resources (local or out-of-state) qualified in providing direct, telephonic or video oral language assistance to individuals with LEP.
- (4) Budget resources for providing interpretation services.
- (5) Utilize Hawaii's participation in the Western States Contracting Alliance (WSCA) contract for telephonic interpreter services.

- (6) Consult with experts (internal or external) who are able to provide technical assistance to grant recipients, sub-recipients, contractors and others to ensure awareness about the obligation to take reasonable steps to provide meaningful access and share language assistance resources and best practices.
- (7) Identify positions appropriate for making bilingual skill a selection criterion for employment, include such criterion in the position description and job announcement, and determine applicant's language skills before making hiring decisions.

### 3. Element 3 – Written Translations

EOA shall proactively identify, translate and make vital documents accessible in print and electronic media. This includes languages other than English in accordance with assessments of need and capacity conducted under Element 1.

#### a. Description:

EOA shall proactively provide written translations of its vital documents to ensure that individuals with LEP have meaningful access and an equal opportunity to participate fully in the services, programs and activities administered by the agency. EOA shall determine what constitutes vital documents and implement a translation strategy. All vital documents, regardless of language, should be easy to understand by target audiences. Matters of plain language and literacy will be considered for all documents before and after the translation process.

Vital documents include, but are not limited to: critical records and notices as part of emergency preparedness and risk communications; online and paper applications; consent forms; complaint forms; letters or notices regarding eligibility for benefits; letters or notices regarding the reduction, denial, or termination of services or benefits that require a response from an individual with LEP; written tests that evaluate competency for a particular license, job, or skill in which knowing English is not required; documents that must be provided by law; and notices regarding the availability of language assistance services for individuals with LEP. All vital documents shall be provided free of charge, at no cost to them.

#### b. Action Steps:

- (1) Identify materials already available in non-English languages, consider offering these materials in audio format with revisions as needed for quality and plain language, and update new translations are accurate, as necessary.
- (2) Identify vital documents and budget resources for translating such documents in accordance with the agency's translation program based on assessments of need and capacity. Identify documents used in areas the

program regularly encounters languages other than English in serving its customers and to provide translation in those non-English languages.

- (3) Use the services of qualified professional translators.
- (4) In the translation of vital documents, EOA shall follow federal and state safe-harbor provisions on the translation of vital documents as follows:
  - i. Written translations of vital documents shall be provided for each eligible LEP language group that constitutes 5% of that group or 1,000 LEP people, whichever is less, of the population of persons eligible to be served or likely to be affected or encountered.
  - ii. Written notice in the primary language shall be provided to the LEP language group of the right to receive competent oral interpretation of those written materials, free of charge, if there are fewer than 50 persons in a language group that reaches the 5% threshold.

#### 4. Element 4 – Policies and Procedures

EOA shall develop, implement and regularly update written policies and procedures for individuals with LEP to have meaningful access to agency programs and activities.

##### a. Description:

EOA shall establish and maintain an infrastructure to implement and improve language assistance services within the agency. The results of the assessment from Element 1 will be used to guide the development of such policies and procedures.

##### b. Action Steps:

- (1) Consult with staff and identify local and national best practices on providing language assistance services.
- (2) Develop specific procedures for the provision of language assistance services in interpretation and translation.
- (3) Develop specific procedures for receiving and addressing language assistance concerns or complaints from customers with LEP, and establish policies and procedures to improve services.
- (4) Develop training and other procedures for meaningful access and improve language assistance services for the agency.
- (5) Assess and update these policies and procedures as necessary.

#### 5. Element 5 – Notification of the Availability of Free Language Assistance

In plain language, EOA shall proactively inform individuals with LEP that language assistance is available to them free or charge and at no cost in accordance with agency needs and capacity.

a. Description:

EOA shall be responsible to ensure meaningful access to its programs. This includes notifying current and potential customers with LEP about the availability of language assistance at no cost. Notification methods may include multilingual posters, signs and brochures; and statements on application forms and informational material distributed to the public (including electronic forms on agency websites, taglines, written documents, etc.). The results from the Element 1 assessment will be used to inform the agency on the languages in which the notifications will be translated. Information about the availability of free language services shall be included in all EOA and grantee announcements and notifications.

b. Action Steps:

- (1) Display multilingual posters developed by the OLA that identify language choices and inform individuals with LEP about the availability of free language assistance.
- (2) Distribute and provide available resources directly and over the Internet to all current grantees, providers, contractors and vendors. Also, to provide technical assistance necessary to make recipients aware that language assistance services shall be provided at no cost to those in need of language assistance services.
- (3) Utilize various methods and networks to ensure the agency's target audiences are aware that language assistance services are provided at no cost to them and inform individuals with LEP that vital documents are available in languages other than English (to include public service announcements, non-English media and community- and faith-based resources).
- (4) Develop and prominently display appropriate language taglines on vital documents; web pages currently available in English only; technical assistance and outreach material; and other notices and documents notifying target audiences that language assistance is available at no cost and how to obtain them.
- (5) Highlight the availability of consumer-oriented materials in plain language and languages other than English on EOA websites and ensure such materials inform individuals with LEP about available language assistance services.

6. Element 6 – Staff Training

EOA shall commit resources and provide employee training as necessary and available to management and staff to understand and be able to implement the policies and procedures of this plan. Agency-designed training will be provided to all employees to ensure they understand the importance of providing effective communication to individuals with LEP in all programs and activities.

a. Description:

EOA shall establish and maintain an infrastructure for staff to implement and improve language assistance services within the agency. EOA will conduct staff training and regularly monitor the efficacy of training provided. EOA shall determine which staff members will receive training in related policies, procedures, and provision of language assistance services.

b. Action Steps:

- (1) Require training on language access for all new staff, with regular training on language access for all staff on a biennial basis.
- (2) Develop, make available, and disseminate training materials that assist management and staff in the procurement and provision of effective communication for individuals with LEP.
- (3) Train management and staff on the language access requirements of federal and state laws and provide training resources to promote awareness of available federal and state guidelines.
- (4) Train management and staff on cultural competency, and on Culturally and Linguistically Appropriate Services (CLAS) standards.
- (5) Train management and staff on the policies and procedures of the agency's language assistance program; on proven language assistance practices; and the use of resources available to provide language assistance to persons with LEP in a timely manner.
- (6) Train staff on the appropriateness of accessing and utilizing oral and written language assistance services; to work with interpreters and translators; to convey complex information using plain language; and to communicate effectively and respectfully with individuals with LEP.
- (7) Train appropriate staff on the procurement of translation services and assure the quality of translation.
- (8) Train bilingual staff on language competency and the ethics of interpretation and translation.

7. Element 7 – Assessment: Access and Quality

EOA shall regularly assess the accessibility and quality of language assistance activities for individuals with LEP, maintain an accurate record of language assistance services, and implement, improve or update LEP outreach programs and activities.

a. Description:

To increase availability and quality of language assistance services, EOA shall establish an infrastructure to assess and evaluate the language assistance services within the agency on an ongoing basis. In addition, EOA shall regularly monitor the efficacy of services provided to individuals with LEP. Areas of evaluation will include customer satisfaction,

quality of written translations, utilization of appropriate communication channels, and the accessibility and quality of language assistance services provided.

b. Action Steps:

- (1) Review and address complaints received from individuals with LEP regarding language assistance services provided in a timely manner.
- (2) Identify local and national best practices for continuous quality improvement regarding agency language assistance activities.
- (3) Implement methods to measure improvements in language access in individual programs and information collected in a manner that increases comparability, accuracy, and consistency across programs.
- (4) Develop and conduct an LEP customer satisfaction survey.
- (5) In all reports, require grantees to include an evaluation section dealing with the accessibility and quality of language assistance services provided.

8. Element 8 – Stakeholder Consultation

EOA shall consult with stakeholder communities to identify language assistance needs of individuals with LEP, implement appropriate language access strategies to individuals with LEP to have meaningful access in accordance with assessments of customer need and agency capacity, and evaluate programs on an ongoing basis.

a. Description:

EOA will obtain important information and insights from stakeholder communities. This information may be critical for conducting the assessments of need, capacity and accessibility under Elements 1 and 7. Stakeholders may provide EOA with qualitative and first-hand data on the needs of their current and potential individuals with LEP.

The term “stakeholder” shall always include beneficiaries but may include recipients of federal and state financial assistance, vendors, advocacy organizations, and representatives from a broad cross section of the language access community. EOA may also use studies, reports or other relevant material produced by stakeholders as forms of stakeholder input. Consultations may include gathering information through town-hall style webcasts, conference calls, letters and in-person meetings with stakeholder advocacy groups and posting information on agency websites for public comment.

b. Action Steps:

- (1) Identify opportunities to include stakeholders in the development of policies and practices that enhance access to agency programs and activities.
- (2) Consult stakeholder communities to assess the accessibility, accuracy, cultural appropriateness and overall quality of EOA’s language assistance services.



- (3) Share EOA's language access plan and resources with stakeholders and solicit feedback. Incorporate stakeholder input in EOA's language access plan, policies and procedures.

## 9. Element 9 – Digital Information

EOA shall develop and implement specific written policies and procedures for digital information accessibility by communities in need of language access.

### a. Description:

To help individuals with LEP access digital information, are aware of and can obtain important program information, and use language assistance services when conducting business with EOA, it is essential to establish and maintain an infrastructure that effectively distributes information online in a manner that provides meaningful access by individuals with LEP. EOA shall regularly monitor the efficacy and quality of services provided to include measuring the ease of use and ease of access by individuals with LEP.

### b. Action Steps:

- (1) Develop and maintain a strategy for making online information publicly available and accessible to individuals with LEP (e.g., electronic records or databases).
- (2) Display links prominently on the agency's English language website to documents and other resources that are also available for viewing or downloading in languages other than English.
- (3) Evaluate and improve its digital policies and activities to make information on its digital platforms accessible by LEP individuals.
- (4) Maintain and update a website that effectively distributes information with meaningful access to LEP persons.
- (5) Use social media to increase awareness and utilization by individuals with LEP of agency programs, activities, language assistance services, and products available in non-English languages.
- (6) Respond to feedback from stakeholders and LEP persons concerning website content.

## 10. Element 10 – Grant Assurance and Compliance

EOA shall ensure grant recipients understand and comply with their obligations under federal and state laws and regulations related to language access.

### a. Description:

While OAA grantees sign a form assuring that they will comply with federal civil rights laws, recipients generally do not fully understand their legal obligations under these laws.

Program reviews present opportunities for EOA to determine recipient compliance with both program and civil rights regulations. Staff training, site visit protocols, and adding civil rights guidance in grant announcements, requirements and policies can help recipients meet their program and civil rights obligations. In addition, EOA will monitor and improve training and site visit protocols as needed.

b. Action Steps:

- (1) Develop grant announcements that include information about the requirements for grant recipient compliance with obligations under relevant civil rights statutes and regulations enforced by federal and state governments related to language access.
- (2) Make current and prospective recipients of agency funds aware of their obligations under federal and state laws and regulations with respect to LEP accessibility (*i.e.*, persons with LEP can utilize language access services).
- (3) Add civil rights compliance language and guidance to the agency's outreach materials for compliance by program staff, sub-recipients, and contractors, to include recommendations that recipients implement language access plans.
- (4) An annual evaluation in its aging plan to identify methods used to provide services to older individuals with LEP.
- (5) Establish guidelines that instruct grantees on the use of translation services in the translation of vital and other typical documents used by LEP persons.
- (6) Inform grantees of assistance resources in developing best practices and policies for enhancing access by LEP persons to EOA-funded programs and activities.
- (7) Incorporate civil rights and language access questions into site visit and monitoring protocols.

11. Element 11 – Language Access Plan Coordination and Implementation

EOA shall designate a staff member who will be responsible for coordinating, implementing and evaluating the various elements of its language access plan.

a. Description:

For proper coordination and implementation of its language access plan, EOA shall identify and designate a staff member to be responsible for developing, coordinating, implementing and evaluating policies and procedures to enable its customers with LEP to have meaningful access to EOA programs, services and activities.

b. Action Steps:

- (1) Identify and designate an EOA language access coordinator. The coordinator may be assisted by a language access committee created for this purpose.
- (2) Conduct annual assessments.
- (3) Develop procedures for providing oral language assistance services.
- (4) Develop procedures for providing written language assistance services, to include the translation of vital documents.
- (5) The coordinator to serve as point of contact for oral and written language assistance services.
- (6) Develop procedures for receiving and addressing language access concerns and complaints.
- (7) Develop procedures for monitoring efficacy of language assistance services.
- (8) Develop and implement a strategy for notifying individuals with LEP that language assistance is available to them at no cost.
- (9) Develop and implement a training program for employees on language access laws and regulations, language access plan implementation, cultural competency, etc.
- (10) Develop and implement additional training programs for bilingual staff on the basics and ethics of interpretation and translation, terminology, and language competency.
- (11) Develop a glossary of aging and disability terminologies.
- (12) Develop and implement a process for tracking and recording language assistance data and to assess language assistance services for quality and accessibility.
- (13) Develop and implement a strategy for making online information publicly available and accessible to individuals with LEP.
- (14) Develop and implement policies and procedures for grant recipients to understand and comply with federal and state laws and regulations related to language access.

As an attached agency to the Department of Health, this Plan takes effect upon approval of the Director of the Department of Health.

Submitted by:



Caroline Cadirao, Director  
Executive Office on Aging

7/1/19

Date

APPROVED:

\_\_\_\_\_  
Bruce Anderson PhD  
Director, Department of Health

\_\_\_\_\_  
Date

## Appendix

### LANGUAGE ACCESS PROCEDURES

#### I. Service Provision Plan

##### A. Interpreter services

EOA shall take the following steps in providing service to walk-in and call-in customers:

1. Identifying a customer's language need
  - a. When a walk-in customer appears to be LEP, front-line staff will attempt to ascertain the primary language spoken by the customer.
    - i. If the customer doesn't self-identify as an LEP person or verbally identify his/her primary language, staff will ask "what language do you speak at home?"
    - ii. If verbal communication is unsuccessful, staff will ask customer to point to the "If you need an interpreter" poster which lists down 22 languages.
    - iii. The "If you need an interpreter" poster shall be posted in the bulletin board of EOA or other public areas.
  - b. When a LEP customer calls in, staff will attempt to ascertain the primary language spoken by the customer.
    - i. If the customer doesn't self-identify as an LEP person or verbally identify his/her primary language, staff will ask "what language do you speak at home?"
    - ii. If verbal communication is unsuccessful, staff will try to get hold of a bilingual staff to help ascertain the caller's primary language.
2. Providing interpreter services
  - a. After determining the customer's primary language, staff will check the agency's list of bilingual staff if somebody qualified is available for the given language.
  - b. If EOA bilingual staff does not have capability in the language needed, or if bilingual staff is not qualified, staff will consult the list of local language service providers and look for a qualified interpreter in the language needed.

- c. The use of minors, family members or friends is not encouraged, except in emergency situations.
  - d. If necessary, EOA shall enter into a contract with a local language service provider or utilize the State of Hawaii's membership in the Western States Contracting Alliance (WSCA) and its telephonic interpretation contract.
3. Documentation of interpretation services

All requests for interpretation shall be documented using a standardized tool. Documentation shall include the language, type of interpretation services used (staff, face-to-face, telephonic), and cost (if any).

4. Timeliness of service

Language assistance shall be provided at a time and place that avoids the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the individual with LEP.

## B. Translation services

1. Vital documents

- a. EOA shall identify and keep a list of its vital documents, translated or not translated, to include the type of language translated. This list should be regularly updated.
- b. EOA shall determine the non-English languages for document translations and translate them on a proactive basis using Census figures based on the safe harbor provisions of federal and state laws.

2. Other documents

Documents that are not considered vital may be translated by EOA upon request based on the four-factor analysis in V.A.1.a.

3. Correspondence in non-English languages

Correspondence (letters, emails, etc.) in non-English languages received by EOA shall be answered in the same non-English language.

4. Use of translators

EOA may use bilingual staff or volunteer translators for the translation of basic and simple documents. More complex or vital documents shall be translated by only qualified/certified translators.

5. Contracting for translation services

- a. EOA shall enter into a contract with a translation company, local or out-of-state, for the translation of its vital documents.
- b. In the contract, EOA shall include quality assurances for translated documents and community testing of translations.
- c. EOA shall be part of any WSCA contract for translation services that may be entered into by the State of Hawaii.

6. Safe harbor provisions

- a. EOA shall follow the safe harbor provisions of federal and state laws on the translation of vital documents.
- b. EOA shall adopt a proactive approach to vital document translation and shall translate vital documents into the most common languages used in Hawaii based on current U.S. Census figures and in accordance with the population thresholds identified in the safe harbor provisions. Currently, the most common languages are: Ilokano, Japanese, Tagalog, Chinese (Cantonese and Mandarin), and Korean.

## **II. Staff Training**

EOA shall provide training for all staff (new and existing) in collaboration with the Office of Language Access, the UH Center for Interpretation and Translation Studies, and other agencies.

A. For all staff:

EOA shall require an initial training for new employees and regular (biennial) training for all employees on the following topics:

1. Language access laws and requirements (federal and state)
2. EOA language access plan

3. Cultural competency/CLAS standards
4. Working with interpreters/translators

B. For bilingual staff:

In addition to the above trainings, EOA shall require its bilingual staff to have the following trainings to ensure bilingual staff competency:

1. Ethics of interpretation and translation
2. Basics of interpretation and translation
3. Aging and related terminology
4. Language competency in source and target languages

Attachment 1: List of EOA Bilingual Staff

EXECUTIVE OFFICE ON AGING

LIST OF BILINGUAL STAFF  
(2015)

Name	Foreign Language(s)	Proficiency: Speaking*	Proficiency: Reading*	Proficiency: Writing*
1. Lum, Josephine	<ul style="list-style-type: none"><li>• Cantonese</li><li>• Mandarin</li></ul>	A D	C C	D D
2. McDermott, John	<ul style="list-style-type: none"><li>• Spanish</li></ul>	D	B	D

\* Proficiency: A fluent or native/near-native proficiency  
B professional or advanced proficiency  
C conversational or limited working proficiency  
D beginner or elementary proficiency



## Attachment 2: List of Language Service Providers in Hawaii



### HAWAII STATE DEPARTMENT OF HEALTH HEALTHY PEOPLE · HEALTHY COMMUNITIES · HEALTHY ISLANDS

DOH and those it funds to provide services must provide access to persons with limited English proficiency and/or with disabilities. Some resources:

**Language Interpreters referral**

Helping Hands Hawaii Bilingual Access Line 526-9724

[http://www.helpinghandshawaii.org/bilingual\\_access\\_line/](http://www.helpinghandshawaii.org/bilingual_access_line/)

Language Services Hawaii -phone 393-7060

<http://languageserviceshawaii.com/>

Pacific Gateway Center - Hawaii Language Bank 851-7005

<http://www.pacificgatewaycenter.org/hawaii-language-bank.html>

**Language Interpreters list**

Hawaii Interpreters and Translators Association Membership Directory

<http://www.hawaiitranslators.com/>

State Judiciary Court Interpreter Registry

[http://www.courts.state.hi.us/services/court\\_interpreting/list\\_of\\_registered\\_interpreters.html](http://www.courts.state.hi.us/services/court_interpreting/list_of_registered_interpreters.html)

**Sign language interpreters referral**

Hawai'i Interpreting Service 394-7706

<http://interpretinghawaii.com/>

Isle Interpret (855) 475-3874

<http://isleinterpret.com/>

**Sign language interpreter list +**

Disability and Communication Access Board (list as of 9/14)

<http://health.hawaii.gov/dcab/files/2014/09/Communication-Access-Providers-List.pdf>

Island Skill Gathering (V. Miehstein) 732-4622

<http://www.isghawaii.com/isgteam.html>

**What qualifies as "access"**

Means to be informed of, participate in, and benefit from the services, programs, and activities offered by the State and who it funds to do those services. Access is provided through the free provision of oral information and/or through the provision of translation of vital documents.

**What qualifies as "State assistance"**

Grants, purchase-of-service contracts, or any arrangement by which the State provides funds or to a person or organization for the purpose of rendering services to the public. This includes Med-QUEST. As recipients of state aid they are subject to the requirements of HRSS321C-2 and HRSS368-1.5.

**What qualifies as "Federal assistance"**

Grants or in-kind to a person or organization, to Health care providers participating in CHIP and Medicaid programs, to hospitals and nursing homes under Medicare Part A, to Medicare Advantage Plans (e.g., HMOs and PPOs) under Medicare Part C, and to Prescription Drug Plan sponsors and Medicare Advantage Drug Plans under Medicare Part D. (Medicare Part B is not considered Federal financial assistance.) As recipients of Federal aid, these entities are subject to the nondiscrimination requirements under Title VI and the Americans with Disabilities Act.

Affirmative Action Office 100814r



Attachment 3: Preliminary List of EOA Vital Documents

EXECUTIVE OFFICE ON AGING  
Department of Health

LIST OF VITAL DOCUMENTS\*

Name of Document	# Pages	Languages Translated Into	Year Translated	Where Original is Located
1. SMP Volunteer Packet		None.		
2. SMP Letter to Applicant	4	None.		
3. SMP Application Form	4	None.		
4. SMP Volunteer Roles	16	None.		
5. Code of Ethics Agreement	1	None.		
6. SMP Volunteer Agreement	3	None		
7. Consent to Perform Driver's License and Records Check	2	None.		
8. Photo Release	1	None.		
9. Volunteer Handbook	27	None.		
10. HRS Chapter 90	4	None.		
11. Contact Us (online form)	1	None (uses Google Translate).		
12. Introduction to Social Security		Arabic, Armenian, Chinese, Farsi, French, Greek, Haitian Creole, Hmong, Italian, Korean Polish, Portuguese, Russian, Somali, Spanish, Tagalog, Vietnamese		
13. The Social Security Number		Same as above.		
14. Work and Earnings		Same as above.		

15. Retirement and Survivor Benefits		Same as above.		
16. Disability Benefits		Same as above.		
17. Supplemental Security Income Benefits		Same as above.		
18. Appeals		Same as above.		
19. Subjects of Special Interest		Same as above.		
20. Medicare		Same as above.		
21. How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings		Spanish.		
22. Traveling? A New Medicare Program May Affect You		Spanish.		
23. What is Medicare? What is Medicaid?		Spanish.		
24. Welcome to Medicare Preventive Visit: 6 Things You Should Know		Spanish.		
25. Welcome to Medicare Q&A		Spanish.		
26. Medicare Physician Quality Reporting Initiative (PQRI) Letter		Spanish.		
27. Understanding the “Notice of Premium Payment Due” Form		Spanish.		
28. Getting Medical Care & Prescription Drugs in a Disaster or Emergency Area		Spanish.		
29. Coordination of Benefits: Getting Started		Spanish.		
30. Medicare’s National Mail-Order Program for Diabetic Testing Supplies		Spanish.		
31. Understanding Medicare Part C & D Enrollment Periods		Spanish.		

32. Your Guide to Medicare's Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program		Spanish.		
33. Durable Medical Equipment and Supplies: A Program to Save You Money & Ensure Quality Services		Spanish.		
34. Bridging the Coverage Gap		Spanish.		
35. Enrolling in Medicare Part A & Part B		Spanish.		
36. Women and Heart Disease		Spanish.		
37. Electronic Prescribing		Spanish.		
38. Accountable Care Organizations and You: Frequently Asked Questions (FAQs) for People with Medicare		Spanish.		
39. Medicare Basics		Spanish.		
40. 2015 Medicare Costs		Spanish.		
41. Medicaid: Getting Started		Spanish.		
42. Medicare Helps Cover Diabetes Services and Supplies		Spanish.		
43. Medicare & You 2015		Spanish.		
44. Medicare: Getting Started		Spanish.		
45. MyMedicare.gov Blue Button Conference Card		Spanish.		
46. MyMedicare.gov-Medicare.gov Conference Card		Spanish.		
47. Get Your Medicare Questions Answered		Spanish.		
48. 4 Programs That Can		Spanish.		

Help You Pay Your Medical Expenses				
49. A Quick Look at Medicare		Spanish.		
50. Withholding Medicare Prescription Drug Premiums from your 2015 Social Security Payment		Spanish.		
51. Meeting with Agents One-on-One		Spanish.		
52. Medicare Supplemental Insurance: Getting Started		Spanish.		
53. You Can Help Protect Yourself and Medicare from Fraud Committed by Dishonest Suppliers		Spanish.		
54. Resident Rights		Bicolano, German, Spanish, Samoan, Ilokano, Korean, Chinese, Cantonese, Japanese		
55. Resident Rights (Minnesota)		Somali, Russian, Hmong, Lao		
56. Resident Rights (Illinois)		Russian, Polish, Spanish, Korean, Chinese		
57. Resident Rights (New Hampshire)		Polish, French, German, Italian, Greek, Portuguese, Spanish		
58. Resident Rights (Ohio)		German		
59. Resident Rights (California)		Spanish, Tagalog, Chinese		
60. Resident Rights (Wisconsin)		Hmong		
61. Resident Rights (Hawaii)		Laotian, Samoan, Ilokano, Chinese		
62. Living in a Nursing Home: Tips for New Residents (Hawaii)		Ilokano, Chinese, Japanese		
63. Resident Rights (NF)		Ilokano, Vietnamese, Korean, Japanese		
64. Resident Rights (ARCH)		Ilokano, Vietnamese,		

		Korean, Chinese, Japanese		
65. Hawaii LTCOP Brochure		Korean, Japanese, Ilokano, Chinese		
66. ADRC Hawaii Brochure		Korean, Chinese, Japanese, Spanish, Hawaiian, Ilocano, Samoan, Tongan, Tagalog, Marshallese		
67.				
68.				
69.				
70.				

\* Vital documents are documents (hard copy or electronic) that contain information that is critical for obtaining government services and/or benefits, or are required by law. They include, but are not limited to: critical records and notices as part of emergency preparedness and risk communications; intake and application forms; consent and complaint forms; letters or notices pertaining to eligibility for benefits; notices of rights and disciplinary action; letters or notices pertaining to the reduction, denial, or termination of services or benefits; letters or notices that require a response from an individual with LEP; prison rulebooks; written tests that evaluate competency for a particular license, job, or skill for which knowing English is not required; notices regarding the availability of language assistance services for individuals with LEP at no cost to them; signs; and outreach and other documents that contain critical information for accessing benefits and services.



## Attachment 4: OLA Multilingual Poster



**Please point here if you need an interpreter  
in this language (at no cost to you).**



<b><u>Hawai‘ian:</u></b>	E kuhikahi mai ‘oe i ‘ane‘i ke pono ka mahele‘olelo (‘a‘ohe kākī).
<b><u>日本語 (Japanese):</u></b>	日本語の通訳が必要な方は、ここを指差してください(通訳費用はかかりません)。
<b><u>한국어 (Korean):</u></b>	통역을 필요로 하시면 다음 약속일 전에 반듯이 통역이 필요하다고 말씀하셔야합니다. 비용은 부담않아서도됩니다.
<b><u>普通话(华语/國語) (Mandarin):</u></b>	如果您需要讲普通话的免费翻译, 请指这里。(如果您需要講國語的免費翻譯, 請指這裡。)
<b><u>廣東話 (Cantonese):</u></b>	如果您需要講廣東話的免費翻譯, 請指這裡。
<b><u>Ilokano:</u></b>	No masapulmo ti paraipatarus iti Ilokano nga awan bayadna, pakitudom ditoy.
<b><u>Tagalog:</u></b>	Kung kailangan mo ng libreng tagasalin sa Tagalog, pakituro lamang dito.
<b><u>Cebuano (Visayan):</u></b>	Kung kinahanglan nimo ug libre nga tighubad sa Binisaya, itudlo lang diri.
<b><u>Tiếng Việt (Vietnamese):</u></b>	Xin chỉ vào đây nếu bạn cần thông dịch viên cho ngôn ngữ này (bạn sẽ được cung cấp thông dịch viên miễn phí).
<b><u>မြန်မာ (Myanmar):</u></b>	သင်နားလည်သောစကားနှင့်, ဘာသာပြန်အလိုရှိပါက ယခုနေရာသို့ညွှန်ပြပါ။ အထက်ပါစကား အတွက်နေ့ကတ်တခေါက်ဆက်သွယ်ရန်လိုအောင်းလျှင်မည်။
<b><u>ภาษาไทย (Thai):</u></b>	กรุณาชี้มาที่ข้อความนี้ ถ้าคุณต้องการล่ามภาษาไทย (โดยที่คุณไม่ต้องเสียค่าใช้จ่ายใดๆ)
<b><u>ភាសាខ្មែរ (Khmer):</u></b>	សូមបង្ហាញនៅក្រុងនេះមក បើសិនជាអ្នកត្រូវការអ្នកបកប្រែជាភាសានេះ (អ្នកមិនត្រូវការថវិកាយ៉ាងអ្វីទាំងអស់)។
<b><u>ອັກສອນລາວ (Lao):</u></b>	ກະ, ນາຊີ ໃສ່ ບໍ່ ອັນນີ້ ຖ້າ ທ່ານ ຕ້ອງການ ວ່າ ພາສາລາວ (ໂດຍ ທ່ານ ບໍ່ ຕ້ອງ ຈ່າຍ ວ່າ ຈ່າຍໃດໆ)
<b><u>Marshallese:</u></b>	Jouj im jitōñe ijin elañe kwoj aikuji juōñ am ri-ukok ilo kajin in (ejjelok wōñāñ ñan yuk).
<b><u>Chuukese:</u></b>	Itini awenewenan ikeei ika pwūn kopwe néunéú emén chón chiakú nón fóosun eei lénú (kosap wisenméeni noum eei chón chiakú).
<b><u>Chamorro:</u></b>	Matka pat apunta este yangen un nesisita intetpiti gi fino Chamorro (dibadi este na silbesio).
<b><u>Pohnpeian:</u></b>	Menlau idih wasa ma ke anahne soun kawehwe (sohte isais).
<b><u>Kosraean:</u></b>	Nunak munas srismgingac aen se nge fwīn kom enenu met in top nuke kahs lom an sifacna (kom ac tia moli).
<b><u>Yapese:</u></b>	Fa'anra bet'uf bae' ninge ayweg nem nge abweg e thin rom (ni dabmu pii' pulwon) meere mog aray.
<b><u>Yapese (Outer Island):</u></b>	Gobe sor gare go tipeli bwo semal yebe gematfa kepatal menel le yetwai yor paluwal ngalug.
<b><u>Samoan:</u></b>	Fa'amolemole tusi lou lima i' i' pe 'ā 'e mana'omia se fa'amatala'upu i le gagana lea (e te lē tofogiina se tupe).
<b><u>Tongan:</u></b>	Tuhu ki heni kapau 'e fiema'u ha taha ke fakatonulea 'oku ta'etotongi.
<b><u>Русский (Russian):</u></b>	Если вам нужен бесплатный переводчик русского языка, пожалуйста укажите пальцем на это предложение.
<b><u>Español (Spanish):</u></b>	Por favor señale aquí con el dedo si necesita un intérprete (sin ningún costo para usted).

For more information, please contact: \_\_\_\_\_



**NEIL ABERCROMBIE**  
Governor  
State of Hawai'i

Attachment 5: LEP Intake Form

**Limited English Proficient (LEP) Encounter Report**

Department – Division – Office: \_\_\_\_\_

Date of Encounter: \_\_\_\_\_ Time of Encounter: \_\_\_\_\_

Language Encountered:

Cantonese  Chuukese  Hawaiian  Ilokano  Japanese  Korean   
Kosraean  LEP Hearing Impaired  Mandarin  Marshallese   
Phonpeian  Portuguese  Samoan  Spanish  Tagalog  Thai   
Tongan  Vietnamese  Visayan  Other  \_\_\_\_\_

Was Oral Language Service Provided?

Yes

What type of interpreter?

- Paid In-Person Oral Interpreter
- By Staff 
  - Within Job duty
  - Volunteer from other department/division/unit
- Contracted Interpreter 
  - Via Interpreter Agency
  - Independent
- Live Paid Telephonic Interpreter
- Community Volunteer
- Other  \_\_\_\_\_

Was a written document orally translated for the LEP? Yes

Was Written Language Service (Translation) Provided?

Yes

What type of Translator?

- By Staff 
  - Within Job duty
  - Volunteer from other department/division/unit
- Contracted Translator 
  - Via Translation Agency
  - Independent
- Community Volunteer
- Other  \_\_\_\_\_

Document: \_\_\_\_\_



## Attachment 6: LEP Reporting Tool

LANGUAGE ACCESS REPORTING TOOL		Period Covered:													
LEP Services by Language		Department:													
Contact Person:		Email:													
		Phone:													
1	2	3						4		5			6		
Language	# of Oral Language Encounters	Oral Language Service Utilized (#)						Translated Documents (#)		Translator Used (#)					Totals (Columns 2 & 4)
		Bilingual Staff (Provides Direct Services in Another Language)	Community Volunteer	In-Person Contracted Interpreter (Agency)	In-Person Contracted Interpreter (Independent)	Telephone Interpreter	Other (including sight Translation)	# of Documents Translated Upon Request	# of Vital Documents Translated	Staff	Contracted (Agency) Translation Services	Contracted (Independent) Translation Services	Community Volunteer	Other # Only (Specify on Separate Sheet)	
Cantonese															0
Chuukese															0
Hawaiian															0
Ilokano															0
Japanese															0
Korean															0
Kosraean															0
LEP Hearing Impaired															0
Mandarin															0
Marshallese															0
Portuguese															0
Samoa															0
Spanish															0
Tagalog															0
Thai															0
Tongan															0
Vietnamese															0
Visayan (Cebuano)															0
Other Total #*															0
<b>Totals</b>	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
*Specify Type of Other Language on a Separate Sheet															
<b>Expenditures:</b>															
<b>Interpretation Total</b>		<b>Translation Total</b>						<b>Interpretation &amp; Translation Total</b>						\$0.00	

## LANGUAGE ACCESS ASSESSMENT AND PLANNING TOOL

**Name of Agency:** \_\_\_\_\_

### 1. Understanding How LEP Individuals Interact with Your Agency

The following series of questions helps agencies understand how an LEP individual may come into contact with your agency.

1. Does your agency interact or communicate with the public or are there individuals in your agency who interact or communicate or might interact or communicate with LEP individuals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Please describe the manner in which your agency interacts with the public or LEP individuals.	<input type="checkbox"/> In-Person <input type="checkbox"/> Telephonically <input type="checkbox"/> Electronically (e.g. email or website)	<input type="checkbox"/> Via correspondence <input type="checkbox"/> Other (please specify)
3. Does your agency <i>receive</i> federal and/or state financial assistance? (Financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance.)	<input type="checkbox"/> Yes <input type="checkbox"/> Federal only <input type="checkbox"/> State only <input type="checkbox"/> Federal and State	<input type="checkbox"/> No
4. Does your agency <i>provide</i> federal and/or state financial assistance to any non-federal entities? (Financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. Recipients of funds can range from state and local agencies, to nonprofits and other organizations.)	<input type="checkbox"/> Yes <input type="checkbox"/> Federal only <input type="checkbox"/> State only <input type="checkbox"/> Federal and State	<input type="checkbox"/> No
5. If your agency does provide financial assistance to non-federal entities: <ul style="list-style-type: none"> <li>a. Do you have an active program in place to require your recipients of financial assistance to comply with federal and state language access standards?</li> <li>b. Does your agency inform recipients of financial assistance that they should budget for language assistance services?</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</li> <li><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</li> </ul>	

c. Does your agency inform recipients of financial assistance about which grants can be used, in whole or in part, to improve language access?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
--	--

**2. Identification and Assessment of LEP Communities**

The following series of questions aims to identify the LEP population you serve:

<p>1. How does your agency identify LEP individuals? (Select all that apply)</p>	<input type="checkbox"/> Assume limited English proficiency if communication seems impaired <input type="checkbox"/> Based on written material submitted to the agency, e.g. complaints <input type="checkbox"/> Respond to individual requests for language assistance services <input type="checkbox"/> We have not identified non-English speakers or LEP individuals <input type="checkbox"/> Self-identification by the non-English speaker of LEP individual <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Ask open-ended questions to determine language proficiency on the telephone or in person <input type="checkbox"/> Use of "I Speak" language identification cards or posters
<p>2. Does your program have a process to collect data on:</p> <p>a. The number of LEP individuals that you serve?</p> <p>b. The number of LEP individuals in your service area?</p> <p>c. The number and prevalence of languages spoken by LEP individuals in your service area?</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Don't know</p>
<p>3. How often does your agency assess</p>	<input type="checkbox"/> Annually <input type="checkbox"/> Not sure

the language data for your service area?	<input type="checkbox"/> Biennially	<input type="checkbox"/> Other: _____
4. What data does your agency use to determine the LEP communities in your service area? (Select all that apply)	<input type="checkbox"/> Census <input type="checkbox"/> Department of Education <input type="checkbox"/> Department of Labor <input type="checkbox"/> DBEDT <input type="checkbox"/> State Agencies	<input type="checkbox"/> Community organizations <input type="checkbox"/> Intake information <input type="checkbox"/> Other: _____
5. Do you collect and record primary language data from individuals when they first contact your programs and activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Don't know
6. If you collect and record primary language data, where is the information stored?		
7. What is the total number of LEP individuals who use or receive services from your program each year?		
8. How many LEP individuals attempt to access your programs or services each month?		
9. How many LEP individuals use your programs or services each month?		
10. Specify the top six most frequently encountered non-English languages by your program and how often these encounters occur (e.g., 2-3 times a year, once a month, once a week, daily, constantly).	Language 1. 2. 3. 4. 5. 6.	Frequency of Encounters 1. 2. 3. 4. 5. 6.

### 3. Providing Language Assistance Services

The following set of questions will help you assess how well your agency is providing language assistance services to LEP individuals:

1. Does your agency currently have a system in place for tracking the type of language assistance services it provides to LEP individuals at each interaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
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<p>2. What data, if any, do you maintain regarding language assistance services? (Select all that apply)</p>	<input type="checkbox"/> Primary language of persons encountered or served <input type="checkbox"/> Use of language assistance services such as interpreters and translators <input type="checkbox"/> Funds or staff time spent on language assistance services <input type="checkbox"/> Number of bilingual staff <input type="checkbox"/> Cost of interpreter services <input type="checkbox"/> Cost of translation of materials into non-English languages <input type="checkbox"/> Other (please specify): _____
<p>3. Does your agency have a system to track the cost of language assistance services?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<p>4. What types of language assistance services does your agency provide? (Select all that apply)</p>	<input type="checkbox"/> Bilingual staff <input type="checkbox"/> In-house interpreters (oral) <input type="checkbox"/> In-house translators (documents) <input type="checkbox"/> Contracted interpreters <input type="checkbox"/> Contracted translators <input type="checkbox"/> Telephone interpretation services <input type="checkbox"/> Video interpretation services <input type="checkbox"/> Language bank or dedicated pool of interpreters or translators <input type="checkbox"/> Volunteer interpreters or translators <input type="checkbox"/> Interpreters or translators borrowed from another agency <input type="checkbox"/> Other (please specify): _____
<p>5. Does your agency a) have a certification or assessment process that staff must complete before serving as interpreters or translators for LEP individuals? b) Does the process include use of standardized language proficiency exams?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<p>6. Does your agency ask or allow LEP individuals to provide their own interpreters or have family members or friends interpret?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

7. Does your agency have contracts with language assistance service providers (in-person interpreters, telephone interpreters, video interpreters, or translators)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
8. Does your agency provide staff with a list of available interpreters and the non-English languages they speak, or information on how to access qualified interpreters?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
9. Does your agency identify and translate vital documents into the non-English languages of the communities in your service area?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
10. Which vital written documents has your agency translated into non-English languages	<input type="checkbox"/> Consent forms <input type="checkbox"/> Applications to participate in programs or activities or to receive benefits or services <input type="checkbox"/> Complaint forms <input type="checkbox"/> Intake forms <input type="checkbox"/> Notices of rights <input type="checkbox"/> Notice of denial, loss or decrease in benefits or services <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> Notice of disciplinary action
11. Does your agency translate signs or posters announcing the availability of language assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
12. When your agency updates information on its website, does it also add that content in non-English languages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

#### 4. Training of Staff on Policies and Procedures

The following series of questions will help you identify whether staff receive appropriate training on your language access policies and procedures:

1. Does all agency staff receive initial and periodic training on how to access and provide language assistance services to LEP individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Who receives staff training on working with LEP individuals? (Select all that apply)	<input type="checkbox"/> Management or senior staff <input type="checkbox"/> Bilingual staff <input type="checkbox"/> New employees

	<input type="checkbox"/> Employees who interact with or are responsible for interactions with non-English speakers or LEP individuals	<input type="checkbox"/> All employees <input type="checkbox"/> Volunteers <input type="checkbox"/> Others (please specify): _____
3. Are language access policies and LEP issues included in the mandatory training curriculum for staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
4. Does your agency staff procedural manual or handbook include specific instructions related to providing language assistance services to LEP individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
5. Does staff receive periodic training on how to obtain and work with interpreters?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
6. Does staff receive periodic training on how to request the translation of written documents into other languages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
7. Do staff members who serve as interpreters receive regular training on proper interpreting techniques, ethics, specialized terminology, and other topics?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
8. Do staff members who serve as interpreters receive interpreter training from competent interpreters or other trainers familiar with the ethical and professional requirements of an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	

### 5. Providing Notice of Language Assistance Services

The following series of questions will help you assess how you provide notice of language assistance services to the LEP population in your service area:

1. How do you inform members of the public about the availability of language assistance services? (Select all that apply)	<input type="checkbox"/> Frontline and outreach multilingual staff <input type="checkbox"/> Posters in public areas <input type="checkbox"/> "I Speak"	<input type="checkbox"/> Social networking website (e.g., Facebook, Twitter) <input type="checkbox"/> E-mail to
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	language identification cards distributed to frontline staff <input type="checkbox"/> Website	individuals on a list serve <input type="checkbox"/> Other (please specify): _____ <input type="checkbox"/> None of the above
2. Do your translated program outreach materials inform LEP individuals about the availability of free language assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
3. Does your agency regularly advertise on non-English media (television, radio, newspaper, and websites)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
4. Does your agency inform community groups about the availability of free language assistance services for LEP individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
5. Does your agency inform current applicants or recipients about the availability of language assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
6. Does the main page of your agency website include non-English information that would be easily accessible to LEP individuals?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
7. Does your agency have multilingual signs or posters in its offices announcing the availability of language assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know

## 6. Monitoring and Updating a Language Access Plan, Policies and Procedures

The following set of questions will help you assess whether you have an effective process for monitoring and updating your language access plan, policies and procedures:

1. Does your agency have a written language access plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
2. If so, is a description of this plan available to the public?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't know
3. How often is your agency's language	<input type="checkbox"/> Annually	<input type="checkbox"/> Not sure



access plan reviewed and updated?	<input type="checkbox"/> Biennially <input type="checkbox"/> Other: _____
4. When was the last time your agency's language access plan was updated?	Month _____ Year _____
5. How often does your agency update its data on the LEP communities in your service area?	<input type="checkbox"/> Annually <input type="checkbox"/> Not sure <input type="checkbox"/> Biennially <input type="checkbox"/> Other: _____
6. Does your agency have a language access coordinator?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. Does your agency have a formal language access complaint process?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
8. Has your agency received any complaints because it did not provide language assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
9. Do you monitor the system for collecting data on beneficiary satisfaction and/or grievance/complaint filing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
10. Do you obtain feedback from the LEP community on the effectiveness of your language access program and the language assistance services you provide?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

## 7. Digital Information

The following set of questions will help you assess whether policies and procedures exist to ensure that digital information is accessible by LEP communities.

1. Does your agency have a strategy for making its publicly available online information accessible to the LEP community?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Does your English language website prominently display links to documents or resources that are in non-English languages?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. Does your agency have a plan to make its website multilingual?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Does your agency explore opportunities to leverage social media to increase awareness and utilization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

by LEP individuals of programs, activities, language assistance services, and products available in non-English languages?	
5. Does your agency respond to feedback from stakeholders and LEP persons concerning website content?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

## 8. Grant Assurance and Compliance

The following set of questions will help you assess whether you have a process for ensuring that grant recipients understand and comply with language access laws and regulations.

1. Does your agency include information about language access requirements in all grant announcements?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. Does your agency make current and prospective fund recipients aware of their obligations under language access laws and regulations?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
3. Does your agency add language access and other civil rights compliance language and guidance in all grantee contracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
4. Does your agency instruct grantees on what documents need translation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. Does your agency inform grantees on how to obtain assistance in developing best practices for enhancing access by LEP persons to EOA-funded programs and activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Are language access and other civil rights questions incorporated in your agency's site visit or monitoring protocols?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

# **APPENDIX F**

## Emergency Preparedness Plan

# **HAWAII DEPARTMENT OF HEALTH**

## **Executive Office on Aging**



## **CONTINUITY OF OPERATIONS PLAN**

**Issue Date: April 27, 2017**

**Revised date: June 3, 2019**

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**I. RECORD OF CHANGES**

<b>COOP Coordinator</b>			
<b>Name</b>	<b>Title</b>	<b>Telephone Number</b>	<b>E-Mail</b>
Caroline Cadirao	Interim Director	586-7297	caroline.cadirao@doh.hawaii.gov

<b>Date</b>	<b>Page Number</b>	<b>Brief Description of Change Made</b>	<b>Person(s) Making Change</b>
3/2/15	6	Delete David. Add Jun	jc
3/2/15	9	Delete Wesley, David and Heather. Add Terri	jc
3/2/15	11	Delete Wesley, David and Heather. Add Terri and Jun. Move Ashley and Charles	
3/2/15	12	Change # of employees	jc
3/2/15	13	Delete Wesley, David and Heather. Add Terri and Jun	jc
3/2/15	16	Add EOA Phone Tree	jc
3/2/15	18	Change # employees	jc
8/26/16	5	Delete Jun – Update Charles’ info	jc
8/26/16	6	Change font size to 11 pt	jc
8/26/16	8	Delete Jun, Nancy, Adele, Pamela	jc
8/26/16	10	Update and delete Position titles – Delete Ashley, Nancy, Pamela, Jun, Adele – Move Josephine, April, and Charles	jc
8/26/16	13	Delete Adele, Jun, Pamela, Sharon, Nancy, Ashley – Add Aaron, Loren, Debbie	jc
8/26/16	16	Delete Phone tree info	jc
8/26/16	18	Change # of Employees	jc
4/26/17	7	Updated the “Continuity Planning Team Organization” Table to reflect EOA’s current staff.	ln
4/26/17	9	Updated the “Order of Succession” table to reflect EOA’s current staff.	ln
4/26/17	10	Change # employees to reflect EOA’s current staff.	ln
4/26/17	11	Updated the “Continuity Communications – Internal” Table to reflect EOA’s current staff and staff’s current contact information.	ln
4/26/17	16	Change # employees to reflect EOA’s current staff.	ln
4/30/19	iii	Delete former EOA Director, Terri Byer Byers to reflect Interim EOA Director Caroline Cadirao	ln

<b>Date</b>	<b>Page Number</b>	<b>Brief Description of Change Made</b>	<b>Person(s) Making Change</b>
4/30/19	4	In the “Continuity Planning Team Organization” table replaced Charles Nagatoshi, Evaluation Analyst with Cristina Valenzuela, Legal Services Developer.	ln
4/30/19	7	Updated the EOA staff assignments for the EOA Incident Command Positions.	ln
4/30/19	9	Updated the Order of Succession to reflect current EOA staff as of 4/30/19.	ln
4/30/19	11	Updated the “Continuity Communications – Internal EOA List” to reflect current EOA staff as of 4/30/19.	ln
5/1/19	14	Updated the “EOA Phone Tree” table to reflect current EOA staff as of 4/30/19.	ln
5/1/19	14	Updated the “EOA Phone Tree” to reflect current EOA staff as of 4/30/19.	ln
5/1/19	16	Updated the “Organizational Census with Employee Pandemic Influenza Risk Assessment Table” to reflect the 18 full time employed EOA staff as of 4/30/19.	ln
6/3/19	7	Updated the “Incident Command System” Table to reflect current EOA Staff as of 6/3/19,	ln
6/3/19	9	Updated the “Order of Succession” Table to reflect current EOA Staff as of 6/3/19	ln
6/3/19	10	Updated the date of the current number of filled positions to “June 2019”.	ln
6/3/19	11	Updated the “Continuity Communications – Internal EOA List” to reflect current EOA staff as of 6/3/19.	ln
6/3/19	14	Updated the “EOA Phone Tree” table to reflect current EOA staff as of 6/3/19.	ln
6/3/19	16	Updated the “Organizational Census with Employee Pandemic Influenza Risk Assessment Table” to reflect the 17 full time employed EOA staff as of 4/30/19.	ln



<b>Date</b>	<b>Page Number</b>	<b>Brief Description of Change Made</b>	<b>Person(s) Making Change</b>

## **II. PREFACE**

*[\*\*Note that individual divisions/programs should develop their own preface; however, DOCD's template is provided as a starting reference\*\*]*

Planning at its best is anticipating and making provisions for the future to avoid events that can disrupt and possibly devastate an organization and a community. Such events may range from minor and restricted to one area or a particular population to major and extensive, including an entire county, the entire state, or beyond. However, even an event as seemingly minor as a power outage can cause major disruptions. Hospitals must switch to emergency generators, elective surgeries might be postponed, people may become trapped or worse in halted elevators, and non-operating traffic lights can result in extreme traffic congestion or worse, accidents.

A well-conceived continuity of operations plan or (COOP) encourages individuals to consider the resources needed and the most basic aspects of an organization's operations to ensure the continuity of operations under the most inconvenient or disastrous situations. What are the essential functions that must be performed to operate as demanded by stakeholders? More pragmatically, what records and files are essential for conducting basic operations, who is in charge if one or more key individuals are not able to perform their duties, and where and how does an organization operate if displaced from the regular physical space (i.e., offices destroyed or deemed inaccessible/unusable)?

Although the material in this manual is directed toward establishing an all hazards COOP, certain disasters present unique challenges. For this reason, one particular type of disaster – pandemic influenza – is addressed distinctly in some sections. Pandemic influenza is a disaster of a very special kind. It defies most of the conventional planning wisdom that applies to other hazards. Whereas natural disasters and even terrorist attacks affect many people and some quite severely in a limited geographical area, an influenza pandemic “affects all of us” in time and is not limited to a particular place. Such an outbreak potentially affects everyone across the state, country, and even the world and may do so for months, maybe a year, or longer, as has been observed with previous pandemics and as we have been witnessing with the 2009 H1N1 pandemic.

Through this document and the plans and preparations it represents, we in the Hawai'i Department of Health (HDOH) EOA hope to meet not only our operational needs during a crisis but especially also the needs of the public's health to mitigate and control the potential devastating direct and indirect impacts of a disaster or emergency.

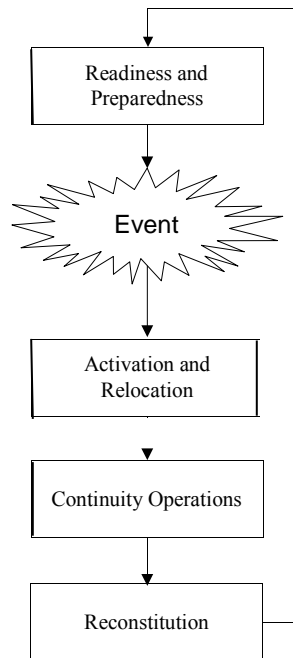
### III. INTRODUCTION

The basis for this Continuity of Operations Plan (COOP) can be found in three federal references: (1) Homeland Security Presidential Directive 20/HSPD-20, May 9, 2007 ([http://www.dhs.gov/xabout/laws/gc\\_1219245380392.shtm](http://www.dhs.gov/xabout/laws/gc_1219245380392.shtm)); (2) National Preparedness Guidelines (NPG), September 2007 ([http://www.dhs.gov/xlibrary/assets/National\\_Preparedness\\_Guidelines.pdf](http://www.dhs.gov/xlibrary/assets/National_Preparedness_Guidelines.pdf)); and (3) National Response Framework, January 2008 (<http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>).

The preparation of the following COOP adheres to the directions found in Continuity Guidance Circular 1 (CGC 1) for Non-Federal Entities, January 21, 2009 ([http://www.fema.gov/pdf/about/org/ncp/cont\\_guidance1.pdf](http://www.fema.gov/pdf/about/org/ncp/cont_guidance1.pdf)). This COOP applies to all-hazard emergencies; however, it recognizes that an influenza pandemic presents a set of circumstances that differ from other emergencies in that it would not limit its reach to this division or part of this division or HDOH or part of HDOH, but rather will affect all state entities (the planning assumptions associated with pandemic influenza are in Appendix A). Thus, each element of the COOP contains one or two sections. If one section, it will be labeled by the heading “Applies to All Hazards AND Pandemic Influenza; and if two sections, it will be labeled by the headings “Applies to All Hazards EXCEPT Pandemic Influenza” and “Applies to Pandemic Influenza.”

The continuity implementation process for DOCD follows four phases—readiness and preparedness, activation and relocation, continuity of operations, and reconstitution. These four phases are linked as shown in the following model.

**Figure 1. Continuity Implementation Process Model**



#### **IV. COOP ELEMENTS**

##### **A. PROGRAM PLANS AND PROCEDURES**

##### **1. CONTINUITY PLANNING ROLES AND RESPONSIBILITIES**

###### **a) Senior Leadership**

Senior leadership is directly responsible for ensuring that continuity plans and programs are developed, coordinated, exercised, and capable of being implemented when required. These responsibilities include:

- Designating a Continuity Coordinator.
- Approving all required continuity plans and programs.
- Notifying appropriate offices and stakeholders upon execution of continuity plans.
- Supporting the work of the Continuity Manager and Continuity Coordinator, including providing the necessary budgetary and other resources to support the continuity program, as required.

###### **b) Continuity Coordinator**

The Continuity Coordinator will coordinate the overall activities of the Continuity Planning Team. The responsibilities of the Continuity Coordinator include:

- Coordinating continuity planning activities with policies, plans, and incentives related to critical infrastructure protection.
- Leading the creation and coordination of the continuity planning process.
- Directing and participating in periodic cross-jurisdictional continuity exercises.
- Coordinating the input of the EOA and ensuring those inputs reflect, support, and sustain the continuation of essential functions.
- Developing and maintaining the continuity plan.
- Developing and administering a continuity program budget and submitting funding requests to Senior Leadership.
- Preparing an annual report summarizing the continuity planning activities of the organization.
- Serving as an advocate for the continuity plan and program.

###### **c) Continuity Planning Team**

The Continuity Planning Team coordinates continuity planning and duties for the entire EOA. These duties include:

- Coordinating the overall continuity for the EOA.
- Guiding and supporting the development of the EOA's continuity plan.
- Coordinating continuity exercises, documenting post-exercise lessons learned, and conducting periodic evaluations of EOA continuity capabilities.
- Understanding the role that other divisions, stakeholders, and partners might be expected to play in certain types of emergency conditions and what support each of those partners might provide.
- Understanding the limits of other divisions' and stakeholders' continuity resources and support capabilities.
- Anticipating the point at which fellow divisions' or other stakeholders' resources will be required.

**d) Individual Employees**

Each employee is responsible for:

- Understanding their continuity roles and responsibilities within the EOA and therefore HDOH.
- Knowing and being committed to their duties in a continuity environment.
- Understanding and being willing to perform in continuity situations to ensure the EOA and therefore HDOH can continue its essential functions.
- Ensuring that family members are prepared for and taken care of in an emergency situation.

**e) Continuity Planning Team Organization**

<b>Name</b>	<b>Title</b>	<b>Telephone Number</b>	<b>E-Mail</b>
Lisa Nakao	Planner V	586-7317	lisa.nakao@doh.hawaii.gov
Cristina Valenzuela	Legal Services Developer	586-7265	cristina.valenzuela@doh.hawaii.gov

**2. CONTINUITY POLICY**

It is the policy of EOA to incorporate continuity requirements into daily operations to assure seamless and immediate continuation of Critical Essential Function capabilities so that critical governmental functions and services remain available to the citizens of Hawaii.

This document will be the response policy of EOA to all hazards and pandemic influenza, to continue Critical Essential Functions and to provide support to the operations of client and external agencies. This Continuity of Operations Plan (COOP) conforms to the standards of the National Incident Management System (NIMS).

**3. GOALS**

The overarching goal of this COOP is to reduce the consequences of any disruptive event to a manageable level. More specifically, this COOP is designed to:

- Clearly and succinctly define the roles, responsibilities, resources, and procedures necessary to assure that operations necessary to provide assistance to citizens remain available before, during, and after an emergency.
- Open and maintain a line of communication/dialog with public and private entities that are functionally-related to the activities and responsibilities of the EOA, HDOH, and the state.
- Encourage functionally-related public and private entities to cooperate with government entities so these entities are able to be a central information collection and dissemination liaison agency for their respective functional area.

**4. CONCEPT OF OPERATIONS**

**a) Applies to All Hazards EXCEPT Pandemic Influenza**

- EOA will be operational during an emergency.

- EOA has defined Critical Essential Function capabilities and is prepared to sustain Critical Essential Functions or restore Critical Essential Functions within 12 hours after a disruption.
- EOA may suspend Short-Term Essential Functions (STEF) for a period of 15 days or less and Long-Term Essential Functions (LTEF) for more than 15 days. Suspensions will be based on Short-Term Essential Function/Long-Term Essential Function priority with lowest priority Short-Term Essential Function/Long-Term Essential Functions suspended first.
- Alternate work locations and work methods will have been established and exercised, to the extent possible. Alternate facilities may be activated for use during an emergency.
- Each manager has identified a complete order of succession for his/her leadership position and key position for each Critical Essential Function. This order of succession will ensure adequate personnel for all Critical Essential Functions.
- Personnel will be re-assigned to assist with the response.
- Each Incident Command system (ICS) position has identified primary, secondary, and tertiary (as available) staff for all roles.

**b) Applies to Pandemic Influenza**

- EOA will be operational during an influenza pandemic and is prepared to sustain Critical Essential Function capabilities during such an event.
- EOA has defined Critical Essential Function capabilities.
- EOA may suspend Short-Term Essential Functions (STEF) for a period of 15 days or less and Long-Term Essential Functions (LTEF) for more than 15 days. Suspensions will be based on Short-Term Essential Function/Long-Term Essential Function priority with lowest priority Short-Term Essential Function/Long-Term Essential Functions suspended first.
- Alternate work locations and work methods will have been established and exercised, to the extent possible. Alternate facilities may be activated for use during an emergency.
- Each manager has identified a complete order of succession for his/her leadership position and key position for each Critical Essential Function. This order of succession will ensure adequate personnel for all Critical Essential Functions.
- Personnel will be re-assigned to assist with the response.
- Each ICS position has identified primary, secondary, and tertiary staff for all roles.
- EOA has documented its Pandemic Influenza by cross referencing sections of this COOP with the sections of “Appendix A of the CDC State Panflu Operations Plan” in Appendix B.

**5. GO-KITS**

A EOA go-kit will include a copy of the EOA COOP, call-down lists, other vital records as described below, and alternate department operating locations as applicable (see CONTINUITY FACILITIES). The go-kit will also contain a laptop computer loaded with EOA and HDOH facility locations, essential human resources and payroll information, and EOA-specific software. Copies of forms needed to continue providing essential services as well as forms that can be used to perform work manually should computer systems not be working properly will be included in the go-kit.

Essential personnel are encouraged to have a personal go-kit that includes personal care items. Some recommended items include:

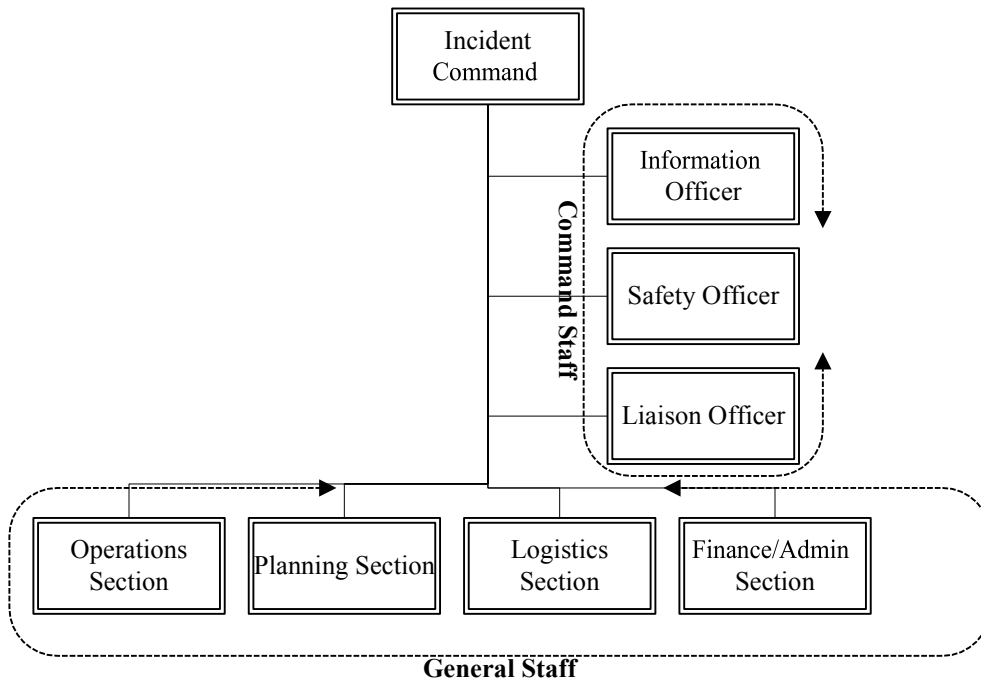
- a change of clothing,
- personal hygiene items (soap, shampoo, etc.),
- drinking water,
- non-perishable food/snacks,

- eating utensils,
- flashlight,
- batteries,
- portable radio,
- blanket,
- first aid kit/first aid items,
- prescription medicines, and
- contact lenses and solution or other eye-care items (if needed)

## 6. INCIDENT COMMAND SYSTEM

Upon Activation, EOA will implement its EOA Incident Command System using the structure shown in Figure 2 with staffing of positions shown in the table that follows Figure 2. A description of the roles and responsibilities of Incident Command System and General Staff positions is presented in Appendix C. The Incident Commander (IC) will “scale” the response to fit the circumstances and in consultation with HDOH Department Operations Center and/or HDOH IC through the combination and separation of jobs during the response to an incident. The pre-identification of assignments within the Incident Command System makes this task simpler.

**Figure 2. Incident Command Structure**



<b>Position</b>	<b>Primary Assignment</b>	<b>First Alternate</b>	<b>Second Alternate</b>	<b>Third Alternate</b>
(Division/program-level) Incident Commander	Caroline Cadirao	Cristina Valenzuela		
Information Officer	Debbie Shimizu	Christopher Tu		
Safety Officer	John McDermott	Lynn Niitani		
Liaison Officer	Tania Kuriki	Philip Ana		
Operations Chief	Aaron Arakaki	Wanda Anae-Onishi		
Planning Chief	Lisa Nakao	April Tabanera		
Logistics Chief	Lani Sakamoto	Kaipolani Cullen		
Finance/Admin Chief	Shannon Chun	Josephine Lum	Caroline Cadirao	



## **B. HAZARD VULNERABILITY ANALYSIS**

The EOA will follow the Department overall hazard vulnerability analysis to guide operations albeit with the understanding that this division will focus efforts especially toward addressing specific subject matter area if applicable.

## **C. BUDGETING AND ACQUISITION OF RESOURCES**

EOA will acquire resources as necessary through standard and emergency procurement processes and activities as defined by state processes at the time of an event or emergency. Key vendors have been identified and the critical resources they provide have been identified and plans for acquisition have been established.

## **D. ESSENTIAL FUNCTIONS and TELEWORK PLAN**

### **1. ESSENTIAL FUNCTIONS**

EOA provides a variety of general operating functions. A set of these functions have been identified as Essential Functions. Essential Functions are defined as those functions, stated or implied, that the EOA is required to perform by statute, executive order, or policy and are necessary to provide vital services, maintain the safety and well-being of the employees, the public served, and visitors during an emergency. Essential functions are further delineated into Critical essential functions, Short-term essential functions, and Long-term essential functions. Essential Functions are prioritized within each category. Priority level 1 is the highest priority.

- Critical Essential Functions are those essential functions that cannot be interrupted or can be only minimally interrupted following an incident.
- Short-term Essential Functions are those essential functions that can be interrupted for a period of up to 15 days following an incident, but must be resumed thereafter.
- Long-term Essential Functions are those essential functions that can be interrupted for more than 15 days following an incident and will be resumed when resources and personnel become available.

### **2. TELEWORK ASSIGNMENTS**

EOA has developed a basic Telework Plan for use during a Pandemic Influenza response. Telework assignments are shown in the following table and the Telework Plan is found at Appendix D. It should be noted, however, that EOA defers to HDOH human resources policy with regard to general telework policies, which ultimately defers to the Hawai'i Department of Human Resources and Development.

**E. ORDER OF SUCCESSION**

<b>Key Position</b>	<b>Credentials Required or NA if not applicable</b>	<b>Incumbent (name)</b>	<b>First Alternate (Title and Name)</b>	<b>Second Alternate (Title and Name)</b>	<b>Third Alternate (Title and Name)</b>
Director	NA	Caroline Cadirao Interim Director			
Program and System Management	NA	Aaron Arakaki Program Specialist V			
Planning & Evaluation	NA	Lisa Nakao Planner V	Tania Kuriki Research Statistician V	Cristina Valenzuela Legal Svcs Developer	
LTC Advocacy Assistance	NA	Lani Sakamoto Program Specialist V	Vacant Program Specialist IV		
Administrative Services Staff	NA	Shannon Chun Accountant IV	Wanda Anae-Onishi Program Specialist IV		
Clerical Services	NA	Josephine Lum Office Assistant III	April Tabanera Office Assistant III		
LTC Ombudsman	NA	John McDermott Program Specialist V	Lynn Niitani Program Specialist IV		
Senior Medicaid Patrol	NA	Kaipolani Cullen Program Specialist IV	Vacant Program Specialist IVI		
Community Assistance Staff	NA	Philip Ana LTC Disability Program Specialist IV	Vacant LTC Community Living Program Spl.		
No Wrong Door	NA	Debbie Shimizu Program Specialist	Christopher Tu Program Specialist		

**F. DELEGATION OF AUTHORITY**

Temporary authority may be delegated whenever an individual with approval authority will be unable to perform his or her duties due to the consequences of responding to an emergency. EOA has established a delegation of authority process that is applied through the Order of Succession table or tables presented in the previous section or sections.

**G. CONTINUITY FACILITIES\***

Critical Essential Function	Current Location	Number of Employees	Alternate Locations
	No. 1 Capitol District 250 South Hotel St., #406	17**	None

\*Note that although [X] office operations may be relocated to [Y] offices, EOA may potentially adhere to HDOH overall plans for relocation of Department operations during an emergency or event that necessitates such. Possibility also exists for operations to be conducted either partially or completely virtually (i.e., via electronic/internet/telephone) depending on the particular circumstances.

\*\*Indicates filled positions as of June 2019.

**H. CONTINUITY COMMUNICATIONS**

**1. CONTINUITY COMMUNICATIONS--INTERNAL**

<b>Name</b>	<b>Work Telephone</b>	<b>Primary e-mail address</b>	<b>Cellular Telephone</b>	<b>Other</b>
Ana, Philip	586-7307	<a href="mailto:philip.ana@doh.hawaii.gov">philip.ana@doh.hawaii.gov</a>	Redacted for privacy	
Anae-Onishi, Wanda	586-4788	<a href="mailto:wanda.anae-onishi@doh.hawaii.gov">wanda.anae-onishi@doh.hawaii.gov</a>	Redacted for privacy	
Arakaki, Aaron	586-7309	<a href="mailto:aaron.arakaki@doh.hawaii.gov">aaron.arakaki@doh.hawaii.gov</a>	Redacted for privacy	
Cadirao, Caroline	586-7297	<a href="mailto:caroline.cadirao@doh.hawaii.gov">caroline.cadirao@doh.hawaii.gov</a>	Redacted for privacy	
Chun, Shannon	586-7323	<a href="mailto:shannon.chun@doh.hawaii.gov">shannon.chun@doh.hawaii.gov</a>	Redacted for privacy	
Cullen, Kaipolani	586-7281	<a href="mailto:kaipolani.cullen@doh.hawaii.gov">kaipolani.cullen@doh.hawaii.gov</a>	Redacted for privacy	
Kuriki, Tania	586-7315	<a href="mailto:tania.kuriki@doh.hawaii.gov">tania.kuriki@doh.hawaii.gov</a>	Redacted for privacy	
Lum, Josephine	586-7295	<a href="mailto:josephine.lum@doh.hawaii.gov">josephine.lum@doh.hawaii.gov</a>	Redacted for privacy	
McDermott, John	586-7268	<a href="mailto:john.mcdermott@doh.hawaii.gov">john.mcdermott@doh.hawaii.gov</a>	Redacted for privacy	
Nagatoshi, Charles	586-7289	<a href="mailto:charles.nagatoshi@doh.hawaii.gov">charles.nagatoshi@doh.hawaii.gov</a>	Redacted for privacy	
Nakao, Lisa	586-7317	<a href="mailto:lisa.nakao@doh.hawaii.gov">lisa.nakao@doh.hawaii.gov</a>	Redacted for privacy	
Niitani, Lynn	586-7291	<a href="mailto:lynn.niitani@doh.hawaii.gov">lynn.niitani@doh.hawaii.gov</a>	Redacted for privacy	
Sakamoto, Lani	586-7277	<a href="mailto:lanisakamoto@doh.hawaii.gov">lanisakamoto@doh.hawaii.gov</a>	Redacted for privacy	
Shimizu, Debbie	586-7321	<a href="mailto:debra.shimizu@doh.hawaii.gov">debra.shimizu@doh.hawaii.gov</a>	Redacted for privacy	
Tabanera, April	586-7270	<a href="mailto:april.tabanera@doh.hawaii.gov">april.tabanera@doh.hawaii.gov</a>	Redacted for privacy	
Tu, Christopher	586-7267	<a href="mailto:christopher.tu@doh.hawaii.gov">christopher.tu@doh.hawaii.gov</a>	Redacted for privacy	
Valenzuela, Cristina	586-7265	<a href="mailto:cristina.valenzuela@doh.hawaii.gov">cristina.valenzuela@doh.hawaii.gov</a>	Redacted for privacy	

**2. CONTINUITY COMMUNICATIONS--EXTERNAL**

<b>Key External Stakeholder</b>	<b>Primary (day-to-day) Communication Method</b>	<b>Primary Communication Address</b>	<b>Redundant Communication Method</b>	<b>Redundant Communication Address</b>
City and County of Honolulu Elderly Affairs Division	768-7705			
Hawaii County Office of Aging	961-8600			
Kauai Agency on Elderly Affairs	241-4470			
Maui County Office on Aging	270-7755			

**3. VITAL RECORDS MANAGEMENT**

N/A

**I. HUMAN CAPITAL**

**1. EVACUATIONS AND RALLY POINTS\***

<b>Rally Point Location (address or land mark)</b>	<b>Person Responsible for Taking Organizational Census at the Rally Point</b>	<b>First Alternate Census Taker</b>	<b>Second Alternate Census Taker</b>
<b>Iolani Palace Bandstand</b>	<b>Josephine Lum</b>	<b>April Tabanera</b>	

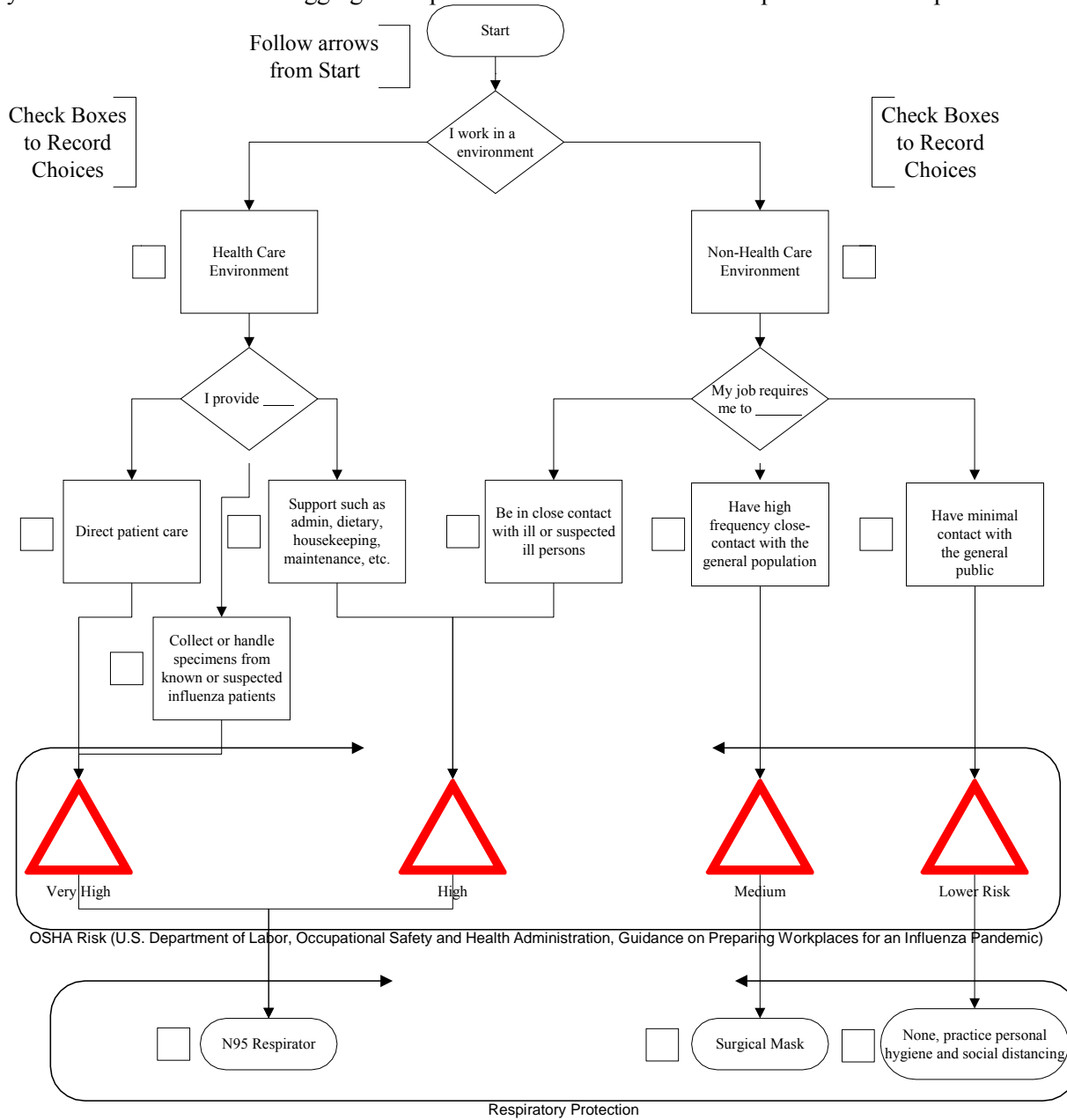
\*Assuming an event or emergency occurs during regular business hours. If an emergency/event were to occur outside of business hours, the EOA call-down tree would be activated to ensure the well-being of all staff as well as their availability/accessibility and to advise staff regarding expected responsibilities and EOA/HDOH operations during the emergency/event.

**EOA PHONE TREE**

	<b><u>Work Ph.</u></b>	<b><u>Home/Cell</u></b>
Caroline Cadirao	586-7297	redacted for privacy
Lisa Nakao	586-7317	redacted for privacy
Lani Sakamoto	586-7277	redacted for privacy
Shannon Chun	586-7323	redacted for privacy
John McDermott	586-7268	redacted for privacy
Josephine Lum	586-7295	redacted for privacy
April Tabanera	586-7270	redacted for privacy
Caroline Cadirao	586-7297	redacted for privacy
Aaron Arakaki	586-7309	redacted for privacy
Philip Ana	586-7265	redacted for privacy
Debbie Shimizu	586-7321	redacted for privacy
Christopher Tu	586-7267	redacted for privacy
Lisa Nakao	586-7317	redacted for privacy
Tania Kuriki	586-7315	redacted for privacy
Charles Nagatoshi	586-7289	redacted for privacy
Cristina Valenzuela	586-7265	redacted for privacy
Lani Sakamoto	586-7277	redacted for privacy
Lynn Niitani	586-7291	redacted for privacy
Wanda Anae-Onishi	586-4788	redacted for privacy
Kaipolani Cullen	586-7281	redacted for privacy

**PANDEMIC INFLUENZA EMPLOYEE RISK ASSESSMENT INSTRUMENT**

EOA requires all staff including contracted/contractors to complete the following Employee PI Risk Assessment Instrument. Responses to this instrument are to be maintained between the staff person and their immediate supervisor only. The latter should use the aggregate responses of all staff under their supervision to complete the next section.



Print Name of Employee: \_\_\_\_\_

Job Classification/Function: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_



**2. ORGANIZATIONAL CENSUS WITH EMPLOYEE PANDEMIC INFLUENZA RISK ASSESSMENT**

Organizational Unit	Number of Full-Time Employees	Number of Part-Time Employees	Number of Contract Employees	Total Number of Employees	Employee Pandemic Influenza Risk Assessment			
					Number of Employees			
					Very High	High	Medium	Lower Risk
Executive Office on Aging	17*	0	0	17				

\*Total number of EOA employees as of May 1, 2019.

**3. MONITORING EMPLOYEE AVAILABILITY AND ABSENCES**

EOA will monitor employee availability and absences during an emergency. The Order of Succession Table (see Section IV E.) will define the individuals that are required to report personnel status to the IC, daily at 0830 hours. In the absence of other means of documentation, the Employee Status Work Sheet will be used to document employee status. Appendix E contains a table that may be used for monitoring employee availability and absences.

HDOH human resource and personnel policies already in place will apply. Policies may be relaxed during an event and expedient measures such as working from home, teleconferencing, and hiring contract workers may be temporarily introduced as permissible or previously negotiated and established. EOA will adhere to such HDOH and State policies as they are adjusted and directives will be issued through Incident Command System.

**J. TEST, TRAINING, AND EXERCISE (TT&E) PROGRAM**

**1. ALL HAZARDS TRAINING AND EXERCISES**

EOA agrees to hold at least one EOA exercise (Table Top Exercise, Functional, or Full-Scale) each fiscal year. Additionally, EOA agrees to establish, maintain, and implement an annual training program for EOA staff based on preparedness courses offered or recommended by the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS), Federal Emergency Management Agency (FEMA), Department of Homeland Security (DHS), or other expert and/or partner agencies and organizations.

Event	Training (X or blank)	Exercise (X or blank)	Date	Location	Attendance Expected

**2. PANDEMIC INFLUENZA TRAINING AND EXERCISES**

EOA agrees to utilize resources provided by CDC, DHHS, DHS, or FEMA to conduct the training and drills specified in the following table.

Organization Unit	Pandemic Influenza Training*	Date of Training	Exercise Elements	Date PI Exercise Completed

**K. DEVOLUTION OF CONTROL AND DIRECTION**

EOA will devolve Essential Functions (Critical Essential Functions, Short-Term Essential Functions, and Long-Term Essential Functions) in order of priority, from lowest priority to highest priority, at the direction of the IC. Once an Essential Function has been devolved and the person responsible for the devolved Essential Function reports to the IC that the Essential Function has relocated and is operational, authority to perform the duties and responsibilities associated with the Essential Function will transfer to the Alternate Location immediately.

**L. RECONSTITUTION OPERATIONS**

EOA will resume normal functioning after the emergency has been declared as over by the IC. Critical Functions that have been devolved will be restored on a priority basis from highest to lowest.

Responsibilities have been assigned for recruiting replacement employees and certifying workplace safety. The Continuity Communications (Section D) will be used to obtain contact information for responsible persons.

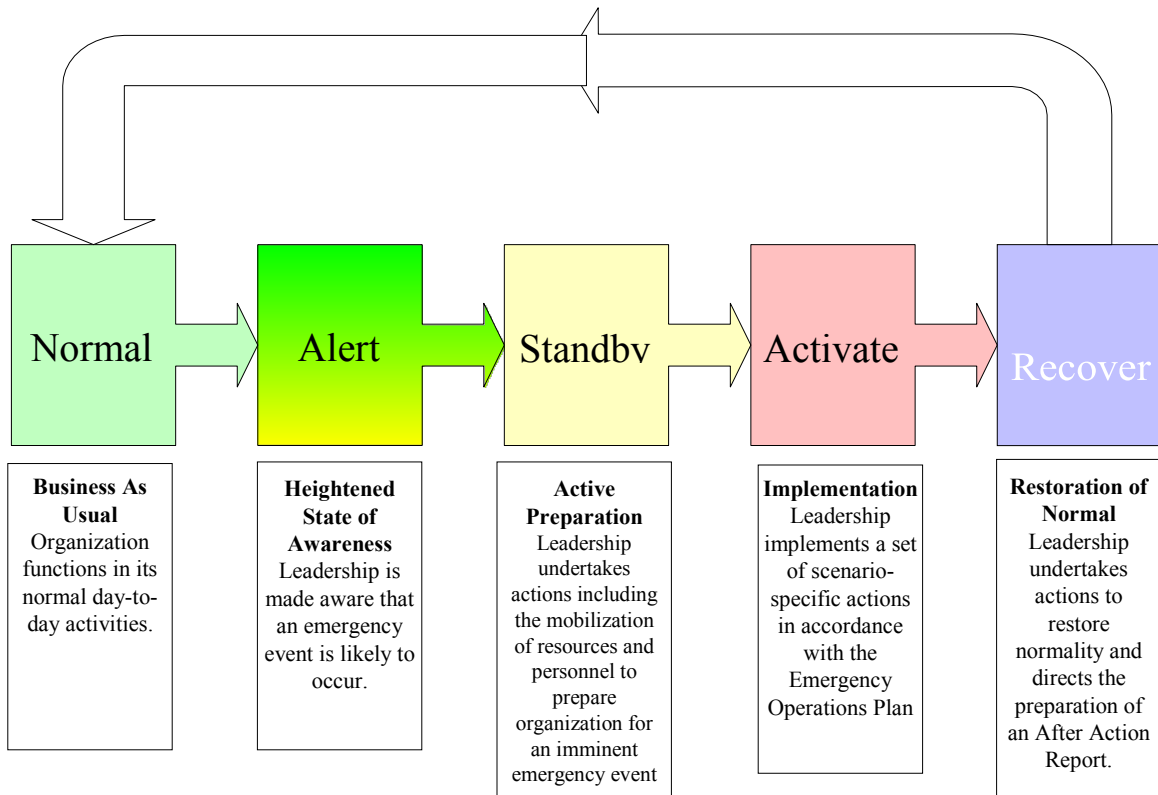
Essential Function	Type (C, ST, or LT)	Priority	Recruiting Replacement Employees (Name and Position)	Certification of Workplace Safety (Name & Position, or Position)

**V. CONTINUITY PLAN OPERATIONAL PHASES AND IMPLEMENTATION**

**A. Alert, Standby, Activate Phases**

EOA has adopted the model shown in Figure 3 as the definition of phases of awareness for All-Hazard emergencies EXCEPT pandemic influenza. The EOA Chief or his or her designee is responsible for establishing the Operational Phase, which in most cases should coincide with the HDOH Operational Phase. Upon the designation of the Activate Phase the ICS process goes into effect and the Time-Based Operational Phases will be applied.

**Figure 3. Alert, Standby, Activate Phases**



**B. Pandemic Influenza**

Activation of the COOP during an influenza pandemic for DOCD will be decided upon by the Division Chief or his or her designee with consultation and direction from the HDOH Director.

**1. OPERATIONAL PHASES**

Phase	Time Frame	Activity
Phase I- Activation and Relocation (latter as necessary)	0-12 Hours	<ul style="list-style-type: none"> <li>• Notify alternate facility manager of impending activation and relocation requirements as necessary.</li> <li>• Notify impacted local, regional and state partners.</li> <li>• Activate plans to transfer to alternate facility, if necessary.</li> <li>• Instruct advance team to ready alternate facility, if necessary.</li> <li>• Notify agency employees and contractors regarding activation of COOP plan and their status.</li> <li>• Assemble documents/equipment required for essential functions (at alternate facility, if necessary).</li> <li>• Order needed equipment/supplies.</li> <li>• Transport documents and designated communications.</li> <li>• Secure original facility.</li> <li>• Continue essential functions at regular facility, if available and move to alternate facility if necessary.</li> <li>• Advise alternate facility on status.</li> <li>• Where are the operations and support teams?</li> <li>• Activate advance, operations, and support teams as necessary.</li> </ul>
Phase II- Alternate Facility/Work Site or Alternate Work Condition Operations	12 Hours to Termination of Emergency	<ul style="list-style-type: none"> <li>• Provide guidance to contingency team personnel and information to the public.</li> <li>• Identify replacements for missing personnel (delegation of authority and orders of succession).</li> <li>• Commence full execution of operations supporting essential functions at the alternate facility or in alternate conditions.</li> </ul>
Phase III- Reconstitution	Termination of Emergency	<ul style="list-style-type: none"> <li>• Inform all personnel that the threat no longer exists.</li> <li>• Supervise return to normal operating facility or normal operating conditions.</li> <li>• Conduct a review of COOP plan execution and effectiveness.</li> </ul>

**2. IMPACT AT VARIOUS EMERGENCY LEVELS**

<b>Level of Emergency</b>	<b>Impact on Entity and COOP Decision</b>
1	<p><b>Impact:</b> Disruption of up to 12 hours, with little effect on services or impact to essential functions or critical systems.  <b>Example:</b> Major accident on highway or transit system.  <b>Decision:</b> No COOP activation required.</p>
2	<p><b>Impact:</b> Disruption of 12 to 72 hours, with minor impact on essential functions.  <b>Example:</b> Computer virus, small fire, or moderate flooding.  <b>Decision:</b> Limited COOP activation, depending on agency requirements.</p>
3	<p><b>Impact:</b> Disruption to one or two essential functions or to a vital system for no more than three days.  <b>Example:</b> Power outage, heightened Homeland Security Advisory System Threat Level.  <b>Decision:</b> May require partial COOP activation to move certain personnel to an alternate facility or location in the primary facility or activation of alternate conditions for less than a week.</p>
4	<p><b>Impact:</b> Disruption to one or two essential functions or to the entire agency with potential of lasting for more than three days but less than two weeks.  <b>Example:</b> Hurricane; minor tsunami; workplace violence; major telecommunications failure or major power outage.  <b>Decision:</b> May require partial COOP plan activation. For example, orders of succession for some key personnel may be required; in addition, movement of some personnel to an alternate work site or location in the primary facility for more than a week may be necessary. Personnel not supporting essential functions may be instructed not to report to work, or be re-assigned to other activities.</p>
5	<p><b>Impact:</b> Disruption to the entire agency with a potential for lasting at least two weeks.  <b>Example:</b> Explosion in/contamination of primary facility; major fire or flooding; earthquake, tsunami.  <b>Decision:</b> COOP plan activation. May require activation of orders of succession for some key personnel. May require movement of many, if not all, essential personnel to an alternate work site for more than two weeks. Personnel not supporting essential functions may be instructed not to report to work, or be re-assigned to other activities.</p>

## **APPENDIX A: PANDEMIC INFLUENZA PLANNING ASSUMPTIONS<sup>1</sup>**

1. Susceptibility to the pandemic influenza virus will be universal.
2. Efficient and sustained person-to-person transmission signals an imminent pandemic.
3. The clinical disease attack rate will likely be 30% or higher in the overall population during the pandemic. Illness rates will be highest among school-aged children (about 40%) and decline with age. Among working adults, an average of 20% will become ill during a community outbreak.
4. Some persons will become infected but not develop clinically significant symptoms. Asymptomatic or minimally symptomatic individuals can transmit infection and develop immunity to subsequent infection.
5. Of those who become ill with influenza, 50% will seek outpatient medical care.
6. With the availability of effective antiviral drugs for treatment, this proportion may be higher in the next pandemic.
7. The number of hospitalizations and deaths will depend on the virulence of the pandemic virus. Estimates differ about 10-fold between more and less severe scenarios. Two scenarios are presented based on extrapolation of past pandemic experience (Table 1). Planning should include the more severe scenario.
8. Risk groups for severe and fatal infection cannot be predicted with certainty but are likely to include infants, the elderly, pregnant women, and persons with chronic medical conditions.
9. Rates of absenteeism will depend on the severity of the pandemic.
10. In a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection may reach 40% during the peak weeks of a community outbreak, with lower rates of absenteeism during the weeks before and after the peak.
11. Certain public health measures (closing schools, quarantining household contacts of infected individuals, “snow days”) are likely to increase rates of absenteeism.
12. The typical incubation period (interval between infection and onset of symptoms) for influenza is approximately 2 days.
13. Persons who become ill may shed virus and can transmit infection for up to one day before the onset of illness. Viral shedding and the risk of transmission will be greatest during the first 2 days of illness. Children usually shed the greatest amount of virus and therefore are likely to pose the greatest risk for transmission.

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<sup>1</sup> <http://www.pandemicflu.gov/professional/pdf/cikrpandemicinfluenzaguide.pdf>, p13.

- 14. On average, infected persons will transmit infection to approximately two other people.
- 15. In an affected community, a pandemic outbreak will last about 6 to 8 weeks.
- 16. Multiple waves (periods during which community outbreaks occur across the country) of illness could occur with each wave lasting 2-3 months. Historically, the largest waves have occurred in the fall and winter, but the seasonality of a pandemic cannot be predicted with certainty.

**Table 1. Number of Episodes of Illness, Healthcare Utilization, and Death Associated with Moderate and Severe Pandemic Influenza Scenarios\***

<b>Characteristic</b>	<b>Moderate (1958/68-like)</b>	<b>Severe (1918-like)</b>
Illness	90 million (30%)	90 million (30%)
Outpatient medical care	45 million (50%)	45 million (50%)
Hospitalization	865,000	9,900,000
ICU care	128,750	1,485,000
Mechanical ventilation	64,875	745,500
Deaths	209,000	1,903,000

\*Estimates based on extrapolation from past pandemics in the United States. Note that these estimates do not include the potential impact of interventions not available during the 20th century pandemics.

**APPENDIX B: DOCUMENTATION OF COMPLIANCE WITH APPENDIX A OF THE CDC STATE PANDEMIC INFLUENZA OPERATIONS PLAN**

<b><u>Appendix A.1: Sustain Operations of State Agencies &amp; Support and Protect Government Workers</u></b>	
	Prepare
A.1.1.1	Assess potential employee absences/ determine potential impact of a pandemic on the agencies' workforce
A.1.1.2	Determine essential functions and which employees have unique credentials
A.1.1.3	Cross-train to provide 3-deep back-ups for the employees performing essential functions or who have unique credentials
A.1.1.4	Establish standard operating procedures for essential functions
A.1.1.5	Create telework plans
A.1.1.6	Assess changes in demands on State agencies' services
A.1.1.7	Identify specific hiring needs and determine needed hiring flexibilities
A.1.1.8	If needed, train and/or prepare ancillary workforce or create alternative plans for staffing of essential functions
A.1.1.9	Consult with procurement staff and major contractors re HR issues
A.1.1.10	Review relationships with suppliers/ shippers/other businesses that support States' essential functions; as necessary, implement backup plans
	Respond and Recover
A.1.1.11	Implement telework and other HR flexible work schedules as per plan
A.1.1.12	Employ pre-identified plans to maintain sufficient staffing (FTE and contractor) for essential functions and high-demand services
A.1.1.13	Collect data and report the status of employees for the purpose of monitoring agency workforce levels and reporting such information to appropriate agencies (This includes a plan for accountability of personnel and their status and a plan to monitor who is sick, those that have recovered, those that are available for re-entry to work)



A.1.1.14	Use pre-identified hiring/contracting flexibilities to replace employees/contractors unable to work (or return to work)
A.1.1.15	Implement previously developed employee-labor relations plan
A.1.1.16	Monitor effectiveness and consistency of application of HR flexibilities by agencies
	<b>Sub-objective A.1.2 - Assist employees of State agencies unable to work for a significant time period</b>
	Prepare
A.1.2.1	Assess flexible work schedules (can include cross reference to telework plans from A.1.1.e.) (States should assess current policies and then report on decisions)
A.1.2.2	Review and revise, as necessary, policies and/or guidance on leave and benefits (States should assess current policies and then report on decisions)
A.1.2.3	Ensure managers/supervisors are familiar with various leave options
A.1.2.4	Consult with procurement staff/major contractors regarding pandemic plans for the contract workforce
	Respond and Recover
A.1.2.5	Implement telework and other flexible work schedules as per plan. Refer to the first Respond and Recover requirement under Sub-Objective A.1.1 - Ensure continuity of government in face of significantly increased absenteeism
A.1.2.6	Implement any special pandemic compensation/ leave/benefit policies
	<b>Sub-objective A.1.3 - Communicate with employees of State agencies</b>
	Prepare
A.1.3.1	Develop a communications plan
A.1.3.2	Convey to all employees the State's pandemic plan
A.1.3.3	Provide reliable pandemic influenza information to employees
	Respond and Recover

A.1.3.4	Update information for employees on State's operating status and latest pandemic influenza information; continue to advise employees concerning HR policies, workplace flexibilities, pay and benefits, etc.
	<b>Sub-objective A.1.4 - Consult with bargaining units (if the State has bargaining unit employees)</b>
	Prepare
A.1.4.1	Consult with bargaining units (if the State has bargaining unit employees)
	Respond and Recover
A.1.4.2	Implement previously developed employee-labor relations plan
	<b>Sub-objective A.1.5 - Make State agency workplaces safe places</b>
	Prepare
A.1.5.1	Establish policies and practices for preventing influenza spread at the worksite; implement those that can be done in advance of a pandemic (e.g., providing infection control supplies)
A.1.5.2	Complete a risk assessment for all jobs (see OSHA guidance at <a href="http://www.osha.gov/pls/publications/publication.searchResults?pSearch=influenza%20pandemic">http://www.osha.gov/pls/publications/publication.searchResults?pSearch=influenza%20pandemic</a> )
A.1.5.3	Develop plans to protect those employees in the very high, high, or medium risk categories including stockpiling personal protective equipment (PPE), if needed; provide needed training and if respiratory protection is indicated, establish a respiratory protection program and fit-test those employees who will be provided with respirators.
	Respond and Recover
A.1.5.4	Implement infection control policies and practices (see OSHA guidance at <a href="http://www.osha.gov/pls/publications/publication.searchResults?pSearch=influenza%20pandemic">http://www.osha.gov/pls/publications/publication.searchResults?pSearch=influenza%20pandemic</a> )
A.1.5.5	Institute protection plans; if in plan, provide PPE to employees in very high, high, or medium risk categories
A.1.5.6	If part of pandemic response plan, distribute antiviral drugs
	<b>Sub-objective A.1.6 - Revise human resource and other workplace policies affecting the safety of State government workers</b>
	Prepare

A.1.6.1	Review and revise policies on leave, as needed; consider new policies for employee compensation and sick-leave absences unique to a pandemic to encourage ill employees or those exposed to ill persons to stay home (States should assess current policies and then report on decisions)
A.1.6.2	Establish guidelines on when a previously ill person is no longer infectious and can return to work
A.1.6.3	Consider establishing policies for restricting travel (States should assess current policies and then report on decision)
A.1.6.4	Collaborate with insurers, health plans, and local healthcare facilities on pandemic planning; evaluate government employee access to and availability of healthcare services
A.1.6.5	Evaluate government employee access to and availability of mental health and social services; develop workforce resilience programs
	Respond and Recover
A.1.6.6	Implement policies/guidance developed to assist employees to stay home when exposed to the influenza or if ill
A.1.6.7	Implement return to work guidelines
A.1.6.8	Implement any travel policies; issue instructions for employees in high-risk situations
A.1.6.9	Activate programs to address the psychological and social needs of government employees

## **APPENDIX C: INCIDENT COMMAND SYSTEM**

**Incident Commander**—responsible for all aspects of the response, including developing incident objectives and managing all incident operations. Unless specifically assigned to another member of the Command or General Staffs, these responsibilities remain with the IC. Some of the more complex responsibilities of the IC include:

- Establish immediate priorities especially the safety of responders, other emergency workers, bystanders, and people involved in the incident.
- Stabilize the incident by ensuring life safety and managing resources efficiently and cost effectively.
- Determine incident objectives and strategy to achieve the objectives.
- Establish and monitor incident organization.
- Approve the implementation of the written or oral Incident Action Plan.
- Ensure adequate health and safety measures are in place.

**The Command Staff**—responsible for public affairs, health and safety, and liaison activities within the incident command structure. The IC remains responsible for these activities or may assign individuals to carry out these responsibilities and report directly to the IC

**Information Officer**—is responsible for developing and releasing information about the incident to the news media, incident personnel, and other appropriate agencies and organizations.

**Liaison Officer**—serves as the point of contact for assisting and coordinating activities between the IC and various agencies and groups. This may include federal personnel, state government officials, local government officials, and criminal investigating organizations and investigators arriving on the scene.

**The Safety Officer**—develops and recommends measures to the IC for assuring personnel health and safety and to assess and/or anticipate hazardous and unsafe situations. The Safety Officer also develops the Site Safety Plan, reviews the Incident Action Plan for safety implications, and provides timely, complete, specific, and accurate assessment of hazards and required controls.

**The General Staff**— includes Operations, Planning, Logistics, and Finance/Administrative responsibilities. These responsibilities remain with the IC until they are assigned to another individual. When the Operations, Planning, Logistics or Finance/Administrative responsibilities are established as separate functions under the IC, they are managed by a section chief and can be supported by other functional units.

**Operations Chief**— responsible for all operations directly applicable to the primary mission of the response.

**Planning Chief**— responsible for collecting, evaluating, and disseminating the tactical information related to the incident, and for preparing and documenting Incident Action Plans (IAP's).

**Logistics Chief**— responsible for providing facilities, services, and materials for the incident response.

**Finance and Administrative Chief** is responsible for all financial, administrative, and cost analysis aspects of the incident.

The modular organization of the ICS allows responders to scale their efforts and apply the parts of the ICS structure that best meet the demands of the incident. In other words, there are no hard and fast rules for when or how to expand the ICS organization. Many incidents will never require the activation of Planning, Logistics, or Finance/Administration Sections, while others will require some or all of them to be established. A major advantage of the ICS organization is the ability to fill only those parts of the organization required. For some incidents, and in some applications, only a few of the organization's

functional elements may be required. However, if there is a need to expand the organization, additional positions exist within the ICS framework to meet virtually any need.

For example, in responses involving responders from a single jurisdiction, the ICS establishes an organization for comprehensive response management. However, when an incident involves more than one agency or jurisdiction, responders can expand the ICS framework to address a multi-jurisdictional incident.

The roles of the ICS participants will also vary depending on the incident and may even vary during the same incident. Staffing considerations are based on the needs of the incident. The number of personnel and the organization structure are dependent on the size and complexity of the incident. There is no absolute standard to follow. However, large-scale incidents will usually require that each component, or section, is set up separately with different staff members managing each section. A basic operating guideline is that the IC is responsible for all activities until command authority is transferred to another person.

**APPENDIX D: PANDEMIC INFLUENZA TELEWORK PLAN**

N/A



## **APPENDIX F: ABBREVIATIONS**

AAR	After-Action Report
ASO	Administrative Services Office
CET	Continuity Evaluation Tool
CI/KR	Critical Infrastructure/Key Resources
CDC	Centers for Disease Control and Prevention
COG	Continuity of Government
COGCON	Continuity of Government Readiness Conditions
COOP	Continuity of Operations
CWG	Continuity Working Group
DHS	Department of Homeland Security
DHHS	Department of Health and Human Services
DOC	Department Operations Center
DOCD	Disease Outbreak Control Division
ECG	Enduring Constitutional Government
ERG	Emergency Relocation Group
ESF	Emergency Support Function
FCD	Federal Continuity Directive
FEA	Federal Executive Association
FEB	Federal Executive Board
FEMA	Federal Emergency Management Agency
HDOH	Hawai'i Department of Health
HQ	Headquarters
HSAS	Homeland Security Advisory System
HSEEP	Homeland Security Exercise and Evaluation Program
HSPD	Homeland Security Presidential Directive
HVA	Hazard Vulnerability Analysis
IP	Improvement Plan
IT	Information Technology
MEF	Mission Essential Function
MOA/MOU	Memorandum of Agreement/Memorandum of Understanding
MYSPMP	Multi-Year Strategy and Program Management Plan
NCC	National Continuity Coordinator
NCP	National Continuity Programs
NCR	National Capital Region
NCS	National Communications System
NEF	National Essential Function
NEP	National Exercise Program
NIMS	National Incident Management System
NIPP	National Infrastructure Protection Plan
NRF	National Response Framework
NSPD	National Security Presidential Directive
OEP	Occupant Emergency Plan
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OSTP	Office of Science and Technology Policy
PMEF	Primary Mission Essential Function
POC	Point of Contact
SCD	State Civil Defense
SIP	Shelter-In-Place



TT&E  
WMD

Test, Training, and Exercise  
Weapons of Mass Destruction

# **APPENDIX G**

## **Core Components and Criteria of a Fully Functioning ADRC**

**Core Components and Criteria of a Fully Functional  
 Aging and Disability Resource Center (ADRC)  
 At-A-Glance  
 Updated March 2012**

**Information, Referral and Awareness (I&R/A)**

- Formal Marketing Plan for All Ages, Income Levels, Disability Types
- Marketing to and Serving Private Paying Populations
- Systematic I&R Processes Provided Across all Operating Organizations
- Follow-Up on I&R Services
- Online Comprehensive Resource Database, Public and Searchable

**Options Counseling and Assistance**

- Formal Standards and Protocols Guiding Delivery to All Income Levels and Disabilities
- Short-term Support in Crisis/Urgent Situations (Preventing Institutionalization)
- Follow-Up on Options Counseling Services
- Futures Planning for Long Term Service and Support (LTSS) Needs

**Streamlined Eligibility Determination for Public Programs**

- Coordinated/Integrated Process for Financial and Functional Eligibility
- Standardized Intake and Screening Across all Operating Organizations
- Uniform Criteria to Assess Risk of Institutionalization
- Functional Eligibility Determined On-Site or Through Seamless Referral Process
- Personalized Assistance in Financial Application Completion
- Financial Eligibility Determined On-Site or Through Electronic Exchange
- Applicants Tracked through Determination Process; Follow-up with Ineligible Individuals

**Person Centered Transition Support**

- Formal Agreements with Critical Pathway Providers and Protocols for Providing Transitions Support, Referral Processes, and Staff Training
- Local Contact Agency Designation (MDS 3.0 Section Q)

**Consumer Populations, Partnerships and Stakeholder Involvement**

- Staff with Capacity and Training to Serve All Ages and Disability Types
- Consumer Involvement in Program Design, Operation, and Quality Improvement
- Formal Partnership Agreements, Protocols, or Contracts with:
  - Critical Aging and Disability Organizations
  - Medicaid
  - State Health Insurance Assistance Program (SHIP), Adult Protective Services (APS), and 2-1-1
  - Veteran's Administration (VA) Medical Center(s)

**Quality Assurance and Continuous Improvement**

- Formal Sustainability Plan with Diverse Funding Sources
- Adequate Staffing and Management
- Continuous Quality Improvement Plan and Procedures in Effect
- IT/MIS Supports All Program Functions
- Routine State Level Performance Tracking
- Routine Local Level Performance Tracking

# **APPENDIX H**

## Acronym/Glossary

## ACRONYM/GLOSSARY

ACRONYM	MEANING	DESCRIPTION
AAA	<b>Area Agency on Aging</b>	In Hawai'i, county agency that is part of a nationwide network of State and local programs that help older people to plan and care for their life long needs. Created under the Older Americans Act. Goal is to keep seniors living independently in their own homes. Provides social services and nutrition services for elders, and support for caregivers
ACL	<b>Administration for Community Living</b>	Newly established federal agency which houses the former Administration on Aging, Center on Disability and Aging Policy, Center for Management and Budget and Administration on Intellectual and Developmental Disabilities.
ACS	<b>American Community Survey</b>	The American Community Survey (ACS) is a survey conducted by the U.S. Census Bureau. It uses a series of monthly samples to produce annually updated estimates for the same small areas (census tracts and block groups) formerly surveyed via the decennial census long-form sample. The ACS includes people living in both housing units and group quarters.
ADRC	<b>Aging and Disability Resource Center</b>	An entity established by the state to provide a coordinated long term care system. This is a federal and state initiative.
ADRD	<b>Alzheimer's Disease and Related Dementias</b>	Dementia is a general term for a decline in mental ability severe enough to interfere with daily life, e.g., memory loss. Alzheimer's is the most common type of dementia.
Aging Network		The network of State agencies, Area Agencies on Aging, Title VI grantees, and the administration and organizations that are providers of direct services to older individuals or are institutions of higher education, and receive funding under the OAA.
APS	<b>Adult Protective Services</b>	Division in the state Department of Human Services that provides crisis intervention, including investigation, and emergency services for vulnerable adults who are reported to be abused, neglected, or financially exploited by others or seriously endangered due to self-neglect.
BRFSS	<b>Behavioral Risk Factor Surveillance System</b>	The CDC's Behavioral Risk Factor Surveillance System (BRFSS) is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

ACRONYM	MEANING	DESCRIPTION
CDC	<b>Centers for Disease Control and Prevention</b>	Part of the Department of Health and Human Services, CDC's main goal is to protect public health and safety through the control and prevention of disease, injury, and disability. CDC focuses national attention on developing and applying disease control and prevention. In addition, CDC researches and provides information on non-infectious diseases such as obesity and diabetes.
CMS	<b>Center on Medicare and Medicaid Services</b>	Federal agency under U.S. Department of Health and Human Services responsible for administering the Medicare and Medicaid Programs.
DDD	<b>Developmental Disabilities Division</b>	Division within the State Department of Health that provides and maintains services for persons with developmental or intellectual disabilities.
DHS	<b>Department of Human Services</b>	State department that provides programs, services and benefits to empower the most vulnerable in Hawai'i to expand their capacity for self-sufficiency, self-determination, independence, healthy choices, quality of life and personal dignity.
DOH	<b>Department of Health</b>	State department that protects and improves the health and environment for all people in Hawai'i.
EOA	<b>Executive Office on Aging</b>	Federal and State designated state unit on aging administratively attached to the State Department of Health. Designated lead state agency in the coordination of a statewide system of aging and family caregiver support services in the State of Hawaii, as authorized by federal and state laws.
HAP	<b>Healthy Aging Partnership</b>	Statewide coalition of partners promoting evidence-based chronic disease management programs.
HAWAII SHIP	<b>Hawaii State Health Insurance Assistance Program</b>	Hawaii SHIP provides free, in depth, one-on-one insurance counseling and assistance to Medicare beneficiaries, their families, friends, and caregivers. The program is funded by a grant from the federal U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL).
HHS	<b>U.S. Department of Health and Human Services</b>	The mission of HHS is to enhance and protect the health and well-being of all Americans. HHS fulfills that mission by providing for effective health and human services and fostering advances in medicine, public health, and social services. HHS is responsible for administering Social Security, and public health and family support services.
HRS	<b>Hawaii Revised Statutes</b>	Codified permanent State laws in Hawai'i passed by the State Legislature.

ACRONYM	MEANING	DESCRIPTION
<b>LGBT</b>	<b>Lesbians, Gay, Bisexual, and Transgender</b>	Terms used to describe sexual orientation and gender identity.
<b>LTC</b>	<b>Long Term Care</b>	Services for people who need ongoing assistance with their daily tasks. Includes institutional and non-institutional types of services.
<b>LTCOP</b>	<b>Long Term Care Ombudsman Program</b>	The LTCOP was established by federal and state statutes. The Ombudsman identifies, investigates, and resolves complaints that are made by, or on behalf of residents, and related to action, inaction, or decisions that may adversely affect the health, safety, welfare, and rights of residents of long term care facilities such as nursing homes, adult residential care homes, assisted living facilities, and other long-term care facilities.
<b>LTSS</b>	<b>Long Term Services and Supports</b>	Services that enable persons with disabilities and older adults live in the community. These include services such as home care, personal care, chore services, home and congregate meal services, etc.
<b>MedQUEST</b>	<b>QUEST: Quality care Universal access Efficient utilization Stabilizing costs Transforming the way health care is provided to members.</b>	Division of the State Department of Human Services. Administers Medicaid programs such as QUEST, which provides health coverage through health plans for medical and mental health services for eligible Hawaii residents.
<b>NWD</b>	<b>No Wrong Door</b>	Federal grant to implement a system that streamlines access to long term care options for all populations and all payers.
<b>OAA</b>	<b>Older Americans Act</b>	1965 federal law that provides assistance in the development of new or improved programs to help older persons. Authorizes grants to states for community planning and services.
<b>PABEA</b>	<b>Policy Advisory Board on Elderly Affairs</b>	Consumer advisory board to the Executive Office on Aging established in Hawaii statute.
<b>SMP</b>	<b>Senior Medicare Patrol</b>	SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. SMPs are grant-funded projects of the federal U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL).

ACRONYM	MEANING	DESCRIPTION
<b>Title III</b>		Title III provides for OAA formula grants to State agencies on aging, under approved State plans, to stimulate the development or enhancement of comprehensive and coordinated community-based systems resulting in a continuum of services to older persons with special emphasis on older individuals with the greatest economic or social need, with particular attention to low-income minority individuals.
<b>Title VI</b>		Provides funds for OAA Title III type services for indigenous populations.
<b>Title VII</b>		Provides OAA funds for vulnerable elderly rights activities.



# **APPENDIX I**

State Planning Meetings with the  
AAAs to Develop the 2019-2023  
Hawaii State Plan on Aging

# 2019-2023 Hawaii State Plan on Aging Planning Meeting with the AAA's

## July 9, 2018 Meeting Agenda

1. Meeting Objectives
  - A. State Plan and Area Agency on Agency (AAA) Plans
  - B. Program Instructions
  - C. Timelines
  - D. Components to include in the AAA's 4-year (2019 - 2023) Plan on Aging
  - E. Development of Goals, Strategies, Objectives
  - F. Agreement of State Goals and Strategies to ensure County Goals and Strategies are consistent with State Goals

2. State Plan and AAA Plans

As required by the Older Americans Act of 1965 (as amended through P.L. 114-144, enacted April 19, 2016; sec. 307, p. 59-71), to be eligible for grants or funding under this Act each State must develop a State Plan and require each area agency on aging to develop their AAA Plans for approval in accordance with a uniform format developed by the State.

3. Program Instructions (AoA-PI-14-01)

AoA Program Instructions, AoA-PI-14-01 (**Handout #1**) provides States guidelines for developing and submitting their FY2015 State Plans as well as requirements that must be met by the Area Agencies on Aging to develop their plans. Per our Region IX, ACL Aging Services Program Specialist, Dennis Dudley, the FY 2015 Program Instructions has not been updated yet and is the most current version to date and should be used and followed by our State and the AAAs in developing our 2019-2023 State Plan and County plans.

Pages 2-3 of the Program Instructions specifically requires all State Plans include measurable objectives that address all the following focus areas: Older Americans Act Core Programs, ACL Discretionary Grants, Participant- Directed /Person-Centered Planning and Elder Justice. **Handout #2** summarizes all the focus areas that are required to be addressed in the State Plan which should also be addressed in your County plans.

Page 9 of the program instructions, include Sec 306(a) which explains what is required by the Area Agencies on Aging in their Area Plans. (**Handout #3**, Area Plans)

4. Timelines (**Handout #4**)

5. Components of the Area Agencies on Aging 4 Year Area Plan on Aging (**Handout #3**)

- A. **Components to Include in the 2013-2019 County Plans on Aging (see Sec 306 (a) of the OAA of 1965 as amended, Program Instructions (AoA-PI-14-01):**

Verification of Intent

Executive Summary

Orientation to the Area Plan

Overview of the Aging Network

Mission and Vision of the AAA

Organization Structure

Planning Process

Identification and Assessment of Needs and provision of services to meet the needs of older individuals and persons with disabilities in the AAA's service areas

Overview and Population Profiles of older individuals and persons with disabilities including individuals with greatest economic and social needs or at risk of institutional placement in the County (low income minorities, residing in rural or hard to reach areas, with severe disabilities, limited English proficiency, with Alzheimer's disease and other related disorders with neurological and organic brain disfunction, etc.)

Service Area Issues of Concern/Unmet needs

Outreach efforts to identify individuals eligible for assistance

Description of Existing Programs and Provision of Services to Meet Needs

Action/Implementation Plan (Development of AAA Objectives consistent with State Policy for providing services (focus areas) to older individuals and persons with disabilities with greatest economic need, social need, or at risk of institutional placement. Discuss how the AAA and their providers will meet the service needs of older individuals and persons with disabilities with greatest economic need, social need, or at risk of institutional placement. in their County and accomplish their objectives as established in their plan)

Financial/Funding Plan

Evaluation Plan

Appendices

Any Questions or Further Information Needed by AAAs?

3. Development of Statewide Goals, Strategies and Objectives
  - A. Definition of a Goal, Strategy and Objective
    - Goal - Broad primary outcome or what you want to achieve
    - Strategy - Approach you take to achieve a goal.
    - Objective - Measurable step you take to achieve a strategy.
  - B. Current Goals & Strategies of the 2017 -2019 Hawaii State Plan on Aging (**Handout #5**)
  - C. Discussion of the Goals & Strategies in the 2019 -2023 Hawaii State Plan on Aging.
4. Agreement of Statewide Goals and Strategies to Align with County Plans
5. Questions or further information needed by AAAs?

**PROGRAM INSTRUCTION**

AoA-PI-14 - 01

TO: State Agencies on Aging Administering Plans under Title III of the Older Americans Act of 1965, as amended

SUBJECT: Guidance on the Development and Submission of State Plans, Amendments and Intrastate Funding Formulas

LEGAL REFERENCES: Sections 305, 306, 307, 308, 373, and 705, of the Older Americans Act of 1965, As Amended

The purpose of this Program Instruction (PI) is to provide States with guidelines for use in developing and submitting FY 2015 State Plans and amendments including intrastate funding formula (IFF) requirements.

Resources available to assist States in the development and writing of their State Plan include:

- Your Administration for Community Living (ACL) Regional Support Center
- The TASC Planning Zone – a national aging services planning model at [http://www.nasuad.org/tasc/tasc\\_index.html](http://www.nasuad.org/tasc/tasc_index.html). As of October 2012, the TASC Planning Zone project ended. Resources on the site may still be helpful; however, they may not be the most current.

**The PI contains the following:**

**I. STATE PLAN PURPOSE AND FOCUS AREAS**

- A. Older Americans Act (OAA) Core Programs
- B. ACL/AoA Discretionary Grants
- C. Participant-Directed/Person-Centered Planning
- D. Elder Justice

**II. STATE PLAN CONTENT**

- A. Signed Verification of Intent Page from State Governor or designee
- B. Narrative
- C. Intrastate Funding Formula
- D. Attachments

**III. STATE PLAN/AMENDMENT SUBMISSION AND APPROVAL**

**IV. ATTACHMENTS:** (to this Program Instruction)

**I. STATE PLAN PURPOSE AND FOCUS AREAS**

The State Plan serves multiple purposes:

- **Documenting** the tangible outcomes planned and achieved as a result of state long-term care reform efforts.

- **Translating** activities, data, and outcomes into proven best practices, which can be used to leverage additional funding.
- **Providing a Blueprint** that spells out the coordination and advocacy activities the state will undertake to meet the needs of older adults, including integrating health and social services delivery systems.
- **Building Capacity** for long-term care efforts in the state.

States should succinctly incorporate into the State Plan as many of their activities related to aging as possible, regardless of funding source, while keeping in mind the maximum length of 30 pages for the plan narrative. The plan should serve as a valuable tool for planning/tracking all efforts on behalf of older adults.

### **Focus Areas for FY 2015 State Plans**

State plans must include measurable objectives that address all of the focus areas, A-D, below. In developing objectives, consider the role these areas serve in optimizing the state’s long-term services and supports system (LTSS) for older adults and their caregivers.

Data and other resources for developing measurable objectives/performance measures are available on the “Resource Links” section of the TASC Planning Zone.

**A. Older Americans Act (OAA) Core Programs** - OAA core programs are encompassed in Titles III (Supportive Services, Nutrition, Disease Prevention/Health Promotion and Caregiver Programs), VI (Native American Programs), and VII (Elder Rights Programs), and serve as the foundation of the national aging services network. Describe plans to: coordinate Title III programs with Title VI Native American programs; strengthen or expand Title III & VII services; increase the business acumen of aging network partners; work towards the integration of health care and social services systems; and integrate core programs with ACL discretionary programs addressed in Focus Area B below.

Specific resources to assist states in maximizing coordination and planning efforts in Core programs are available on the “Resource Links” section TASC Planning Zone:

**B. ACL Discretionary Grants** – For each of the following ACL Discretionary Grant programs received by your state, develop measurable objectives that include integration of these programs with OAA core programs above (Focus Area A): Alzheimer’s Disease Supportive Services Program (ADSSP); Evidence-Based Disease and Disability Prevention Programs; Senior Medicare Patrol (SMP) and programs that support community living.

Note: For ADRC Discretionary grants, list your 1) Projected Objectives, 2) Partners, and 3) Budget leading to the statewide expansion of ADRCs and full integration with OAA core programs.

Specific resources to assist states in developing objectives for respective ACL discretionary grants are available at links below as well as on the “Resource Links” section of the TASC Planning Zone.

**Community Living** (ADRCs, Community Living Program, Alzheimer’s Disease Supportive Services Program)

<http://www.adrc-tae.org/tiki-index.php?page=HomePage>

### **Evidence Based Disease Prevention Programs**

<http://www.healthyagingprograms.org/content.asp?sectionid=32>

States should also describe how they are or will take advantage of opportunities through the Affordable Care Act, e.g., *Money Follows the Person Program, Balancing Incentives Program, Community-Based Care Transition Program, etc.* Are there new activities taking place as a result of this funding? Have new partnerships formed? Include information about existing or new plans in this area.

**C. Participant-Directed/Person-Centered Planning** – Making fundamental changes in state policies and programs which support consumer control and choice is recognized as a critical focus for State Plans. OAA Title VII programs and services are designed to support this effort, and opportunities also exist for maximizing consumer control and choice in Title III and VI programs. Describe your planned efforts (measurable objectives) to support participant-directed/person-centered planning for older adults and their caregivers across the spectrum of long term care services, including home, community and institutional settings.

Specific resources to assist states with building consumer choice and control into aging programs are available at the link below as well as on the “Resource Links” section of the TASC Planning Zone.

### **National Resource Center for Participant Directed Services**

<http://www.bc.edu/schools/gssw/nrcpds/>

**D. Elder Justice** - As part of their leadership role in coordinating programs and services for the protection of vulnerable adults under Title VII,<sup>1</sup> States should describe their activities to prevent, detect, assess, intervene, and/or investigate elder abuse, neglect, and financial exploitation. Describe planned efforts (with measurable objectives) to support and enhance multi-disciplinary responses to elder abuse, neglect and exploitation involving adult protective services, LTC ombudsman programs, legal assistance programs, law enforcement, health care professionals, financial institutions, and other essential partners across the state.

Specific resources to assist states in supporting multi-disciplinary responses to elder abuse are available at the links below, as well as, on the “Resource Links” section of the TASC Planning Zone.

### **LTC Ombudsman:**

[www.ltcombudsman.org](http://www.ltcombudsman.org)

### **Elder Rights**

[http://www.nasuad.org/tasc/elder\\_rights\\_program.html](http://www.nasuad.org/tasc/elder_rights_program.html)

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<sup>1</sup> Adapted from Section 721(d) of the OAA

## II. STATE PLAN CONTENT

The State plan is made up of:

- A. Signed Verification of Intent Page from State Governor or designee;
- B. Narrative;
- C. Intrastate Funding Formula; and
- D. Attachments.

*In order to facilitate a timely review of the plan, please provide an index and page numbers.*

### **A. Signed Verification of Intent Page from State Governor or Designee;**

The state plan must be signed by the Governor or the individual (designee) to whom the Governor has granted signature authority. Such authority should be obtained in writing from the Governor's office and be on file should ACL need to verify the designation.

### **B. Narrative:**

The narrative portion of the State Plan should be comprised of no more than 30 pages. In order to stay within this maximum, the State may wish to submit lengthy survey information, demographics, etc., as separate attachments to the plan. The narrative should clearly address the following areas:

1. Executive Summary (approximately 3 pages) - The executive summary should stand alone in summarizing the state's planned efforts on behalf of older individuals. A well written summary can aid the state in educating the public, lawmakers, and other agencies, and can assist in securing additional resources.
2. Context – The context sets the stage for the State Plan and describes the issues to be addressed in the rest of the document. *A summary of needs assessment activities undertaken by the state, as well as the findings of such activities, should be included here. Further, the findings should correspond to the outlined goals and objectives in "3" below. Indicate how your state solicited input for development or the plan, e.g., public hearings, website, etc.*
3. Goals and Objectives – Goals are visionary statements that describe the strategic direction in which the state is moving while objectives are the attainable, specific, and measurable steps the State will take to achieve its goals. *One or more objectives should be included for each of the 4 focus areas on Pages 2 & 3 of this PI.*
4. Strategies – Strategies outline how the goals and objectives will be achieved. *Indicate whether your state will implement cost sharing during the plan period, and if so, how you will meet the statutory requirements outlined in OAA Sec. 315(a). List possible barriers and how the State plans to address them.*
5. Outcomes and Performance Measures related to Focus Areas – Outcomes document the benefit older individuals should derive from the state plan goals, objectives and

strategies. *Such measures are encouraged either as measurable objectives outlined in “3” above, or in addition to objectives.*

6. Quality Management – Quality management of service programs encompasses three functions: data collection to assess ongoing program implementation, remediation of problem areas, and continuous improvement. *Describe any quality management activities that will be undertaken during the plan period, e.g., implementation of the HCBS Quality Framework.*  
(<http://www.nasuad.org/hcbs/article/home-and-community-based-services-supports-quality-indicator-database-website-and>)

Specific resources are available for each of the above sections on “The Plan” drop down menu of the TASC Planning Zone at [http://www.nasuad.org/tasc/tasc\\_index.html](http://www.nasuad.org/tasc/tasc_index.html).

### **C. Intrastate Funding Formula:**

Each new State plan submittal must include a copy of the current intrastate funding formula (IFF) and the resulting funding allocation to the planning and service areas. Any revisions to the IFF must be clearly indicated and take into consideration the statutory requirements listed in Attachment C, Intrastate Funding Formula Requirements. Any change to IFF factors or weights requires approval by the Assistant Secretary. Revisions that do not coincide with a new State plan submittal must be submitted as a State plan amendment. Attachment C to this PI, Intrastate Funding Formula (IFF) Requirements, is a guide to the development of new or revised IFFs and is provided for information purposes.

### **D. Attachments** (to the State Plan document):

The number and type of state plan attachments will vary from state to state; however, *every state plan must include Attachment A from this PI, State Plan Assurances and Activities, as well as, Attachment B, Information Requirements.* Other attachments to the plan could include demographic data, needs analysis, special initiatives, etc. In order to facilitate review of intrastate funding formulas (IFFs), please include your State IFF as a separate and labeled attachment to the plan.

## **III. STATE PLAN/AMENDMENT SUBMISSION AND APPROVAL**

A State Agency on Aging may elect to develop a new State Plan for a two, three or four-year period. A State with a current two or three-year plan may request an extension, or may amend its current plan if needed; however, at the end of a four-year plan, the State must develop a new Plan. *There is no statutory authority to extend a Plan beyond a four-year period.*

The deadline for submission of new State Plans, extensions, and plan amendments to the appropriate Regional Support Center is **July 1, 2014**, or at least 90 days prior to the end date of the current plan. *States should seek technical assistance from their ACL Regional Support Center throughout State Plan development, and may want to submit at least one draft prior to submission of the final plan to ensure a complete and satisfactory submission.* This will allow problems to be addressed before signatures of State officials are obtained.



While most State Plan amendments are submitted during the timeframe for new plans, amendments may be submitted anytime they are needed to keep the plan current, and/or to incorporate significant changes desired by the State. States may submit two different types of State plan amendments to their respective Regional Support Centers:

- An amendment for Assistant Secretary (ASA) approval is submitted when a State proposes either of the following:
  - Changes to the intrastate funding formula; or
  - Major changes in objectives such as initiating or deleting an objective related to funding a particular service/initiative, e.g., starting/stopping a transportation program, starting/stopping an ADRC or similar long term care reform project.
  
- An amendment for update purposes i.e., to keep the plan current, is submitted when a State undertakes any of the following:
  - Changes to planning and service areas (PSAs) and/or the designation of area agencies on aging (AAAs);
  - Changes to the State agency on aging structure; or
  - Any other significant change to the plan not listed above.

States should contact their Regional Support Center for assistance with submission of both types of amendments.

State Plans/Amendments are submitted electronically via email to the appropriate Regional Support Center of the Administration for Community Living (ACL). The Verification of Intent with original signatures of approving officials may be scanned into or attached to the plan document. The Regional Support Center will review State Plans/Amendments and send recommendations to the Assistant Secretary regarding approval. Certain amendments will be transmitted by the Regional Support Center to the Central Office of ACL for update purposes only.

#### **IV. ATTACHMENTS:** (to this Program Instruction)

Attachment A – State Plan Assurances and Required Activities includes all statutory assurances and activities related to the development/implementation of State plans, and must be reviewed, signed and included in the State plan. In addition, documentation of how the State will address each assurance must be maintained at the State and made available for review by ACL, as appropriate.

Attachment B – Information Requirements includes all specific information requirements related to development/implementation of the State plan. The State responses to these requirements must be listed within the Attachment and submitted with the State plan.

Attachment C -- **Intrastate Funding Formula (IFF) Requirements** is a guide to the development of new or revised IFFs and is provided for informational purposes. This attachment **does not need** to be included in the State plan/amendment submittal.

EFFECTIVE DATE: Immediately

INQUIRIES TO:       Regional Administrators on Aging  
                          ACL Support Centers

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Kathy Greenlee  
Assistant Secretary for Aging

**FY 2015 State Plan Guidance  
Attachment A**

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

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

**ASSURANCES**

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

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

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

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

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

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

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

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

**Sec. 306(a), AREA PLANS**

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and  
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

- (I) older individuals residing in rural areas;
- (II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (IV) older individuals with severe disabilities;
- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

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

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

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will

pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

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

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

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

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

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

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency

response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

### **Sec. 307, STATE PLANS**

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

(7)(B) The plan shall provide assurances that--

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

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

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

(11)(A) The plan shall provide assurances that area agencies on aging will--

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

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in

the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

- (A) public education to identify and prevent abuse of older individuals;
- (B) receipt of reports of abuse of older individuals;
- (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D) referral of complaints to law enforcement or public protective service agencies where appropriate.

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

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

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

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—



(A) identify individuals eligible for assistance under this Act, with special emphasis on—

- (i) older individuals residing in rural areas;
- (ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- (iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- (iv) older individuals with severe disabilities;
- (v) older individuals with limited English-speaking ability; and
- (vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

- (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
- (B) are patients in hospitals and are at risk of prolonged institutionalization; or
- (C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall

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

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

- (23) The plan shall provide assurances that demonstrable efforts will be made--  
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and  
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.
- (24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.
- (25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.
- (26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.
- (27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

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

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

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

- (1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.
- (2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

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

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

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

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

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

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

(iii) upon court order

**FY 2015 State Plan Guidance  
Attachment A (Continued)**

**REQUIRED ACTIVITIES**

**Sec. 307(a) STATE PLANS**

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

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

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

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

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

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

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

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*Signature and Title of Authorized Official*

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*Date*

**FY 2015 State Plan Guidance**  
**Attachment B**  
**INFORMATION REQUIREMENTS**

*States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.*

**Section 305(a)(2)(E)**

*Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;*

**Section 306(a)(17)**

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.*

**Section 307(a)(2)**

The plan shall provide that the State agency will:

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

**Section (307(a)(3)**

The plan shall:

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

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

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

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

**Section 307(a)(10)**

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

**Section 307(a)(14)**

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) *identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency;* and

(B) *describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.*

**Section 307(a)(21)**

The plan shall:

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

**Section 307(a)(29)**

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

**Section 307(a)(30)**

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

**Section 705(a)(7)**

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

(7) *a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).*

*(Note: Paragraphs (1) of through (6) of this section are listed below)*

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

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

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

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

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

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

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

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

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

*(ii) receipt of reports of elder abuse;*

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

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

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

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

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

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

*(iii) upon court order*



## FY 2015 State Plan Guidance Attachment C

### INTRASTATE (IFF) FUNDING FORMULA REQUIREMENTS

Each State IFF submittal must demonstrate that the requirements in Sections 305(a)(2)(C) have been met:

OAA, Sec. 305(a)(2)

*“States shall,*

*(C) in consultation with area agencies, in accordance with guidelines issued by the Assistant Secretary, and using the best available data, develop and publish for review*

*and comment a formula for distribution within the State of funds received under this title that takes into account--*

*(i) the geographical distribution of older individuals in the State; and  
(ii) the distribution among planning and service areas of older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority older individuals.”*

- For purposes of the IFF, “best available data” is the most recent census data (year 2010). More recent data of equivalent quality available in the State may be considered.
- As required by Section 305(d) of the OAA, the IFF revision request includes: a descriptive Statement; a numerical Statement; and a list of the data used (by planning and service area).
- The request also includes information on how the proposed formula will affect funding to each planning and service area.
- States may use a base amount in their IFFs to ensure viable funding across the entire state.

**PROGRAM INSTRUCTION**

AoA-PI-14 – 01

**Detailed Focus Areas for FY 2015 State Plans**

State plans must include measurable objectives that address all of the focus areas, A-D, below. In developing objectives, consider the role these areas serve in optimizing the state’s long-term services and supports system (LTSS) for older adults and their caregivers.

**A. Older Americans Act (OAA) Core Programs** - Serve as the foundation of the Nat’l Aging Services Network:

1. Title III Services and Programs
  - a. **Supportive Services** (Personal Care, Homemaker, Chore, Home Delivered Meals, Adult Day Care, Case Management, Assisted Transportation, Transportation, Congregate Meals, Information and Assistance, Outreach. Other services)
  - b. **Nutrition** (Nutrition Counseling, Nutrition Education, Outreach, Other services)
  - c. **Disease Prevention/Health Promotion** (Outreach, Other Services)
  - d. **Caregiver Programs** (Counseling, Support Groups, Caregiver Training, Respite Care, Access Assistance Information Services, Supplemental Services, Outreach)
2. Title VI Native American Programs
3. Title VII Elder Rights Programs (Information and Assistance, Outreach, Other Services)

Describe plans to: coordinate Title III programs with Title VI Native American programs; strengthen or expand Title III & VII services; increase the business acumen of aging network partners; work towards the integration of health care and social services systems; and integrate core programs with ACL discretionary programs addressed in Focus Area B below.

**B. ACL Discretionary Grants** – For each of the following ACL Discretionary Grant programs received by your state, develop measurable objectives that include integration of these programs with the OAA core programs above (Focus Area A):

1. **Alzheimer’s Disease Supportive Services Program (ADSSP);**
2. **Evidence-Based Disease and Disability Prevention Programs;**
3. **Senior Medicare Patrol (SMP);** and
4. **Programs that support community living.**

Note: For ADRC Discretionary grants, list your 1) Projected Objectives, 2) Partners, and 3) Budget leading to the statewide expansion of ADRCs and full integration with OAA core programs.

States should also describe how they are or will take advantage of opportunities through the Affordable Care Act, e.g., *Money Follows the Person Program, Balancing Incentives Program,*

*Community-Based Care Transition Program, etc.* Are there new activities taking place as a result of this funding? Have new partnerships formed? Include information about existing or new plans in this area.

- C. Participant-Directed/Person-Centered Planning** – Making fundamental changes in state policies and programs which support consumer control and choice is recognized as a critical focus for State Plans. OAA Title VII programs and services are designed to support this effort, and opportunities also exist for maximizing consumer control and choice in Title III and VI programs.

Describe your planned efforts (measurable objectives) to support participant-directed/person-centered planning for older adults and their caregivers across the spectrum of long term care services, including home, community and institutional settings.

- D. Elder Justice** - As part of their leadership role in coordinating programs and services for the protection of vulnerable adults under Title VII, States should describe their activities to prevent, detect, assess, intervene, and/or investigate elder abuse, neglect, and financial exploitation.

Describe planned efforts (with measurable objectives) to support and enhance multi-disciplinary responses to elder abuse, neglect and exploitation involving adult protective services, LTC ombudsman programs, legal assistance programs, law enforcement, health care professionals, financial institutions, and other essential partners across the state.

**NOTE:** *The following is an excerpt of Sec 306 (a) of the Older Americans Act of 1965 , as amended, relating to the format of Area Plans, from Program Instruction (AoA-PI-14-01), ACL Guidance on the Development and Submission of State Plans, Amendments and Intrastate Funding Formulas:*

**PROGRAM INSTRUCTION  
AoA-PI-14 - 01**

**Sec. 306(a), AREA PLANS**

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services -

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--

(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

(6)(F) Each area agency will:

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

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

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including -

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

- (13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.
- (13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
- (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
  - (ii) the nature of such contract or such relationship.
- (13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.
- (13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.
- (13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.
- (14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.
- (15) provide assurances that funds received under this title will be used
- (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
  - (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;
- (17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

**2019-2023 State Plan and AAA County Plans on Aging Timeline** (rev 07-09-18)

October 1, 2019 - September 30, 2023

1. July 9, 18 WebEx to discuss the development of the 2019-2023 State Plan on Aging & County's planning efforts to develop their County Plans on Aging.  
Discuss Statewide Goals
2. July 19, 18 Obtain Timeline of the AAA County Plan
3. Aug 15, 18 Progress of AAA County Plan – Provide any technical assistance needed (WebEx)
4. Aug 15, 18 Determine preliminary Strategies & Objectives with the AAAs for the 2019-2023 State Plan on Aging.
5. Sept 20, 18 Progress of AAA County Plan – Provide any technical assistance needed (WebEx)
6. Feb 4, 19 **Draft AAA County Plans due to EOA**
7. **Mar 30, 19** **Final Draft AAA County Plans**
8. April 31, 19 2019-2023 State Plan on Aging Completed
9. May 1-30, 19 Public Hearings
10. June 1, 19 Submit Final 2019-2023 State Plan on Aging to Governor for Approval
11. July 1, 19 Submit 2019-2023 State Plan on Aging to ACL Region IX for Approval

**Goals and Strategies (Source: 2017-2019 Hawaii State Plan on Aging)**

**Goal 1: Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.**

Strategy 1-1: Utilize Title IIID funds to expand the existing wellness and health

Strategy 1-2: Continue to provide ongoing support to the Healthy Aging Partnership for Medicare reimbursement for Stanford's Diabetes Self-Management Program.

Strategy 1-3: Provide the AAAs with options to enhance their nutrition services to appeal to a broader segment of older adults and to address the difficulty they face in finding qualified dietitians to provide nutrition counseling.

*Strategy 1-4: Encourage more older adults to serve as volunteers in the OAA grant programs.*

**Goal 2: Forging partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.**

Strategy 2-1: Have individuals in need of Long term support services (LTSS) receive a common intake and assessment, person-centered counseling, an individualized support-plan, care coordination as appropriate, and be referred and have easy access to the appropriate services.

Strategy 2-2: Train AAA and provider staff on the needs and concerns of persons with dementia and their caregivers and on available resources in the community.

Strategy 2-3: Improve access to culturally sensitive services for older adults of Hawaiian ancestry.

**Goal 3: Developing a statewide ADRC system for older adults and their families to access and receive long-term services and supports (LTSS) within their counties.**

Strategy 3-1: Review the ADRC 5-Year Plan for components that need to be met and incorporated into the NWD implementation plan.

Strategy 3-2: Strengthen the linkage between the ADRC and the OAA grant programs.

Strategy 3-3: Monitor the performance of participant-directed coaches, assessors, and the fiscal management service.

Strategy 3-4: Implement EOA's Language Access Plan which is currently being reviewed by the State Attorney General (See Appendix E).



**Goal 4: Enabling people with disabilities and older adults to live in their community through the availability of and access to high-quality LTSS, including supports for families and caregivers.**

Strategy 4-1: Work closely with all service providers to efficiently administer existing OAA Title III home and community-based support programs to persons with disabilities.

Strategy 4-2: Coordinate with Medicaid for older adults who may benefit from access to needed LTSS through Medicaid.

**Goal 5: Optimizing the health, safety, and independence of Hawaii’s older adults.**

Strategy 5-1: A key responsibility of the LTCOP is to improve the quality of care and the quality of life of for Hawaii’s long-term care residents through advocacy and information dissemination. LTCOP will develop agreements that will enable it to better secure the safety of older adults in Hawaii.

Strategy 5-2: LTCOP will put into place measures that will allow it to expeditiously respond to reports of suspected mistreatments of older adults.

Strategy 5-3: SMP will continue to pursue ways to better educate Medicare beneficiaries about Medicare fraud, the danger of medical identity theft, and ways to prevent, detect, and report Medicare fraud, errors, and abuse; and will pay attention to the hard-to-reach populations.

Strategy 5-4: SMP will continue to partner and meet quarterly with other stakeholders in the prevention, detection, and prosecution of Medicare fraud and abuse. The partners include representatives from the Centers of Medicare and Medicaid Services, Offices of the U.S. Attorney and the State Insurance Commissioner, Medicaid Fraud Control Unit, U.S. Postal Inspection Service, Better Business Bureau, AAAs, Hawaii SHIP, and the State LTCOP.

**NOTE: Focus areas in Program instructions that should be included in 2019-2023 State Plan:**

- 1. Supportive services**
- 2. Caregiver programs**
- 3. Alzheimer’s Disease Supportive Services Program (ADSSP)**
- 4. Programs that support community living**
- 5. Participant - Directed/Person - Centered Planning**
- 5. Elder Justice**

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**Cc:** [Kuriki, Tania L.](#); [Nagatoshi, Charles T.](#); [Valenzuela, Cristina C.](#); [Byers, Terri](#); [Cadirao, Caroline M.](#)  
**Subject:** Follow-Up to WebEx re: State Plan on Aging & AAA County Plans on Aging  
**Date:** Tuesday, July 10, 2018 5:41:00 PM  
**Attachments:** [Handout #4 - Rev Timeline 2019-2023 State Pln & County Plns on Aging rev 070918.docx](#)  
[2019-2023 Hawaii State Plan on Aging Goals rev 07-09-18.docx](#)  
[Funding Plan - Title III Federal Funds.pdf](#)  
[Funding Plan - 4 yr Planned Svc Outputs & Resource Allocations.pdf](#)  
[Minimum % for Title III part B Categories of Svcs.pdf](#)

Hi Everyone!

I would like to thank all of you for attending and providing your valuable input at our WebEx meeting yesterday regarding the development of our 2019 - 2023 State Plan on Aging and the 2019 – 2023 County Plans on Aging. As a follow up to your comments, attached are the following:

1. **“Handout 4: Revised 2019-2023 State Plan & AAA County Plans on Aging Timeline”** – Handout was revised to reflect input (see highlighted areas) from the AAAs that preliminary drafts of their county plans will be submitted in February 2018 to the EOA with a Final Draft County Plan submitted in late March.
2. **“2019-2023 Hawaii State Plan on Aging Goals rev 07-09-18”** – As a result of a group discussion and input from all the AAAs, Five (5) State Goals were developed and agreed upon (SEE Attached Goals). Input received were as follows:
  - a. All Goal Statements should start with a strong “Action Verb” such as Maximize, Forge, Strengthen, Enable, Optimize
  - b. Goal 1 should, “Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.”
  - c. Goal 2 should, “ Forge partnerships and alliances that will give impetus to meeting Hawaii’s greatest challenges of the aging population.”
  - d. The group expressed that in our previous plans the State and the AAAs were in the process of developing their Statewide ADRC system. In the next 4 years the group hopes to work on further strengthen the ADRC system for persons with disabilities, older adults, and their families. Hence, Goal 3 should, “Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.”
  - e. By strengthening the statewide ADRC in Goal 3, this will then lead towards the achieving Hawaii’s Goal 4 to “Enable older adults to live in their communities through the availability of and access to high quality long term care services and supports (LTSS), including supports for their families and caregivers.”
3. **Financial/Funding Plan** – The group recommended that EOA seek input from Shannon as well as Caroline as to what was needed by the AAAs to include in their County Plans. Caroline suggested that the AAAs include the following:
  - a. FY2018 Title III Federal Funds Expenditures for Priority Services (**SEE ATTACHED**

File named, “*Funding Plan – Title III Federal funds,*” excerpt from the 2007-2011 Kauai County Area Plan on Aging).

- b. A Four (4) year (FY2020, FY2021, FY2022, FY2023) planned Service Outputs and Resource Allocation Level (**SEE ATTACHED** file named “Funding Plan-4 yr Planned Svc Outputs,” excerpt from the 2007-2011 Kauai County Area Plan on Aging).
- c. Minimum Percentage of for Title III, Part B Categories of Services. (**SEE ATTACHED** File named “Minimum % for Title III, Part B Categories of Services”)

Should you have any questions, please feel free to call or e-mail me.

Lisa

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**2019-2023 Hawaii State Plan on Aging**  
**State Goals**

- Goal 1:** Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.
- Goal 2:** Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.
- Goal 3:** Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.
- Goal 4:** Enable older adults to live in their communities through the availability of and access to high quality long term services and supports (LTSS), including supports for their families and caregivers.
- Goal 5:** Optimize the health, safety, and independence of Hawaii's older adults.

**EXHIBIT T- PART IV - Funding Plan  
 Previous Year Expenditures for Priority Services  
 (FY 2006)  
 Title III Part B Federal Funds Only**

In accordance with the Older Americans Act [Section 306 (a) (2)) the Area Agency is disclosing the amount of funds expended for each category of services during the fiscal year most recently concluded.

Service	Budgeted Compliance Amount (Dollars)	FY 06 Actual Expenditures	% for Title 111 Categories
Access			
Information & Assistance	25,471	89,050	
Outreach	6,368	22,282	
Sub-total	31,839	111,332	
Supportive Services: In-Home			
Friendly Visiting	5,307	33,347	16%
Telephone Reassurance	5,307	33,347	
Sub-total	10,614	66,694	
Legal			
Legal Assistance	42,452	91,082	
Sub-total	42,452	91,082	
Title 111 Part B Total	84,905	269,108	

Budgeted Compliance Amount — minimum amount required to be in compliance

**2019-2023 Hawaii State Plan on Aging  
Planning Meeting with the AAA's**

**August 15, 2018 (Wednesday)  
9:30 am – 11:00 am**

**WebEx Meeting Agenda**

1. "State Plan Assurances & Required Activities" has been updated.  
  
(SEE Handout, "State Plan Guidance, Attachment A, STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES, Older Americans Act, As Amended in 2016".)
2. U.S. Dept of Health and Human Services, Administration for Community Living (ACL)  
Site Visit to Hawaii  
Dennis Dudley, ACL Aging Services Program Specialist - Region IX
3. AAA's Progress Report in their Development of their County Plans
  - a. Hawaii County
  - b. Maui County
  - c. Kauai County
  - d. Honolulu County
4. 2019-2023 State Plan Goals (handout)
5. Development of Draft 2019-2023 State Plan Strategies (handout)
6. Questions or Technical Assistance Needed by AAAs

**From:** Nakao, Lisa R.

**To:** June Renaud (JRenaud@kauai.gov); Debbie Wills (dwills@hawaiicounty.gov); Clayton Honma (clayton.honma@hawaiicounty.gov); Ashley Muraoka (amuraoka@honolulu.gov); James Mariano (James.Mariano@co.maui.hi.us)

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**Subject:** Recap of today's, Aug 15, 18, WebEx on the State Plan & County Plan

**Date:** Wednesday, August 15, 2018 4:33:00 PM

**Attachments:** Rev Timeline 2019-2023 State Pln & County Plns on Aging rev 081518.docx  
2019-2023 State Plan on Aging Goals and Possible Strategies.docx  
Examples of Possible Strategies for 2019-2023 State Plan on Aging.docx

Hi Everyone!

Thank you everyone for participating in our 2019-2023 State and County Plan WebEx meeting this morning!

The following are some key issues and outcomes that was discussed at this morning's meeting:

1. All of the AAAs are planning to utilize surveys and focus groups to do their community needs assessments. To better improve their community survey instrument, the AAAs felt it would be very helpful to see the surveys of the other AAAs. **As a result, all of the AAAs are requested to e-mail their community surveys to Lisa Nakao ([lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov)) and Lisa in turn, will send the surveys to all of the AAAs.**
2. The AAAs requested the most current BRFSS data to use for their County Plan. Charles Nagatoshi will look into this and send all the AAAs the most current BRFSS data that is available.
3. **Please contact Charles Nagatoshi (phone: 586-7289; e-mail: [charles.nagatoshi@doh.hawaii.gov](mailto:charles.nagatoshi@doh.hawaii.gov) ) for all data requests or data related questions.**
4. The AAAs felt that they are too early in their process of doing their community needs assessment to recommend strategies that need be included in the State Plan. As a result, the group agreed that all the AAAs will turn in their recommended strategies to be included in the 2019-2023 State Plan on Aging by September 2018. As a result, the WebEx Meeting on September 20, 2019 will be rescheduled to September 27, 2018. **(See attached revised Timeline rev 08/15/18 and handouts to assist you in recommending Strategies)**
5. **Nutrition related issues were discussed:**  
Maui County AAA – Currently working with the University of Hawaii at Manoa, College of Tropical Agriculture and Human Resources (CTAHR) on nutrition for their meals programs. They also did a generation/intergenerational activity for grandparent raising grandchildren which went really well and everyone enjoyed themselves.



Hawaii County AAA – Would like to provide more ethnic foods in their meal program that are nutritious and taste good and asked if there are nutritionists to look at the nutritional value of these local foods. The other AAAs recommended that they work with CTAHR to assist them. A list of some CTAHR resources, local recipes and their nutritional content as well as who to contact from CTAHR for more info are as follows:

<https://www.ctahr.hawaii.edu/NEW/resources.htm>

<https://www.ctahr.hawaii.edu/NEW/userzones.htm>

<https://foodskills4starters.wordpress.com/food-recipes/>

<https://www.ctahr.hawaii.edu/NEW/GG/RecipeIndex.htm>

#### 6. **Adult Abuse Issues were discussed**

Hawaii County AAA – Hawaii County currently has a pilot project shelter in Pahoia that is available for older adults that are at risk of elder abuse. The shelter is near bus stops that are convenient to meet the needs of the residents. There is a 60 time limit for the resident to transition back home. Hope Services registers residents through the Hawaii County AAA.

Maui County AAA – In 2017 Maui County AAA held an all-day Elder Abuse Awareness Conference in celebration of World Elder Abuse Awareness Day. Some topics discussed at the conference include the different types of elder abuse, how to recognize the signs of adult abuse, what to do when you suspect adult abuse is occurring, what happens once a case of adult abuse is reported, etc. There was such a good turnout at the conference that Maui County AAA is in the process of planning another conference next year.

#### 7. **Key Dates (see attached updated Timeline):**

**Sept 20, 2018 – Submit** your recommended Strategies (For each Goal) for the 2019 – 2023 Hawaii State Plan on Aging

**Sept 27, 2018 – Next WebEx Meeting – State Plan and Technical Assistance on County Plan**

Thanks again everyone for attending today's WebEx meeting! See you at our next meeting on September 27th!

Lisa

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**2019-2023 Hawaii State Plan on Aging & County Plans on Aging  
Planning Meeting with the AAA's**

**November 29, 2018 (Thursday)  
9:30 am – 11:00 am**

**WebEx Meeting Agenda**

1. Recap of issues discussed at the last Planning Meeting in Aug 15, 2018
2. Revisit the 2019-2023 State Plan Goals (Handout)
3. AAA's Progress Report in their Development of their County Plans
  - a. Hawaii County
  - b. Maui County
  - c. Kauai County
  - d. Honolulu County
4. Discussion of Draft 2019-2023 State Plan Strategies and Objectives from the Counties
5. Questions or Technical Assistance Needed by AAAs

## **Recap of the last Aug 15, 2018 Planning Meeting on the Development of State Plan & County Plans on Aging**

1. All of the AAAs were going to utilize surveys and focus groups to do their community needs assessments. To better improve their community survey instrument, the AAAs were encouraged to share their surveys with each other.
2. The AAAs requested the most current BRFSS data to use for their County Plan. Charles Nagatoshi offered his assistance in providing the AAAs with any current BRFSS data needed by the AAAs.
3. The AAAs felt that it was too early in their process of doing their community needs assessment to recommend strategies that need be included in the State Plan. As a result, the group agreed that all the AAAs will turn in their recommended strategies to be included in the 2019-2023 State Plan on Aging by September 2018. This deadline was then extended to November 26 and then November 28 in anticipation of today's meeting.
4. Nutrition related issues were discussed. Several of the AAAs mentioned that they would like to provide more ethnic foods in their meal programs that are delicious and nutritious. Several of the AAAs mentioned that they are working with the University of Hawaii at Manoa's College of Tropical Agriculture and Human Resources (CTAHR) to assist them. A list of some CTAHR resources, local recipes and their nutritional content as well as who to contact from CTAHR for more info were provided in my August 15, 2018 e-mail that was sent to our State Plan and County Plan's Planning Group.

## 2019-2023 Hawaii State Plan on Aging

### State Goals

- Goal 1:** Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.
  
- Goal 2:** Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.
  
- Goal 3:** Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.
  
- Goal 4:** Enable older adults to live in their communities through the availability of and access to high quality long term services and supports (LTSS), including supports for their families and caregivers.
  
- Goal 5:** Optimize the health, safety, and independence of Hawaii's older adults.

**2019-2023 State Plan and AAA County Plans on Aging Timeline** (rev 11-13-18)

October 1, 2019 - September 30, 2023

1. July 9, 18 & WebEx to discuss the development of the 2019-2023 State Plan on Aging & County's planning efforts to develop their County Plans on Aging. Discuss Statewide Goals
2. July 19, 18 Obtain Timeline of the AAA County Plan
3. Aug 15, 18 (WebEx) Progress of AAA County Plan – Provide any technical assistance needed
4. Aug 15, 18 Discussed Strategies & Objectives with the AAAs for the 2019-2023 State Plan on Aging.
5. Nov 20, 18 **Deadline:** AAAs submit strategies to be in the 2019-2023 State Plan on Aging.  
E-mail to EOA via: [lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov) )
6. Nov 29, 18 **WebEx Mtg:** 2019-2023 State Plan Strategies & progress of AAA County Plan.
7. Jan 14, 2018 **Deadline:** AAAs submit objectives to be in the 2019-2023 State Plan on Aging  
E-mail to EOA via: [lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov) )
8. Feb 4, 19 Draft AAA County Plans due to EOA
9. Mar 30, 19 Final Draft AAA County Plans
10. April 31, 19 2019-2023 State Plan on Aging Completed
11. May 1-30, 19 Public Hearings
12. June 1, 19 Submit Final 2019-2023 State Plan on Aging to Governor for Approval
13. July 1, 19 Submit 2019-2023 State Plan on Aging to ACL Region IX for Approval

## City and County of Honolulu Elderly Affairs Division (EAD) Strategies

**Goal 1: Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.**

Strategy 1.1: Explore evidence-based health maintenance and fall prevention programs.

Strategy 1.2: Combat loneliness and isolation to ensure that older adults have a sense of purpose and improve their quality of life.

Strategy 1.3: Expand programs and services to be inclusive of all generations of seniors, and persons with disabilities.

**Goal 2: Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.**

Strategy 2.1: Expand, strengthen and collaborate with the Aging Network.

Strategy 2.2: Explore innovative partnerships and leverage resources to address the needs of older adults and their caregivers.

**Goal 3: Strengthen the statewide ADRC system for older adults, persons with disabilities and their families.**

Strategy 3.1: Deliver culturally competent and linguistically appropriate services to address the needs of our diverse community.

Strategy 3.2: Expand and update the resources and information on the ADRC website, to address the needs of older adults, persons with disabilities and their caregivers.

Strategy 3.3: Optimize and strengthen the ADRC system processes, accountability and sustainability.

Strategy 3.4: Develop outreach strategies that enable services to be targeted to those most in need.

**Goal 4: Enable older adults to live in their communities through the availability of and access to high quality long term services and supports (LTSS), including supports for their families and caregivers.**

Strategy 4.1: Expand and collaborate with the Aging Network to develop innovative, person centered, integrated systems and programs that meet the needs of older adults and their caregivers.

Strategy 4.2: Increase access to high-quality home and community based services for older adults and their caregivers.

Strategy 4.3: Increase awareness of the needs and challenges faced by older adults and their caregivers.

## **Goal 5: Optimize the health, safety, and independence of Hawaii's older adults.**

Strategy 5.1: Foster collaboration with the Aging Network to ensure older adults, and persons with disabilities, are safe from abuse, neglect and fraud.

Strategy 5.2: Develop partnerships to ensure that disaster preparedness planning accounts for older adults and persons with disabilities.

Strategy 5.3: Promote awareness of culturally appropriate long term care planning, including planning for the end of life.

## **HCOA 2019 -2023 Goals, Objectives, and Strategies DRAFT**

### **Goal 1 -- Age Well:**

*Maximizing opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.*

### **Keep Seniors Active**

**Objective 1.1:** Support Elderly Activities Division in their efforts to maintain, develop, and/or enhance programs that keep seniors active and socially engaged.

**Rationale 1.1:** Keeping seniors active and healthy is the cornerstone of the Hawaii County Aging Network for a number of reasons. First, active seniors spend less time in the hospital which helps to limit the rising costs of healthcare. Second, active seniors give back to the community through volunteerism which translates to huge cost savings in salary and wages. Lastly, a large percentage of active seniors are caregivers who provide care to loved-ones that would otherwise be dependent on private or state funded services.

### **Baseline 1.1:**

HCOA supports EAD through contractual arrangements for services such as RSVP, STEP, nutrition, and transportation services.

### **Outcomes 1.1:**

1. 80% of seniors who participate in HCOA county contracted programs will have favorable opinions regarding their experiences.
2. Participation in EAD programs will be sustained over time and possibly increase despite fluctuations in funding.

### **Major Action Steps 1.1:**

1. Work closely with Elderly Activities Division (EAD) by monitoring the various contracts and supporting their mission to keep seniors active and engaged.
2. Partner on county-wide initiatives that promote active health and disease prevention.
3. Advocate for continual county, state, and federal funding that support the activities and programs that keep seniors active and healthy.
4. Increase cross-training opportunities that address active and frail senior issues.

### **Effective Measures 1.1:**

1. Participant surveys assessing satisfaction.
2. Annual monitoring results



## **Enhance Nutrition Program**



- **Objective 1.2:** Explore innovative strategies to maintain senior participation in the congregate meal sites.

### **Rationale 1.2:**

Participation in the OAA Nutrition Congregate Meal program offers opportunities for seniors to engage in their community, connect socially, participate in fun activities, go shopping, and go on excursions. Congregate dining programs also provide educational activities pertaining to food nutritional values, health, chronic disease management, fall prevention, the benefits of exercise, among others. The national trend of declining congregate participation can be attributed to the aging of the current participants from the traditionalist or silent generation transitioning to Home Delivered meals or other LTC options. Addressing the needs and wants of the Baby Boomer generation presents a challenge to nutrition program providers. This generation is generally more health-conscious, well-educated, higher income, and have varied interests from previous congregate site participant cohorts of the Big Island. They tend to prefer café environments with varied meal options and other Multi-purpose Senior Center activities and services including exercise, computer labs, child care for grandchildren, for example. HCOA's objective is to assist the Hawaii County Nutrition Program in looking at innovative ways to increase and/or sustain participation at the congregate meal sites.

### **Baseline 1.2:**

Congregate meal participation over the years has leveled off at 900-1000 individuals.

### **Outcomes 1.2:**

1. Participation will be sustained at 1000 individuals or increased.
2. Number of congregate meals will be sustained or increased.
3. Over 80 percent of participants will report being satisfied with the menu.
4. Over 80 percent of participants will report being satisfied with the program.
5. Over 80 percent of participants will report maintaining or improved health.

### **Major Action Steps 1.2:**

1. Collaborate with the Hawaii County Nutrition Program, Elderly Activities Division (EAD), and other partnering agencies to plan for the enhancement of nutrition sites through providing healthier meals, offering meaningful activities, and expanding marketing strategies.
2. Research potential models, conduct cost benefit analysis, and make viable recommendations.
3. Work with EAD to consider enhancing potential or current sites with additional services such as medication management, health status monitoring, intergenerational activities, chronic disease self-management, and enhanced fitness, among others.

### **Effective Measures:**

1. # of participants.
2. # of meal sites.
3. % of participants being satisfied with the congregate meal menu.
4. % of participants being satisfied with the congregate meal program.
5. % of participants whose baseline scores on the nutritional risk assessment survey are maintained or improved annually.

### **Sustain Healthy Aging Program**



- **Objective 1.3:** As funding permits, ensure that the Better Choices, Better Health Program are available to older adults throughout Hawaii County, which includes training of Lay Leaders as needed to provide services.

### **Rationale 1.3:**

Nutrition awareness is key to sustained health for all seniors. This Stanford Patient Education Research Center is now Self-Management resource Center SMRC an Evidenced Based Program that aims to provide participants with information, motivation, inspiration, and group bonding experiences that help them make better lifestyle choices around nutrition and exercise to enhance self-efficacy.

**Baseline 1.3:** In 2018, there was a total of 73 enrolled and 52 participants completed classes and a total of 10 Lay Leaders.

### **Outcomes 1.3:**

1. By 2023, HCOA will have trained 60 participants and 70% (7 out of 10) of these participants will be surveyed with results showing an improvement or maintenance of their physical health status 6 months and 12 months after the end of each workshop.
2. Maintain Lay Leaders to a minimum of 6 on up to 12 in 2023.
3. Comparison of pre-post data will show a decrease number of visits to physicians' offices and the emergency room.
4. At 6-month follow-up, participants will report exercising more and having fewer negative health symptoms.

***\*Note: Funding streams are instable at this time and adjustments to goals may need to be made.***

### **Major Action Steps 1.3:**

1. Conduct a minimum of 6 workshops per year.

2. Identify and secure potential sites to conduct workshops and new areas in the community where workshops have not been offered.
3. Schedule workshops and coordinate training for trainers and lay leaders.
4. Evaluate each workshop with an “outside” evaluator or Master Trainer.
5. Maintain “Better Choices, Better Health” license.
6. Conduct one Lay Leader training each year as needed to maintain a pool at minimum of 5- 6 Lay Leader participants.
7. Increase visibility and outreach of program through the development and implementation of an expanded public relations effort.
8. Increase outreach efforts to Native Hawaiians.

**Effective Measures:**

1. 4 of workshops and 20 of graduates each year.
2. 70% of participants showing improvement in managing their health.
3. Better Choices, Better Health –Ke Ola Pono Outcome Data



**Goal 2 – Forge Partnerships**

*Forging partnerships and alliances that will give impetus to meeting Hawaii’s greatest challenges of the aging population.*

**MOUs**



- **Objective 2.1:** Establish and update MOU’s with government, health care, social services, financial institutions, faith-based organizations, Hawaiian organizations such as Hui Malama, and the Alzheimer’s Association just to name a few.

**Rationale 2:1:**

Services and supports for kupuna would not be possible without collaboration with partnering agencies within the aging network. In order to sustain these services, partnerships and on-going cross-agency information sharing are critical.

### **Baseline 2.1:**

In 2014, HCOA had MOU's with 15 partnering agencies.

The ADRC has provided \_\_\_ presentations and in-service training to partner organizations.

### **Outcomes 2.1:**

1. The ADRC will conduct at least two in-service presentations to partner agencies each month.
2. The ADRC will revise and execute MOU's with main partner agencies.
3. 75% of partners will express satisfaction with coordination efforts of the ADRC.

### **Major Action Steps 2.1:**

1. Identify appropriate partners, government agencies, including public and private entities.
2. Draft and execute Memoranda of Understanding.
3. Revise and implement ADRC resource inclusion/exclusion policies.
4. Establish and solidify working relations with partners.
5. Annual meeting to evaluate effectiveness of partnerships.

### **Effective Measures:**

1. Number of ADRC presentations conducted per year.
2. # of partners completing MOUs.
3. % of partners satisfied with the coordination (partnership) efforts of HCOA.

### **Rationale 2.2:**

In 2014, in Hawaii, there are approximately 25,000 individuals 65 and over who are diagnosed with Alzheimer's Disease. This is a conservative estimate, because there are likely more who are undiagnosed or who develop dementia before age 65, or those with memory loss who have not been diagnosed. The single greatest risk factor in developing Alzheimer's Disease and Related Dementias (ADRD) is age, and as the baby boomers reach 65, dementia cases will rise. Over 5.2 million people nationwide have ADRD.

### **Baseline 2.2:**

ADRC staff participate in online and in-person training on Alzheimer's disease and related dementias, as well as screening tools available for use in identifying potential dementia.

### **Outcomes 2.2:**

1. Staff and volunteers serving older adults gain knowledge on how to work with individuals with dementia, and their caregivers and families.
2. The East and West Hawaii ADRC becomes a dementia capable center.
3. People with dementia and/or their families will report satisfaction with East and West Hawaii's ADRC as dementia friendly and capable.

### **Major Action Steps 2.2:**

1. Provide dementia-capable training to HCOA staff.
2. Provide dementia-capable training to HCOA contract providers and other interested partners.
3. Establish the ADRC staff and programs as a “dementia capable” environment.

### **Effective Measures:**

1. # of dementia-capable trainings.
2. # of training participants.
3. Trained participants report feeling more empowered to work with individuals with dementia.
4. Assessment of a Dementia-capable worksite.

### **Grandparents Raising Grandchildren**



- **Objective 2.3:** Partner with private and public agencies to promote Summer and school break respite camps and organize educational opportunities for grandparents raising grandchildren.

### **Rationale 2.3:**

There are a number of grandparents raising grandchildren and it can be quite a burden caring for a child fulltime. The stress that comes with providing caregiving for a child is very high and grandparents need help. Thus, collaborating with Department of Human Services, Parks and Recreation, Recreation and Aquatics Division and private entities like Liliuokalani Trust (LT), the former Queen Liliuokalani Children’s Center (QLCC), will be key implementing an educational event for grandparents raising grandchildren.

**Baseline 2.3:** Grandparents raising grandchildren is a new initiative for the 2023 area plan.

### **Outcomes 2.3:**

1. At least 35 participants will register for a workshop.
2. Over 90% of participants will report satisfaction with the workshop.
3. As a result of the training, and or summer or school break respite at least 80% of grandparents will report that they are more confident in their grand-parenting skills.

### **Major Action Steps 2.3:**

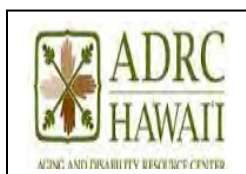
1. Establish partnerships with grandparent raising grandchildren agencies like DHS, County of Hawai'i P&R and LT.
2. Work together to identify grandparents who could benefit from training on raising children in today's era.
3. Organize a half-day workshop on grandparents raising grandchildren.
4. Select a site and make arrangements for a half or full-day training.

### **Effective Measures:**

1. # of participants.
2. % of participants satisfied with respite program camp.
3. % of participants who report feeling more confident and or rested because of the training or respite camp received at the workforce or during school breaks.

### **New Suggested Strategies for the 2019-2023 State Plan:**

- Expand respite camp throughout Island, especially in areas on Island to ensure service preference.
- Provide opportunities for healthy aging and caregiver Training classes throughout the Island.



### **Goal 3: Enhance the ADRC**

***Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.***

### **ADRC Compliance**



- **Objective 3.1: Maintain ADRC State and Federal Compliance.**

### **Rationale 3:1:**

The Hawaii County Aging Network also includes State partners, particularly the Hawaii Department of Health's State Executive Office on Aging. Over 70% of the funding for kupuna services on Hawaii island gets channeled through the State office and it's imperative that working relations remain respectful and collaborative.

### **Baseline 3:1:**

1. HCOA is currently 85% in compliance with State ADRC mandates.
2. Participant data is readily available through a HIPPA-compliant statewide database.

### **Outcomes 3:1:**

1. HCOA operates a seamless, high quality long-term supports and services system.
2. Participants served through HCOA's ADRC receive person-centered assistance and options counseling.

### **Major Action Steps 3.1**

1. Continue to use the statewide standardized tools for intake, eligibility screening, assessment, support planning, and service authorization.
2. Maintain agency participation in the Statewide Consolidated Database.
3. Implement inclusion of service providers in the Statewide Database.
4. Continue to educate local and state elected officials regarding the need for ADRC funding.

### **Effective Measures:**

1. HCOA receives Fully Functional ADRC designation from the Executive Office on Aging.
2. ADRC intake and assessment tools are consistently used across operations.
3. # of service providers activity listed and updated in the Online ADRC Resource Database.
4. # of staff able to provide person-centered options counseling.

### **Person-Centeredness**



- **Objective 3.2:** Provide relevant person-centered information, assistance, referrals, and options counseling to consumers requesting services through the ADRC.

### **Rationale 3:2:**

The person-centered approach was first introduced by psychotherapist Carl Rogers in the late 1950s and then re-introduced as a key customer service philosophy that empowers clients to direct their own care and services. It is crucial that HCOA adopts this model of service delivery.

**Baseline 3:2:** HCOA has some staff trained on the general person-centered approach (AHA-Aloha, Help, A Hui Hou model of customer service) and two staff trained in person-centered options-counseling. Person-centered counseling is currently provided through EOA.

**Outcomes 3:2:**

1. All ADS staff and I&A staff shall attain AIRS certification.
2. All staff will be trained in the AHA person-centered approach to customer service.
3. All ADRC will be trained in providing person-centered, information & referral/assistance, and options counseling.
4. HCOA service providers will participate in person-centered training.

**Major Action Steps 3.2:**

1. Staff will be trained on person-centered concepts for application in their work with individuals who receive information and referral/assistance from the ADRC.
2. HCOA service providers will be trained on person-centered concepts for application in their service provision to individuals receiving HCOA-funded services.
3. Utilize effective options counseling to develop person-centered support plans that meet individual and caregiver needs.
4. HCOA will adopt a general person-centered customer service approach (i.e., AHA-Aloha Training) that will guide interaction with walk-ins, call-ins, and individuals representing partnering agencies.
5. Conduct training and certification for AIRS (Alliance of Information and Referral Systems) for ADS and I&A staff.
5. At least 90% of persons receiving services from HCOA will report satisfaction.

**Effective Measures:**

1. % of ADS and I&A staff with AIRS certification.
2. % of staff trained in the person-centered approach.
3. % of customers satisfied with the information, assistance, and supports given to them by HCOA's ADRC.
4. Fully-functioning designation by the State Executive Office on Aging.

**Information**



- **Objective 3.3:** Ensure that each year of the planning period that the resource directory will be updated and available on the HCOA/ADRC website.



### **Rationale 3.3:**

Information is power. Majority of the walk-ins and calls to HCOA/ADRC are individuals seeking information regarding supports and services for seniors, people with disabilities, or caregivers. HCOA has a newsletter, TV show, resource library, and a web-based system that serve as pathways to information and assistance.

### **Baseline 3.3:**

ADRC Resource Database management is guided by statewide ADRC “Inclusion and Exclusion” policies that help ADRCs ensure the resources listed in online databases are legitimate and applicable for its target populations.

### **Outcomes 3.3:**

1. The procedure for soliciting, vetting, and publishing ADRC resources on the ADRC website will be updated and enacted.
2. Resources registered in the ADRC resource database will be updated annually.
3. The ADRC will explore ways to enhance its online presence on the ADRC website and through social media.
4. The ADRC website intake will be updated for more collection of more pertinent online referrals.
5. HCOA brochures and other printed material will be kept updated.

### **Major Action Steps 3.3:**

1. **ADRC website** to include items such as an improved intake application, updated resource directory, video introduction of services and video provider interviews, on-line provider training, translation materials, and important documents and reports.

### **Effective Measures:**

1. Implementation of ADRC Resource Database policies and procedures.
2. # of resources available on the ADRC website and the ADRC resource library.
3. # of web-based enhancements post 2016.
4. # of updated brochures and other printed material concerning the ADRC or HCOA.
5. # of contacts made through the ADRC website.
6. Consumers are comfortable utilizing the ADRC website as an alternative or supplement to their inquiry of long-term services and supports.

## ADRC Marketing



- **Objective 3.4:** Use marketing strategies to promote community awareness of the ADRC.

### Rationale 3.4:

Older adults have always been the target population since HCOA first opened its doors in 1966. However, in 2006 HCOA aligned itself with the State Executive Office on Aging initiative to also serve people with disabilities regardless of age. Although the service is limited to information, assistance, referral, and options counseling, the ADRC still provides the “one-stop-shop” for clients and caregivers needing long-term services and supports. This is why a strong marketing approach to inform the community of the ADRC is critical.

**Baseline 3.4:** 2014 data shows outreach efforts informing 2,584 people island-wide. Also, in 2014, county-wide averages for call-ins were 350 and walk-ins were 200.

### Outcomes 3.4:

1. The community will see the ADRC as a visible entity where they can obtain correct information about long-term care issues.
2. Community members will demonstrate increased usage of the online ADRC portal as a means of acquiring relevant information and assistance.



### Major Action Steps 3.4

1. Update ADRC marketing materials.
2. Develop procedures for scheduling and tracking outreach activities.
3. Conduct outreach activities with different geographic areas and segments of the population.
4. Utilize the HCOA newsletter to inform as many seniors as possible about ADRC related events.
5. Update the ADRC website to include caregiver resources, video testimonials, etc.
6. Develop ADRC marketing plan to increase general \_\_\_\_\_

### Effective Measures:

1. Completion of an ADRC marketing plan.
2. Development of ADRC outreach procedures.
3. Update of ADRC marketing materials.

4. Number of ADRC presentations conducted in the community.
5. # of ADRC contacts per month.

### **Disability Parking Placards.**



- **Objective 3.5:** Strengthen the disability parking placard program.

### **Rationale 3.5:**

HCOA recognizes the disability parking placard program as a vehicle for marketing the services and supports provided by the ADRC. It is not uncommon for people with disabilities to come to the Office of Aging seeking a placard and leave with brochures and other resources regarding services and supports for older adults and people with disabilities. This is why it is important that HCOA continues to strengthen the placard program by utilizing a person-centered approach to customer service.

**Baseline 3.5:** In 2017, East Hawaii ADRC processed on average of 7 placards per day, while West Hawaii ADRC processed an average of 4 placards per day.

### **Outcomes 3.5:**

1. The community will know that disability placards are processed at the East and West Hawaii ADRC.
2. Disability parking placard applicants will be offered information on additional supports and services that may be available to them.
3. Placard applicants will report being satisfied with the service they received.-

### **Major Action Steps 3.5:**

1. Update HCOA and ADRC brochures to include information about the placard program.
2. Update the ADRC website with information on how to apply for a disability placard.
3. All staff who issue disability parking placards to become Certified Information & Referral Specialists for Aging/Disability from the Alliance of Information & Referral Systems to insure applicants are receiving person-centered and appropriate information and referrals.
4. Include information about the placard program in ADRC presentations to the public.

5. Develop an optional survey for placard recipients to complete to measure customer satisfaction and person-centered information and referral

### **Effective Measures:**

1. # of placards per month per ADRC location.
2. # of trainings that mention the disability placard program.
3. Level of customer satisfaction after receiving their disability placard.

### **Language Access**



- **Objective 3.6:** Complete HCOA's language access plan.

### **Rationale 3.6:**

Language access and communication is a basic right. Having a language access plan or policy detailing what to do with a consumer who prefers to speak in their primary language is critical. Hawaii County has a county-wide language access plan, but HCOA needs to have one specific to the population it serves.

**Baseline 3.6:** A first draft of the plan has been completed.

### **Outcomes 3.6:**

1. Individuals with limited English-proficiency will have the opportunity to access services and participate fully in their service delivery.
2. Individuals receive written information in their preferred language.
3. HCOA staff will demonstrate increased competency in communicating with individuals with Limited English-proficiency.

### **Major Action Steps 3.6:**

1. Finalize language access plan and submit to State language access coordinator for approval.
2. Draft and finalize an interpreter policy and procedure (P&P) to be implemented at HCOA and its ADRC.

3. Send P&P to County language access liaison for feedback and approval.
4. Review and refine P&P.
5. Acquire and distribute the most common requested informational brochures in a variety of languages.
6. Increase overall staff knowledge of access to and use of assistive technologies as needed.

**Effective Measures:**

1. Completion of Language Access Plan.
2. # of written materials provided in non-English languages.
3. # of interpreters or assistive technologies utilized upon request.

**Goal 4: Enable older adults to live in their communities through the availability of and access to high-quality long-term services and supports (LTSS), including supports for families and caregivers.**

**Case Management**



- **Objective 4.1:** Provide effective home and community-based services via case management.

**Rationale 4:1:**

Case management using needs based and person-centered strategies is a key component in providing home and community-based services for eligible seniors who are frail and dependent. Given the high demand for such services and the temporary nature of the service model, it is crucial that we continue to look at strategies to ensure that we are making the best use of our case management contracted provider and the corresponding vendor pool of providers.

**Baseline 4:1:**

In 2018, HCOA served 435 clients, and in a study of kupuna receiving these services, \_\_\_% were able to stay in their home while being served by the program.

#### **Outcomes 4:1:**

1. HCOA operates a seamless, high quality long-term supports and services system.
2. Participant data is readily available through a HIPPA-compliant statewide database.
3. Participants served through HCOA's ADRC receive person-centered assistance and options counseling.
4. Participants receive a home assessment within 10 days of their initial request for support.
5. While adhering to a need based person-centered model of care, case management staff will work to transition participants into informal supports, private pay, or public funded systems within a safe and reasonable period of time to minimize wait-time for other eligible participants awaiting services (if applicable).
6. Case management shall adhere to general and program specific provision and assurances.
7. Collaborate with public health nursing to ensure seamless referral system of care.
8. At least 75% of participants will remain in their homes after transition from HCOA's services  
Participants receive satisfaction surveys as a kupuna care recipient and upon discharge to meet HCOA/ADRC quality assurance standards

#### **Major Action Steps 4.1**

1. Ensure case management services are being appropriately authorized, monitored, and that service issues are being resolved.
2. Periodically revisit the case management model of services while taking into account outcome measures, such as a) time from initial inquiry to a home visit; b) length of service before transitioning to private pay or informal supports; c) eligibility criteria; etc.
3. Ensure that case management staff develop person-centered and need based support plans that meet the needs of both clients and their caregivers.
4. Ensure case management provides a smooth transition for both clients and their caregivers as part of discharge planning. Services (long-term care placement, Medicaid, private pay) must be in place prior to discharge.
5. Assess and monitor the quality and quantity of services provided by HCOA's vendor pool, which include services such as adult day care, assisted transportation, attendant care, caregiver services, chore, homemaker, and personal care.
6. Provide technical assistance and support to all vendors when needed.
7. Ensure that staff utilize person-centered support plans that meet the client and their caregivers needs.
8. Access and monitor the quality and quantity of services provided by HCOA's vendor pool, which include services such as assisted transportation, caregiver services, heavy chore, homemaker, and personal care.

**Effective Measures:**

1. # of unduplicated clients served.
2. # of months clients remain in the program before being transitioned.
3. # of days before an assessment is conducted after initial request for services.
4. 90% of clients and caregivers report being satisfied with services they received.



**Caregiver Support**



- **Objective 4.2:** Provide active support for family caregivers through training, annual conferences, respite, counseling, and informational materials.

**Rationale 4.2:**

Unique challenges lay ahead for the Baby boomers, who are also the sandwich generation: caring for parents as well as their own children and at times grandchildren. Caregivers of all ages are the backbone of the service delivery system. Caregivers needs support in various forms (conferences, educational workshops, caregiver training, and respite) in order to continue providing the care needed to keep frail seniors at home.

**Baseline 4.2:**

2018 data shows the following:

- a. East Hawaii and West Hawaii Caregiver Conference Participants - Total Caregivers=**603**;
- b. Counseling and Training Services: HCOA will again contract for approximately **140 hours** of counseling, peer support groups, and training to help caregivers better cope with the stresses of caregiving.

- c. Respite Care Services: HCOA contracted for the services of **40 caregivers with 4,097 hours of temporary relief** – at home, or in an adult day care or institutional setting – from their caregiving responsibilities.

**Outcomes 4.2:**

1. Caregiver stress and burnout are reduced.
2. Caregivers are informed of what resources are available and feel supported by the services provided by HCOA.
3. Caregivers remain active, healthy, and optimistic.

**Major Action Steps 4.2:**

1. Caregivers will be welcomed at every access point of the continuum of care.
2. Identify and recruit partner agencies to strengthen current relationships with stakeholders that support Caregivers in our community.
3. Address the unique challenges of today's caregivers. Baby boomers are also sandwich generation who care for parents and children/grandchildren. Needs vary dependent upon who needs what type of care.
  - Physical Needs: training for working with recipient at ADRC (or partner agencies).
  - Emotional Needs, Counseling and peer supports, Caregiver support groups.
  - Medical, explore invite educate on varied plans for caregiver population.
  - Finances, explore incentives
  - Education- Respite, advocacy and counseling.
4. Develop a caregiver plan.
5. Develop Level of care spectrum for Caregivers, on one end in-home care on the other is long term care facility-“Knowing where you and your loved ones fall and what it will look like when you are in need of long term care facility”.
6. Importance of several Legal documents: “Do you have your documents in Order.”
  - Advanced Care Directive.
  - Power of Attorney.
  - A Will.
7. Continue to monitor current Caregiver contracts on a monthly basis. Review program activities and fiscal records. Explore respite program for Grandparents caring for grandchildren.
8. Conduct evaluations and surveys of all workshops and conferences



### **Effective Measures:**

1. Total # of caregivers receiving services in the system.
2. # of caregivers participating in the annual caregiver conference.
3. # of caregivers receiving counseling and individual training.
4. # of caregivers receiving respite care services.
5. pre- and post-tests demonstrating positive change among caregivers via caregiver training.

### **New Suggested Strategies for the 2019-2023 State Plan:**

- Continue current goals, add Powerful Tools for Caregivers as a EB Training program offered on East and West sides of Hawaii Island.
- Partner with Non-profit organizations on Caregiver and workshops offered.

### **Goal 5: Optimize the health, safety, and independence of Hawaii's older adults.**

#### **Disaster Preparedness**



- **Objective 5.1:** Partner with civil defense to ensure annual updates of a county-wide emergency disaster plan and protocol for older adults and people with disabilities.

#### **Rationale 5.1:**

A record-breaking 2015 hurricane season was full of close calls for Hawaii County with 11 storms becoming major hurricanes throughout the Pacific. Disaster preparedness for frail seniors and people with disabilities has been a re-energized focus since 2014's hurricane Iselle hit Hawaii County causing widespread power outages, crop damages, and downed trees. HCOA became a central station for information, deployment, and debriefing.

#### **Baseline 5.1:**

HCOA and Hawaii County Civil Defense meet periodically but not on a regularly scheduled basis, and there are some printed material but it needs to be reviewed and updated.

#### **Outcomes 5.1:**

1. HCOA and Civil Defense will meet at least six times a year to discuss concerns, issues, and potential solutions concerning disaster preparedness.
2. Older adults and people with disabilities will be better informed of disaster preparedness protocols and procedures, and how to be safe in the event of a natural or man-made disaster.

### **Major Action Steps 5.1**

1. Establish a working alliance with the Hawaii County Civil Defense.
2. Meet quarterly or as needed to review inter-agency disaster preparedness protocols and procedures.
3. Ensure that all currently served clients have updated contact information including address, home and cell phone, and emergency contact information on file.
4. Solicit disaster preparedness training opportunities that target older adults and people with disabilities.
5. Produce and make available printed material (brochures, flyers) to inform seniors and people with disabilities on disaster preparedness guidelines and precautions.

### **Effective Measures:**

1. # of meetings with Civil Defense
2. # of brochures or pamphlets targeting older adults and people with disabilities that are made available to help increase disaster preparedness awareness.
3. % of older adults and people with disabilities (via a random survey) knowing what to do prior, during, and after a natural or man-made disaster.



- **Objective 5.2:** Work with partnering agencies to promote awareness and address elder neglect, abuse, and fraud protection.

### **Rationale 5.2:**

As stated below, only 1 in 6 cases of elder abuse is reported. Protecting kupuna from abuse, neglect, fraud, and being taken advantaged of is an important goal for HCOA as well as the State Executive Office of Aging.



### **Baseline 5.2:**

In 2014, 4 events reaching an estimated 100 elders, their caregivers and professionals in the Aging Network were noted.

### **Outcomes 5.2:**

1. HCOA will participate with partnering agencies to coordinate trainings, conduct presentations, and distribute printed material on elder abuse and fraud prevention.
2. Hawaii County rates of elder abuse and neglect will decrease over time.
3. Hawaii County rates of fraud (identity theft) will decrease over time.

### **Major Action Steps 5.1**

1. Identify and recruit partnering agencies to implement an educational campaign to end elder abuse.
2. Strengthen current relationships with case management and Adult Protective Services.
3. Partner with AARP and the State Ombudsman to circulate material (brochures, posters) that message antifraud and elder abuse issues.
4. Continue to monitor current Legal and Elder Abuse contracts on a monthly basis. Review program activities and fiscal records.
5. Review tools used to monitor current contracts and determine level and need for individual registration for service. Is current system really working?
6. Look into the possibility of safe havens for older adults who are afraid to return home and thus need emergency shelter.

### **Effective Measures:**

1. # of meetings with Adult Protective Services.
2. # of training, presentations, media productions, and printed material addressing abuse, neglect, and fraud prevention.
3. Hawaii County annual rates of abuse, neglect, and fraud.

### **Previous Plan Accomplishments**

#### **Continuum of Care**

The objective was to **Increase stakeholder awareness of the aging continuum of care** and efforts to support the sustainability of services for all seniors along the continuum.

This was accomplished by updated brochures, county website updates, newsletter message exchanges, and 17 group presentations by the executive for various parents within the Aging Network.

### **Community Involvement**

It has been noted that good health is not just simply making good health choices, because the health choices seniors make depends on the health choices they have and not every kupuna have the same health choices given the various health determinants such as, where they live, income level, education, and so on.

This is why it is critical that HCOA supported Hawaii County's Blue Zones Initiative from 2015 to the present because it shaped social policy to help make the best health choice the easy choice. Examples of this were initiatives such as, supermarkets placing healthy options at the check out line, or enforcing no smoking policy areas in county housing facilities.

### **Nutrition**

**Cost-Benefit Analysis Completed for Congregate & Home Delivered meals.**

**2 additional meal sites developed, one in East Hawai'i and one in West Hawai'i.**

**Hm D undup increased 61% & units increased 34% in FY18 (from FY15)**

**Congregate undup increased 9% & units increased 16% FY17 (from FY15) (FY18 data incomplete)**

**Overall Nutrition Program undup increased 14% & units increased 30% FY18 (from FY15) (not up-to-date- will be higher)**

## 2019-2023 Kauai Agency on Elderly Affairs

### Area Plan Goals and Strategies

**Goal 1:** Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.

Strategy 1-1: Promote healthier living through evidence-based programs and volunteerism.

**Goal 2:** Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.

Strategy 2-1: Expand and strengthen access to services with the Aging Network.

Strategy 2-2: Increase the quality of life for older adults and persons with disabilities living in the community.

**Goal 3:** Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.

Strategy 3-1: Promote and strengthen the ADRC system processes.

**Goal 4:** Enable older adults to live in their communities through the availability of and access to high quality long-term services and supports (LTSS), including supports for their families and caregivers.

Strategy 4-1: Promote and expand innovative programs that meet the needs of older adults and their caregivers.

Strategy 4-2: Pursue and promote a person-centered system that meets the needs of older adults and their caregivers.

**Goal 5:** Optimize the health, safety, and independence of Hawaii’s older adults.

Strategy 5-1: Expand and foster collaboration with the Aging Network to ensure older adults and persons with disabilities live safely and independently.

## 2019-2023 Hawaii State Plan on Aging

### State Goals

MAUI/MCOA suggested strategies in color below 11/27

**Goal 1:** Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities.

- Provide statewide support to volunteer/faith based/and social groups that focus on aging well programs/services (body/mind/soul)

**Goal 2:** Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.

- Workforce development- caregivers
- Technology- apps

**Goal 3:** Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.

- Encourage statewide activities involving advocacy groups/boards/committees of aging and disability (HDRC/CILs)

**Goal 4:** Enable older adults to live in their communities through the availability of and access to high quality long term services and supports (LTSS), including supports for their families and caregivers.

- Assess and strengthen KC caregivers program statewide
- Memory clinics: Explore model that was done with Federally Qualified Health Clinics: Multidisciplinary Focus on Med/Psych/Legal/Nut/SW

**Goal 5:** Optimize the health, safety, and independence of Hawaii's older adults.

- Encourage the AAAs to look into different home modification innovations that can be implemented in respective county
- Continue education about Universal Design and visitability

# APPENDIX J

## Public Comments Received on the 2019-2023 Hawaii State Plan on Aging:

1. May 3, 2019 PABEA Meeting.
2. May 23, 2019 In-Person Meeting at the Hawaii State Capitol.
3. May 24, 2019 WebEx Meeting (Statewide)
4. May 29, 2019 WebEx Meeting (Statewide)
5. Comments received from other organizations and individuals



Comments Received  
at the  
May 3, 2019  
PABEA Meeting Attendees

POLICY ADVISORY BOARD FOR ELDER AFFAIRS  
May 3, 2019

MEETING MINUTES (DRAFT-Not yet approved by PABEA)

PRESENTATION: Sharen L. Truex Nakashima, Partnership Specialist, Honolulu, Los Angeles Regional Census Center presented *The Road to the 2020 Census*.

CALL TO ORDER: Gary Simon called the meeting to order at 12:00 noon. A quorum was established as eleven members were present at the call to order. (This twenty-one member board requires eleven members present to establish quorum.)

Members Present: Linda Axtell-Thompson, James Cisler, Joy Miyasaki, Shelly Ogata, Suzie Schulberg, Gary Simon, John Tomoso, Beverly Jean Withington, Kathleen Wyatt, Barbara Yamashita, and Sarah Yuan.

Members Absent: Colette Brown, William Kinaka, and Kipukai Kualii.

Others Present: Ex-officio: Alan Burdick, DLIR, Kathy Ishihara, DHS; Kanoe Margol, ERS; and Keith Ridley, DOH.

EOA Staff and AAAs: Caroline Cadirao, Tony Krieg, Tania Kuriki, Josephine Lum, Ashley Muraoka-Mamaclay, Charles Nagatoshi, Lisa Nakao, Lani Sakamoto, Debra Shimizu, Rebecca Soon, and Deborah Stone-Walls.

Guests: Barbara Service.

MEMBER INTRODUCTIONS: The attendees introduced themselves.

MINUTES:

The PABEA meeting minutes of December 2018 and February 2019 were approved as distributed.

CHAIRS REPORT:

Gary met with Representative Sylvia Luke on April 23 to advocate for the Hawaii Saves bill.

The nomination committee chaired by Marilyn Seely submitted the following for PABEA officers for the term beginning July 1: for chair, Linda Axtell-Thompson; for first vice chair, Gary Simon; and, for second vice chair, Suzie Schulberg.

LEGISLATIVE COMMITTEE:

Sarah presented a review of the 2019 Legislative Session:

- Kupuna Care: add \$4,145,695 to base budget (to become \$9 million total).
- Aging and Disability Resources Centers: \$3.1 million in base budget.

- Alzheimer's Disease and Related Dementia Services Coordinator: \$26,478 (FY20), \$52,956 (FY21).
- Healthy Aging Partnership: \$550,000.
- Kupuna Caregivers: \$1,500,000 (\$210 per week various services) and other reporting and planning requirements.
- New board members' confirmation: Shelly Ogata and William Kinaka
- PABEA's Quorum: A majority of the currently serving members but no fewer than 8 shall constitute quorum.
- Hearing aids (HB469 HD1 SD1): Required insurance provisions and benefits at a minimum of \$1,500 per hearing-impaired ear every 36 months. Senate conferees appointed April 17.
- Hawaii Saves (SB1374): established Hawaii Retirement Savings Program for private employees. No action taken in conference on April 26.
- Active Aging: SR 83 adopted.

PLANS AND PROJECTS REVIEW COMMITTEE:

The 4 year area plan for the City and County of Honolulu is on the EAD website.

RECOGNITION AND AWARDS COMMITTEE:

For the Outstanding OAM Luncheon, Jim asks PABEA to arrive at 8:30 a. m. to assist with set-up.

Payment for those who will attend can be provided to Shannon.

EOA:

EOA did a brief presentation of the draft 2019-2023 Hawaii State Plan on Aging to those present at the PABEA meeting. All States are required by the Administration for Community Living (ACL) to submit a State Plan on Aging to receive any Federal Older Americans Act funding. EOA briefly went over the draft goals, strategies, and objectives of the State Plan on Aging and is seeking for any input that PABEA members and their guest agencies and representatives at the PABEA meeting may have on the State Plan. The 2019-2023 Draft State Plan on Aging will also be posted on the ADRC website and all PABEA members will also be mailed a hard copy of the draft State Plan. Copies of the State Plan to anyone interested may also be mailed upon request by contacting the EOA. Public meetings both in-person and via WebEX has also been scheduled during late May with locations and times to be announced.

EAD:

The services report for July 1, 2018 to May 2, 2019 was distributed.

KAUAI AGENCY ON ELDERLY AFFAIRS:

Kealoha had distributed her services report via email.

MCOA:

Deborah reintroduced Tony Krieg. 5 new staff members have been hired in the last six weeks. MCOA is finalizing Maui County's area plan.

STATEMENTS:

Shelley suggests a presentation from HIEMA to PABEA in light of hurricane season.

ANNOUNCEMENTS:

OAM Luncheon: June 7, 15 Craigside.

Next PABEA Meeting, June 7, 2019, 1:00 p. m., 15 Craigside Solarium

ADJOURNMENT: Gary adjourned the meeting at 1:16 p. m.

**From:** John Tomoso  
**To:** DOH.EOA, Executive Office on Aging  
**Cc:**  
**Subject:** State Plan on Aging Edits from John A. H. Tomoso  
**Date:** Monday, May 13, 2019 10:49:24 AM  
**Attachments:** 2019-2023 State Plan on Aging Goals, Strategies & Obj rev 05-03-19-JAHT edits.docx  
see ATTACHED  
2016-2020 PABEA Member-Maui

**Strategy 1-2:** Engage older adults through civic engagement, **community partnerships** and learning opportunities to improve their quality of life and be valuable members of society.

**Strategy 2.1:** Collaborate and strengthen the Aging Network's **statewide** workforce to enhance and improve service efficiency and quality of services being provided to Hawaii's older adults and their caregivers.

**Strategy 2.2:** Explore innovative partnerships **and alliances, leveraging** resources to address the needs of older adults and/or their caregivers.

**Strategy 2.3:** Collaborate with partners **and alliances** in the community to address the needs of the at-risk and homeless older adults.

**Goal 3:** Strengthen the statewide **AAA/ADRC** system for persons with disabilities, older adults, and their families.

**Strategy 3.1:** Assist the AAAs **in all counties** to ensure that services and supports are culturally competent and **therapeutically and** linguistically appropriate for a diverse community.

**Strategy 3.2:** Promote community awareness of the **AAA/ ADRC system**.

**Objective 3.2:1:** Coordinate marketing activities with the AAA **in all counties** to increase the visibility of the ADRC.

**Strategy 3.3:** Maintain, expand and update the resources and information available through the **AAA/ ADRC, including on-line**, to address the needs of **each** community **statewide**.

**Strategy 3.4:** Strengthen the statewide **AAA/ADRC** processes, accountability, **cultural and therapeutic competencies** and sustainability.

**Goal 4:** Enable older adults **and persons with disabilities** to live in their communities through the availability of and access to high quality, long term services and supports (LTSS), including supports for their families and caregivers.

**Strategy 4.1:** Collaborate with the Aging Network **statewide** and other public and private agencies to enhance access to quality long term services and supports (LTSS) that is innovative **culturally and therapeutically competent** and person centered.

**Strategy 4.2:** Ensure statewide consistency, **cultural and therapeutically competency** and compliance for long-term services and supports for Kupuna Care.

**Strategy 4.3:** Provide person centered **and culturally and therapeutically competent** support and services for family caregivers, including grandparents raising grandchildren, through training, education, counseling, respite and referrals.

**Goal 5:** Optimize the health, safety, and independence of Hawaii’s older adults **and persons with disabilities**.

**Strategy 5.4:** Advocate for the rights of older adults **living** in long term care facilities.

**Strategy 5.5:** Recruit, train, and support volunteers, **Statewide**, to provide information, education, referrals, advocacy, and one-on-one assistance to Medicare beneficiaries, their families, and caregivers.

**Strategy 5.7:** Develop partnerships **and alliances** to ensure that disaster preparedness planning address the needs of older adults and persons with disabilities.

**From:** Eldon L. Wegner

**To:** ktakahashi@kauai.gov; Audrey Suga-Nakagawa; Nalani Aki; Cadirao, Caroline M.; Jeani Withington; Cullen Hayashida; Kuriki, Tania L.; John Tomoso; Nakao, Lisa R.; Sarah Yuan; Laural Coleman MD; Suzie Schulberg; Joanne Kealoha; Kimo Alameda; Gary Simon; Charlene Iboshi; John A. H. Tomoso

**Subject:** Fw: TSF: Governor Newsom Calls for Master Plan for Aging!

**Date:** Tuesday, June 11, 2019 9:44:43 AM

Aloha,

FYI. We are in the process of updating our state plan on aging. I just learned about a new effort in California to develop a Masterplan. See below. I'm sure we could expand our ideas by acquainting ourselves with the discourse taking place in California.

Cheers,

Eldon

Eldon L. Wegner, Ph.D.  
Honolulu, HI

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**From:** charlene iboshi

**To:** Eldon L. Wegner

**Cc:** ktakahashi@kauai.gov; Audrey Suga-Nakagawa; Nalani Aki; Cadirao, Caroline M.; Jeani Withington; Cullen Hayashida; Kuriki, Tania L.; John Tomoso; Nakao, Lisa R.; Sarah Yuan; Laural Coleman MD; Suzie Schulberg; Joanne Kealoha; Kimo Alameda; Gary Simon; John A. H. Tomoso

**Subject:** Re: TSF: Governor Newsom Calls for Master Plan for Aging!

**Date:** Tuesday, June 11, 2019 10:44:44 AM

**Attachments:** Dementia\_Provision1.pdf

- 1) I like the idea.
- 2) Each County is different, but the overall supports should be uniform statewide.
- 3) The Hawaii State Bar Association is working on a Well-Being Task Force. Healthy Aging and LTC needs will be considered.
- 4) The Senior Counsel Division did a mini-Aging Fair with the Residential Alternatives, senior Services. Most attorneys are in denial about the costs of LTC.
- 5) Many do not want live with advanced Alzheimer conditions. We may want to consider the dementia addendum for AHCDs.  
[https://www.compassionandchoices.org/wp-content/uploads/2016/02/Dementia\\_Provision1.pdf](https://www.compassionandchoices.org/wp-content/uploads/2016/02/Dementia_Provision1.pdf)

Aloha

Charlene Iboshi

Sent from my iPhone



Comments Received at the  
May 23, 2019  
Hawaii State Capitol Mtg  
10:00 am – 11:00 am  
415 S Beretania St., Room 224  
Honolulu, HI 96813

**2019-2023 Hawaii State Plan on Aging  
Public Comment Meeting**

**May 23, 2019**

**Hawaii State Capitol, Room 224**

415 S Beretania St.  
Honolulu, HI 96813  
10:00 am – 11:00 am

**Attendees:**

<b>Name</b>	<b>E-Mail Address</b>	<b>Program</b>
Lisa Amador	<a href="mailto:lamador@dhs.hawaii.gov">lamador@dhs.hawaii.gov</a>	Adult Prot. Svcs Branch
Leslie Tanoue	<a href="mailto:letanou@alulike.org">letanou@alulike.org</a>	Alu Like, Inc.-Title VI
Tricia Medeiros	<a href="mailto:tricia@plazaassistedliving.com">tricia@plazaassistedliving.com</a>	ALF
Rick Tabor	<a href="mailto:rick@eldercareoahu.com">rick@eldercareoahu.com</a>	Right at Home
Lori Tsuruda	<a href="mailto:LTsuruda@dhs.hawaii.gov">LTsuruda@dhs.hawaii.gov</a>	DHS - Adult Protective Svcs
Ray Rice	<a href="mailto:SRice@dhs.hawaii.gov">SRice@dhs.hawaii.gov</a>	DHS - Adult Protective Svcs
Robert Choy	<a href="mailto:r.choy@capitol.hawaii.gov">r.choy@capitol.hawaii.gov</a>	Rep. Della Au Balatti's Office
Michiyo Tomioka	<a href="mailto:mtomioka@hawaii.edu">mtomioka@hawaii.edu</a>	HAP
Kimberly Ryan	<a href="mailto:Kimberly.Ryan@mail.house.gov">Kimberly.Ryan@mail.house.gov</a>	Rep. Ed Case's Office
Donna Shitabata	<a href="mailto:dshitabata@dhs.hawaii.gov">dshitabata@dhs.hawaii.gov</a>	DHS - Adult Protective Svcs
Tracy L. Yadao	<a href="mailto:tyadao@dhs.hawaii.gov">tyadao@dhs.hawaii.gov</a>	DHS - Adult Protective Svcs
A Williams	<a href="mailto:h.williams@capitol.hawaii.gov">h.williams@capitol.hawaii.gov</a>	Senate
Mary Kate Murray	<a href="mailto:m.murray@capitol.hawaii.gov">m.murray@capitol.hawaii.gov</a>	Senate
Mimari Hall	<a href="mailto:mhall@dhs.hawaii.gov">mhall@dhs.hawaii.gov</a>	DHS Director's Office
Joy San Buenaventura	<a href="mailto:repsanbuenaventura@capitol.hawaii.gov">repsanbuenaventura@capitol.hawaii.gov</a>	Hawaii State Representative
Bonnie Castonguay	<a href="mailto:bonnie@hookelehealth.com">bonnie@hookelehealth.com</a>	Home Care
Tanya Fernandes	<a href="mailto:tanya@hookelehealth.com">tanya@hookelehealth.com</a>	Home Care
Michelle Cordero-Lee	<a href="mailto:michelle@hmow.org">michelle@hmow.org</a>	Hawaii Meals on Wheels
Ian Ross	<a href="mailto:iaross@alz.org">iaross@alz.org</a>	Alzheimer's Association
Rona Fukumoto	<a href="mailto:rfukumoto@lanakilapacific.org">rfukumoto@lanakilapacific.org</a>	Lanakila Meals on Wheels
Robert Hirokawa	<a href="mailto:rhirokawa@hawaiiPCA.org">rhirokawa@hawaiiPCA.org</a>	HPCA
Peter L. Fritz	<a href="mailto:plflegis@fritzhq.com">plflegis@fritzhq.com</a>	Attny

**All Public Comments Received on the  
2019-2023 State Plan on Aging  
at the May 23, 2019 Meeting at the State Capitol**

**Notes from 2019-2023 HI State Plan on Aging Meeting on May 23, 2019**

**Location: Hawaii State Capitol**

**Facilitator: Caroline Cadirao**

**Goal 1- Healthy Aging**

Strategy 1.1

Objective 1.1.1

- Ensure dementia friendly and dementia capable is addressed throughout the plan

Objective 1.1.2

- What about expanding the number of lay leaders and Master trainers. Obj currently states that we will maintain.
- Instead of “expand” use the word “increase”
- Add instructors for EF to Obj 1.2
- Add some sort of public awareness of EBI – to promote classes and participation. What is EBI?
- How can we address the needs of homebound elders to remain healthy?
- Medication management
- 

Strategy 1.2

- Instead of volunteer programs may want to replace with social engagement to be inclusive
- Look at innovate ways to include the meal programs to engage them in active aging
- Incorporate more than a meal

May want to have something related to increase workforce for elder programs/services. Current capacity can't serve the growing elder population.

**Notes from 2019-2023 HI State Plan on Aging Meeting on May 23, 2019**  
**Location: Hawaii State Capitol**  
**Facilitator: Debbie Shimizu**

## **Goal 2- Partnerships**

NOTES FOR GOAL 2 (Partnerships)

Group participants: Ian Ross (Alzheimer's Association), Lisa Amador (APS), Mimari Hall (DHS)

**Goal 2: Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.**

**Strategy 2.1: Collaborate and strengthen the Aging Network's workforce to enhance and improve service efficiency and quality of services being provided to Hawaii's older adults and their caregivers.**

**Objective 2.1:1:** Survey the Aging Network to identify workforce barriers faced by service providers and others who serve older adults and their caregivers.

- Care home staff are not trained to deal with individuals who have Alzheimer's disease or dementia. If the care home cannot handle the individual, they are kicked out. Need training and certification when staff receive training on Alzheimer's disease and dementia.

**Objective 2.1:2:** Develop workgroups to look at changes to the Aging Network that will address workforce barriers and enhance the capacity of providers and stakeholders to provide a more coordinated system of supports statewide.

- Partner with Alzheimer's Association to develop dementia care guidelines that work across settings (public and private). What does effective care look like?
- Need programs to deal with compassion fatigue and vicarious trauma for staff. Also, self-care for caregivers. If this is addressed, it will result in better workforce and better quality work at the agencies.

**Strategy 2.2: Explore innovative partnerships and leverage resources to address the needs of older adults and/or their caregivers.**

**Objective 2.2:1:** Collaborate, develop partnerships, and leverage resources to develop more age friendly communities that promote aging in place and active aging.

- Develop partnerships for transportation. Alzheimer's Association is talking with Lyft to develop a concierge program that will take individual from care home to where ever. However, need to figure out an individual to receive the kupuna and escort them to their doctor's office or appointment

and the get them back onto Lyft to take them back to the care home. This is being done in other states. Needs to be affordable.

**Objective 2.2:2:** Collaborate and educate agencies in the community to increase the number of Dementia-Friendly (Dementia-Capable) agencies.

**Objective 2.2:3:** Maintain, enhance, and leverage resources for No Wrong Door (NWD) efforts with NWD agencies and partners to continue seamless access, information sharing, and person-centered trainings.

- Need more collaboration with agencies. Learn what other agencies do
- It should not be a one-stop-shop agency but one-stop-shop for the consumer
- Decrease duplication, leverage resources, cross-pollination, cross-training of agency staff
- Establish a steering committee? Advisory council? To discuss global issues of aging, share information, and ensure a coordinated system and streamline referral

**Objective 2.2:4:** Collaborate with partners in the community to update the Alzheimer's Disease and Related Dementias (ADRD) State Plan to address the needs of individuals with ADRD.

**Strategy 2.3: Collaborate with partners in the community to address the needs of the at-risk and homeless older adults.**

- Develop partnerships with APS to develop resources to deal with individuals who self-neglect and have capacity. These individuals are not eligible for APS. We need to be more proactive and develop services that prevent these individuals from losing their capacity and then become a vulnerable adult.

**Objective 2.3:1:** Develop partnerships with organizations serving the aged homeless and at risk of homelessness population to advocate for specific needs of the older adult population.

**Objective 2.3:2:** Work with partners and the Aging Network to develop strategies and action steps to address housing concerns.

**Notes from 2019-2023 HI State Plan on Aging Meeting on May 23, 2019**  
**Location: Hawaii State Capitol**  
**Facilitator: Lisa Nakao**

### **Goal 3- Strengthen the Statewide ADRC**

Goal 3: Strengthen the statewide ADRC system for persons with disabilities, older adults, and their families.

#### **Public Input**

1. Information on the ADRC website is not accessible for people disabilities.
  - a. The ADRC info is not compatible with the JAWS (Job Access with Speech) system which is a computer screen reader software developed for computer users whose vision loss prevents them from seeing screen content or navigating with a mouse. JAWS provide speech and Braille output for the most popular computer applications on a PC and enables the user to navigate the Internet, write a document, read an email and create presentations from their office, remote desktop, or from home.
  - b. The ADRC is not accessible to other disabilities who may need captioning for webinars, alternate text, etc.
2. A group member mentioned that Sprint offers HI Relay Services that allows telephone conversations on webinars and meetings to be captioned for the hearing impaired. The State and the County Agencies should contact a Lisa Tom (E-mail: [Lisa.L.Tom@sprint.com](mailto:Lisa.L.Tom@sprint.com)) to look into utilizing this service.
3. Restore jurisdiction to the Hawaii Civil Rights Commission (HCRC) to look at age related disabilities.
4. Need policies statewide to ensure documents are accessible to all persons with disabilities. State agencies should work with Doug Murdock, Chief Information Officer, from the Office of Enterprise Technology Services (ETS) on how to create accessible documents for persons with disabilities.
5. County Offices should talk to the Disabilities Rights Organization to ensure that ADRC information is accessible to persons with disabilities.
6. The ADRC should include a list of contact information of interpreters that are available for the public to use, documents and videos that are culturally competent and with captions in different languages that meet the needs of the aging population who may have hearing, vision, and other impairments.
7. The ADRC should be partnering and working with the Hawaii Chapters of the

National Center of the Blind, Easter Seals, AARP, Alzheimer's Association, Health Plans, Human Resources Departments, etc in developing their website, services, etc.

8. Need to evaluate the accountability of the ADRC.
9. Non-profits that provide services on the ADRC should provide input to the County Area Agencies on Aging's (AAA) evaluation.

## **Notes from 2019-2023 HI State Plan on Aging Meeting on May 23, 2019**

**Location: Hawaii State Capitol**

**Facilitator: Christopher Tu**

### **Goal 4 - LTSS**

2019-2023 Hawaii State Plan on Aging Comments

Goal 4: Enable older adults to live in their communities through the availability of and access to high quality, long term services and supports (LTSS), including supports for their families and caregivers.

Goal 4 – this group was the guy from Baker’s office (used to work at DHS); the Meals-On-Wheels lady; a service provider who used to work in King County, WA where they apparently have all sorts of resources we don’t; and two other women

- Need for better/more accessible website/phone system at ADRC & EOA (hearing impaired, etc.), more live interactions for seniors
- Outreach/education: build partner network/relationships; grocery stores, Longs; more advertising in Midweek, Generations; want us to have brochures/fliers in every doctors’ office; police
- Services need to be truly person centered, cost not an issue; more responsive to participants wants/particular situations; making accommodations for scheduling, etc.
- Need more doctors in the state; need more doctors that accept Medicare/Medicaid; reimbursement rates too low
- Want co-located daycare for seniors/children
- Build a community of care with HMSA, Kaiser, health plans – all contributing funds/resources
- Want us to get more funding from the Federal government
- Supposedly DHS has a system called “megahit” that allows intake workers to press a button and pull up all medical records – we should have this ability
- ADRC:
  - 4 page intake too long
  - Don’t like having to fill out intake to find out what services qualify for, would like to know beforehand
  - Inconsistent/non-transparent appeal process for terminated service/denied eligibility; would like appeal to go out of ADRC, rather than higher level review within agency; no documentation; accusations of bias/unfair



- Need to account for unreliable participants with potential cognitive impairment; have a family member, friend, guardian/POA at intake
- Would like all intakes to call PCP, Cardiologist, Neurologist to get/confirm medical info
- Inconsistent application of eligibility standards; “wobble room”; example given was dressing – if individual takes 40 minutes to dress, is that truly capable of dressing?

These are transcribed as requested by the participants. If any of these are unclear let me know & I'll try to provide clarification.

**Notes from 2019-2023 HI State Plan on Aging Meeting on May 23, 2019**  
**Location: Hawaii State Capitol**  
**Facilitator: Cristina Valenzuela**

## **Goal 5 – Health, Safety, and Independence of HI’s Older Adults**

### **GOAL 5: Optimize the Health, Safety, and Independence of Hawaii’s Older Adults**

Goal 5-

Attendees: Trisha Medeiros (President? of the Plaza), Donna Shitabata & Samuel? (APS), and another woman (Meals program)

- No Geriatric Mental Health Provider. No or lack of mental health providers for older adults.
- Strategy 5.2- clarify what type of services and supports are available for elder abuse, neglect, and fraud. Accessibility of services, particularly for high need individuals. Clarify how to access those services and supports. Have consistency in eligibility determination, standardize eligibility
- Use data (i.e. # of older adults/caregivers on waitlists b/c there’s a high demand and/or lack of resources and for what specific services or supports and other data) for future planning
- Missing in plan- workforce development (who will help to care for older adults). Address the shortage of physicians, homecare aides/professional caregivers/ case managers, etc
- Resources are limited- how do we leverage what we have
- Mental Health an issue amongst service providers- need more training (Rosalyn Carter grant that provides training on dementia)
- Case Management- long term. Most case management provided is short term. Long term case management can be a cost savings benefit (older adults better able to remain in their home longer if they receive long term case management)
- Build partnership with designated County Mental Health representative
- Guardianship, conservatorship, wills, trust, POA- more education and awareness of the process, expectations, et. Getting guardianship is difficult
- Develop resource list of geriatric physicians who provide mental capacity assessments and for mental health.

A couple people lumped in dementia and Alzheimer’s with mental health issues, but a couple people talked about it separate from “mental health”.

Comments Received at the  
May 24, 2019  
WebEx Meeting  
9:00 am – 10:00 am

**2019-2023 Hawaii State Plan on Aging  
Chat Comments from Friday, May 24, 2019 WebEx Meeting  
(17 Participants)**

**List of Participants**

1. Tania Kuriki (EOA Staff)
2. David
3. Debbie
4. Debbie Wills (HCOA)
5. Doug
6. Hope Young
7. James Mariano (MCOA)
8. Jeannette Kojane (Kokua Mau)
9. June
10. Leinani
11. Lindsey Ilagan
12. Lisa Nakao (EOA)
13. Mary
14. Meizhu Lui
15. Shelly
16. Call in-User
17. Caroline Cadirao

**Aloha and welcome to the State Plan on Aging. We will begin promptly at 9 a.m. Thank you.**

**from Debbie (privately):** start recording?

**from EOA Grants Management to everyone:** test

**from Meizhu Lui to everyone:** I can't hear - would it be better to call in?

**from Hope Young to everyone:** call in works

**from EOA Grants Management to everyone:** Meizhu Lui - please call in by phone

**from Meizhu Lui to everyone:** yes, I've called in all ok

**from Meizhu Lui to everyone:** can you give a few examples of civic engagement?

**EOA:** Volunteer opportunities in the community to give back in a meaningful way. Many older adults giving back to their community is another example.

**from Meizhu Lui to everyone:** and is it the state or the ADRC that identifies these opportunities?

**EOA:** Each AAA (Area Agency on Aging) has their own county plan on aging that will

have more specific and detailed strategies and objectives [to meet the unique needs of older adults residing] in each county. Need to check the ADRC website to get more involved with your AAA in the County that you live in. The Hawaii State Plan on Aging is a “Statewide” Plan that has more overarching strategies and objectives that accounts for the needs of the entire State [includes all the counties as a collective].

**from Lindsey Ilagan to everyone:** While these strategies look great, I'm wondering if we've thought about how we will measure progress over time. Or are these strategies meant to be more overarching with more specific measurable activities TBD?

**EOA:** Performance objectives are found in the plan. The [public] input period will [be collected] until the end of the month of May [2019]. Please provide [any] input [that you have] to any performance measure(s). [You may also add performance measure(s) that you think need to be added to the current list of performance measures.]

**from Jeannette Kojane to everyone:** I am happy to give input but am hesitant as I don't know all the strategies and goals. Can we have an overview and then go individually?

**from Jeannette Kojane to everyone:** End of May? One more week?

**from Lindsey Ilagan to everyone:** I see, mahalo for clarifying! :)

**from Leinani to everyone:** I think there are more than 10 percent with cognitive disability. I've read that it is estimated that there are about 25,000 individuals with Alzheimer's disease who live in Hawai'i, and approximately 90% of our kūpuna have a diagnosis of Alzheimer's or other dementias. How can we help this population age well, remain active and engaged in their communities?

**EOA:** There is currently a Hawaii 2025: State Plan on Alzheimer's Disease and Related Dementias. The 2019 Legislative Session established a [coordinator] position (SB366, SD2, HD2) for the implementation of the State Plan on Alzheimer's Disease and Related Dementias. Keeping seniors active and engaged in their communities is vital to this Alzheimer's Plan.

**from Leinani to everyone:** Mahalo!

**from Meizhu Lui to everyone:** Do counties share their strategies with each other - for example, helping homeless elders?

**EOA:** The Counties [AAAs] share with each other and meet regularly to discuss the strategies of their county plans with each other. There are monthly meetings with the counties to network. Counties often discuss issues with the State to ask for technical assistance.

**from Debbie Wills to everyone:** Workforce development is of great concern for our rural areas, as well as nationwide. Any strategies to increase our Home Care workforce services funded by Kupuna Care and TIII?

**EOA:** EOA wants to survey the aging network to identify the issues and problems are relating to workforce development. Is the problem the hiring process? Is it the standards that

we require? Is it the services and support that are provided to our older adult consumers? Is it a procurement issue? Are there themes that we can see in workforce development that we can work on? Should the focus be on working with younger adults to provide them more information and raise awareness of the careers that are available to work with and assist older adults?

**from Meizhu Lui to everyone:** ... and to add to that, will there be a legislative strategy? For example, travel time isn't covered which is one factor in people not wanting to serve rural areas...

**EOA:** Serving [Kupuna in] rural areas are important. Travel time to access consumers in rural areas are longer, time consuming, and costly. Need to look at how we can provide service providers incentives and build in a pricing strategy to compensate providers to service rural areas that may be harder to access.

**from Debbie Wills to everyone:** Our concerns address capacity issues or lack thereof.

**from Shelly to everyone:** Would the State Plan perhaps reference the State Homeless Plan to capture the elder component? Do EOA and the AAAs have seats on the various Community Alliance Partners coalitions?

**EOA:** EOA is currently working with the State Homeless Coordinator to better link [and coordinate] issues relating to homelessness and Hawaii's older adults. There is currently a shortage of affordable housing and affordable senior housing and we need to work together to discuss how we can address these issues.

**from Meizhu Lui to everyone:** Perhaps a booklet on best practices re cultural competence for Hawaii's diverse populations would be a helpful resource not just to AAAs but other groups

**EOA:** EOA will take this suggestion. Not sure if there is a booklet of best practices regarding cultural competency for Hawaii's diverse population of older adults. It was suggested that EOA should work with the UHM Center on Aging to see if there are resources that are available.

**from Meizhu Lui to everyone:** Great idea re UH - no sense in each organization re-inventing the wheel!

**from Meizhu Lui to everyone:** "Enhancing access" to LTC is a huge cost issue, and with the growing elder population, we will need more than just collaboration. There was LTC commission some years ago; again, do we need a legislative strategy?

**EOA:** This past 2019 Legislative Session focused upon establishing a retirement savings program which includes universal long term care for Hawaii's younger working adults. While this legislative measure did not pass during the session, as it often takes years for any bill to be passed into law. However, this measure did provide some public information on the importance of the issue of retirement savings and long term care to the forefront of the public.

**from Shelly to everyone:** Does person-centeredness incorporate cultural competence?

**EOA:** Yes, there are person-centered trainings that are currently being done in EOA's No Wrong Door project approach.

**from Debbie Wills to everyone:** In addressing "statewide consistency..." costs vary from island to island as well as district to district. How do you account for the KC Caregiver program funding based on Oahu unit rates?

**EOA:** The Kupuna Caregiver Program helps working caregivers to remain at work by providing services to their Kupuna. During the 2019 Legislative Session, Kupuna Caregiver monies were restricted and provided Caregivers a daily rate of services. However, the 2019 Legislative Session provided more flexibility and services were provided from a daily rate to a weekly rate which allows for more flexibility to the Kupuna Caregivers.

**from Meizhu Lui to everyone:** The retirement legislation was great - but it's not enough - there was a proposal for universal long-term care at one time. We need to pressure our legislators; they are fiddling while Rome burns! The elder population will be huge before they act!

**from James M / MCOA to everyone:** As we continue with ADRC efforts the next 4 yrs of this plan, I am hoping that we continue to collaborate with our many Disability Partners in addressing access to LTSS services.

**from Meizhu Lui to everyone:** There isn't funding for legal services for elders who are more likely to be targeted for scams, what are the possibilities there?

**EOA:** EOA recently hired a full time legal services program specialist. The AAAs also have legal services contracts to provide legal services to their consumers. The Hawaii State Department of Human Services (DHS) Adult Protective Services Section is the State agency that provides protective services for vulnerable adults and home and community-based services to prevent premature institutionalization of clients. The Hawaii State Department of Commerce and Consumer Affairs also holds public information fairs that educate seniors on adult abuse and neglect, fraud, and scams targeting Hawaii's older adults and vulnerable populations. The EOA has their Advocacy Education, and Outreach Staff Office that educates older adults on Medicare fraud.

**from Leinani to everyone:** I am concerned about the homebound seniors who can't get to the store to purchase food. Hawaii Meals on Wheels has certain requirements that some seniors can't meet. Is there a program to help those that Meals on Wheels can't help?

**EOA:** Seniors who are eligible for medicaid are eligible for meal programs that have less stringent requirements for their recipients. There are also various pantries and other non-profit programs that may assist in meal programs.

**from James M / MCOA to everyone:** It's hard to find providers in our county that will do Financial/Money mgmt. Most don't want to handle the complex cases and the ones that say they can cost too much. Meanwhile, the requests we get to help seniors in this area keeps growing. Does anyone have ideas on how to address this?

**EOA:** EOA needs to look at these issues on a network perspective and consider possibly forming a multidisciplinary group and invite some financial money management professionals, banks, financial institutions to discuss this issue.

**from Meizhu Lui to everyone:** Information is good - but research shows the senior brain is more susceptible to scams; we do need funding for lawyers for individuals who have been

scammed.

**from Shelly to everyone:** Our community FCUs seem to be doing a lot more outreach regarding these financial literacy issues.

**from Hope Young to everyone:** One need is workforce development for direct care service providers such as home care aides and home health aides. When the pay is equivalent to flipping burgers, it becomes a challenge finding qualified and caring individuals to care for kupuna in their home.

**from Shelly to everyone:** Even if the pay is equivalent, we need to figure out how to give home care aides a consistent and stable shift. It's very difficult to plan a family budget when you don't have consistent work hours.

**from Hope Young to everyone:** Absolutely, Shelly!

**from Shelly to everyone:** Does the ombudsman also advocate for adults in residential care homes and foster homes?

**EOA:** Yes, the long term care ombudsman not only looks at long term care facilities but will also advocate for adults in residential care home and foster homes. The reauthorization of the Older Americans Act under Title VII was expanded to include adults in residential care homes and foster homes.

**from Debbie Wills to everyone:** Does Strategy 5.5 include similar services/information regarding Medicaid?

**EOA:** Caroline recommended that you contact Lani Sakamoto from EOA on this issue. You can contact Lani at 586-7277.

**from Debbie Wills to everyone:** FYI: The SHIP volunteers here state that they do not counsel or have any training or information on Medicaid.

**from Lisa Nakao to everyone:**

Cristina Valenzuela, Legal Svcs developer - 586-7265,

John McDermott, LTC Ombudsman-586-7268

Lani Sakamoto- Medicare assistance - 586-7277

**from Shelly to everyone:** Will EOA have a seat at the table with HIEMA to help develop disaster plans that address the needs of older adults?

**from Hope Young to everyone:** Who do we contact to make suggestions on the ADRC website?

**EOA:** Contact Caroline Cadirao via e-mail at [Caroline.Cadirao@doh.hawaii.gov](mailto:Caroline.Cadirao@doh.hawaii.gov)

**from EOA Grants Management to everyone:** [Caroline.Cadirao@doh.hawaii.gov](mailto:Caroline.Cadirao@doh.hawaii.gov)



**from Meizhu Lui to everyone:** How big is the state EOA staff? - before we ask too much of you!

**EOA:** EOA consists of 17 full time staff

**from Meizhu Lui to everyone:** Thank you for doing this, and welcome Caroline!

**from Shelly to everyone:** my HiEMA question :) Will EOA have a seat at the table with HIEMA to help develop disaster plans that address the needs of older adults?

**from Shelly to everyone:** Can we get a copy or link to the document?

**from Shelly to everyone:** Doesn't have to be now LOL

**from Debbie Wills to everyone:** Mahalo!!

**from James M / MCOA to everyone:** Bye everyone. have a nice weekend

**from Shelly to everyone:** thanks!

Comments Received at the  
May 29, 2019  
WebEx Meeting  
10:00 am – 11:00 am

**2019-2023 Hawaii State Plan on Aging  
Chat comments from Wednesday, May 29, 2019 Webinar  
10:00 am – 11:00 am  
(8 PARTICIPANTS)**

**List of Participants**

Captioner  
Debbie  
Diane  
Judy  
Kait  
Representative Nakamura  
Whitney H.  
Pedro

**from Whitney U to everyone:** yes, I can hear!

**from Diane to everyone:** How will you measure achievement of goal and effectiveness of strategies? Performance measures have no #s or % ages for achievement.

**EOA:** Performance measures are listed for the strategies and objectives under each Goal. If there are any comments on the performance measures, please contact Lisa Nakao by phone at 586-7317 or via e-mail at [lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov). You may access the complete draft plan online at the ADRC website at <https://www.hawaiiadrc.org>.

**from Lisa Nakao to everyone:** [lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov)

**From Caroline to everyone:** One of the comments made from last week's WebEx meeting on the 2019-2023 Hawaii State Plan on Aging to see if the website would be updated. This is something that EOA is looking at. While it is not part of one of strategies in the plan, EOA is looking to update and strengthen access to the ADRC website. Website was launched about 8 years ago and EOA is currently working at updating the site.

**from Diane to everyone:** Is there any plan to make Participant Directed services available to Honolulu County elders?

**EOA:** Yes, there is a plan to make Participant Directed services available to Honolulu County 's older adults. EOA started Participant Directed Services and Supports on the neighbor islands through a Federal Grant EOA received back in 2011. EOA demonstrated through this grant that participant directed services is an option for people to receive services & support. Instead of the consumer getting traditional services and supports that is needed through the ADRC with only service providers that are contracted by the AAAs. Participant directed services is another model that allows the individual participant to have a budget, work with a coach (similar to a case manager) and fiscal intermediary that takes care of the payrolls of all individuals that the participant hires to provide his/her services that is needed. This model started in the Neighbor Islands and EOA wants to eventually start the Participant Directed Services option in Honolulu soon.

**from Representative Nakamura to everyone:** How do you address kupuna caregiver program funding?

**EOA:** Kupuna Caregiver is an offshoot of the Kupuna Care program. The difference is that the Kupuna Caregiver is addressing the needs of our working caregivers. EOA has been provided funding that has been provided by the legislators. If approved by the Governor, the legislators awarded 1.5 mil over the next two years for the Kupuna Caregiver Program. EOA is learning a lot even though the program has only been in existence for a little over a year now. EOA will be engaging communities, stakeholders, partners, providers, AAAs. One of the requirements is that EOA need to come up with a plan and to address more individuals and provide for more caregivers. EOA wants to engage the community and will be working on this during the summer as EOA moves forward.

**from Representative Nakamura to everyone:** thanks! I think it's important to make sure funding goes to the most needy caregivers.

**EOA:** It is important to EOA that the funding for Kupuna Caregiver Program goes to the most needy caregivers. EOA is starting to build this into the Kupuna Caregiver Program.

**from Representative Nakamura to everyone:** Based on Kauai flood experience, strategy 5.6 is critical

**EOA:** Just being prepared for disasters is so critical. EOA works closely with the County executives of each of the AAAs whenever there is a possible natural disaster event that may occur to find out what each county is doing to ensure that their older adults in their counties are safe. Consumers of the ADRC are provided an assessment home visit to determine the type of services and supports the consumer wants and needs from the ADRC. During these assessment, the consumers are given an option to receive assistance in developing their own personal disaster readiness plan.

**from Diane to everyone:** In your Performance Measures, item 6, re: % of EOA/AAA staff trained on abuse & neglect should be ALL staff (100%). And again, your Performance Measures have no proposed #'s or % ages to achieve so how will you measure success?

**EOA:** EOA will go back and review EOA's performance measures to ensure that the performance measures are measurable.

**from Diane to everyone:** The demographic info in the plan is helpful. Is there a way to include some data on ADRC utilization to be able to gauge what type of requests are received, how many are connected to services, what increase in calls/assessments are seen from year to year?

**EOA:** Yes, you make a good point that we should look at the ADRC utilization to better gauge the type of requests are received, how many are connected to services, and whether the call/assessment are increased from year to year.

**from Pedro to everyone:** Thank you!

**from Whitney U to everyone:** Thank you!

Comments Received on  
2019-2023 Hawaii State Plan on Aging  
from other  
Organizations and Individuals

**From:** [Nakao, Lisa R.](#)  
**To:** [Cadirao, Caroline M.](#)  
**Subject:** FW: Re: State Plan on Aging Edits from John A. H. Tomoso **Date:**  
Tuesday, May 21, 2019 12:11:00 PM

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Hi Caroline!

After receiving Barbara Yamashita's e-mail below this morning (5/21/19), I called Barbara Yamashita to clarify what changes are Shirley and her recommending to be made to one of the objectives in the draft 2019-2023 State Plan on Aging. Barbara responded that Shirley Kidani, Cullen Hayashida and several others belong to an organization called "Change Agents Hawaii" and they want EOA to consider including an objective under "Goal 2: Forge Partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population" that will take into account the need to include active aging. After a detailed discussion and brainstorming, Barbara agreed that under Goal 2, Objective 2.2.:1 should be modified (change notated in **RED**) to state the following:

**Objective 2.2:1: Collaborate, develop partnerships, and leverage resources to develop more age friendly communities that **promote promising practices** for aging in place and active aging.**

I will reflect their comments above on the final draft of the 2019-2023 State Plan on Aging.

Lisa

*Lisa Nakao, Planner  
Executive Office on Aging  
Hawaii State Department of Health  
250 S Hotel Street  
Honolulu, HI 96813  
Office Phone: (808) 586-7317  
Fax: (808) 586-0185  
E-Mail Address: [lisa.nakao@doh.hawaii.gov](mailto:lisa.nakao@doh.hawaii.gov)*

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**From:** babsyamz@hawaii.rr.com <babsyamz@hawaii.rr.com>  
**Sent:** Monday, May 20, 2019 7:37 PM  
**To:** Nakao, Lisa R. <Lisa.Nakao@doh.hawaii.gov>  
**Subject:** FW: Re: State Plan on Aging Edits from John A. H. Tomoso

Lisa,

Can we add this to the plan? Give me a call to discuss. Thanks for looking at this. B

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From: "Shirley Kidani"  
To: "Cullen Hayashida"  
Cc: "Barbara Yamashita"  
Sent: Monday May 13 2019 3:26:02PM  
Subject: Re: State Plan on Aging Edits from John A. H. Tomoso

Cullen and Barb:

I think time is of the essence. See cover memo, looks like they are going to public hearing week of May 20.

**For Consideration: Goal #2 (Forge partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population)**

How about using same language in proposed legislation?

**Strategy:** "update the 2013 white paper on active aging to help create a new social policy paradigm"

Goal 2 offers a larger umbrella to include ageism, financial well being, employment, community development etc.

On May 13, 2019, at 2:49 PM, Shirley Kidani <[sskid@hawaiiantel.net](mailto:sskid@hawaiiantel.net)> wrote:

In reviewing the State Plan, I searched for the Area Plans. (Older Americans Act requires that the State Plan be based on the area plans). See attached Maui and Honolulu plans. Take note of Maui's and HNL's Goal #1 and Goal #2 and objectives.

My initial reaction is that Goal #5 may not be the appropriate one to build on. Goal #5 includes persons of disabilities. Perhaps, you could expand the strategies for Goal #1, **or** Goal #2.

Maybe goal #2 would work better.....Still thinking.

<DRAFT 2019-23 Maui county Area Plan (2).pdf>  
<Area\_Plan\_2019-2023\_for\_PEAD.pdf>

On May 13, 2019, at 11:44 AM, Cullen Hayashida <[cullenhaya@gmail.com](mailto:cullenhaya@gmail.com)> wrote:

OK. I will take a look at it. When's the deadline for feedback to EOA or to PABEA?

Shirley, please chime in.

If time is not too tight, perhaps we can draft something and solicit input at the next Change AGENTS Hawaii meeting.

Cullen

On Mon, May 13, 2019 at 11:40 AM <[babsyamz@hawaii.rr.com](mailto:babsyamz@hawaii.rr.com)> wrote:

Would you look at goal 5 and help me develop a strategy or two for active aging. Also if more appropriate under another goal..let me know that. Really need your help

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