2017 – 2019 HAWAII STATE PLAN ON AGING
(Extension of the 2015 – 2017 Hawaii State Plan on Aging)

For Older Americans Act
Title III and Title VII Programs

For the period:
October 1, 2017 – September 30, 2019

Department of Health

Executive Office on Aging

"E Loa Ke Ola"
May Life Be Long

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VERIFICATION OF INTENT

The Executive Office on Aging hereby submits the Hawaii State Plan on Aging for the period October 1, 2015 to September 30, 2017. The Executive Office on Aging has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Older Americans Act, as amended in 2006, and is primarily responsible for the coordination of all state activities related to the purposes of the Act. The plan charts the direction over the next two years and includes the development of a comprehensive and coordinated system of services. The Executive Office on Aging serves as an effective and visible advocate for the older adults in the State.

The State Plan on Aging is hereby approved by the Governor and constitutes authorization to proceed with activities under the plan upon approval by the U.S. Assistant Secretary for Aging, Administration on Aging. The plan, as submitted, has been developed in accordance with all Federal statutory and regulatory requirements.

_____ _____

Date

Terri Byers
DIRECTOR, EXECUTIVE OFFICE ON AGING
STATE OF HAWAII

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

_____ _____

Date

David Y. Ige
GOVERNOR
STATE OF HAWAII

Mission Statement:
Optimize the health, safety and independence of Hawaii's older persons. We support Kupuna and their caregivers through advocacy, planning development, and coordination of policies, programs and services.

EXECUTIVE SUMMARY

The Hawaii State Department of Health's (DOH), Executive Office on Aging (EOA) is submitting this 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) which covers the period from October 1, 2017 - September 30, 2019. This extension plan builds upon the 2015 – 2017 Hawaii State Plan on Aging and describes the goals, strategies, and objectives that will be followed for the next two years, 2017 - 2019, to better implement a comprehensive and coordinated system of long term services and supports that is needed by Hawaii's older adults and individuals with disabilities, along with their caregivers. This extension plan complies with the requirements of the Older Americans Act, as amended in 2016 through P.L. 114-144, and the Administration on Aging (AoA) Program Instruction, 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. As Hawaii's aging population increases the need for home and community-based services will in turn continue to rise.

While in the process of developing the 2015- 2017 Hawaii State Plan on Aging, EOA met with the Area Agencies on Aging (AAAs) and 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). This effort resulted in 5 statewide goals to enable older adults and persons with disabilities to continue to live in the safety and security of their communities for as long as they find feasibly possible. The five goals are:

1. Maximize opportunities for older adults to age well, remain active, and enjoy quality lives while engaging in their communities;
2. Forging partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges for the aging population;
3. Developing a statewide Aging and Disability Resource Center (ADRC) system for older adults and their families to access and receive long-term services and supports (LTSS) within their respective counties;

4. Enabling people with disabilities and older adults to live in the community through the availability of and access to high-quality LTSS, including supports for families and caregivers; and
5. Optimizing the health, safety, and independence of Hawaii's older adults.

All goals, objectives, and strategies outlined in this extension 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. This 2017-2019 Hawaii State Plan on Aging extends the strategies, goals, and objectives outlined in the 2015-2017 Hawaii State Plan on Aging to enhance implementation of a comprehensive and coordinated support system of long term services and supports 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 long term services and supports are provided to Hawaii's older adults and persons with disabilities. We believe that only by 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 better achieving a comprehensive and coordinated support system of care for Hawaii's older adults and persons with disabilities.

I. INTRODUCTION

The Executive Office on Aging of the Hawaii State Department of Health (DOH) is submitting this 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) for Older Americans Act Title III and Title VII funds for the period of October 1, 2017 - September 30, 2019 to the U.S. Administration on Aging (AoA), the U.S. Department of Health and Human Services (HHS), for approval.[1] This plan complies with the requirements of the Older Americans Act (OAA), as amended in 2016 through P.L. 114-144 and the AoA Program Instruction 14-01 which outlines criteria by the Assistant Secretary for Aging.

A. Organizational Structure for Title III Programs in Hawaii

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 to maintain their well-being and independence.

On April 18, 2012, the Administration for Community Living (ACL) was created and is organizationally part of HHS. From the beginning, ACL was based on a commitment to one 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.

AoA heads the Aging Network on the federal level, directed by the Assistant Secretary for Aging. AoA awards OAA Title III, IV, and VII funds to the states and monitors and assesses state agencies that administer these funds. The agency also develops, coordinates and administers programs nationwide; provides leadership, direction, technical assistance and advocacy; and develops policy to meet the needs of elderly individuals.

At the State level, the designated lead agency or State Unit on Aging in the network is the DOH, Executive Office on Aging (EOA). EOA is required to plan and lead the coordination of access to home and community-based services to the older adult

[1] Title III funds are for nutrition and supportive home and community based services and Title VII funds are for vulnerable elderly rights activities.

population at both the state and local levels, which involves:

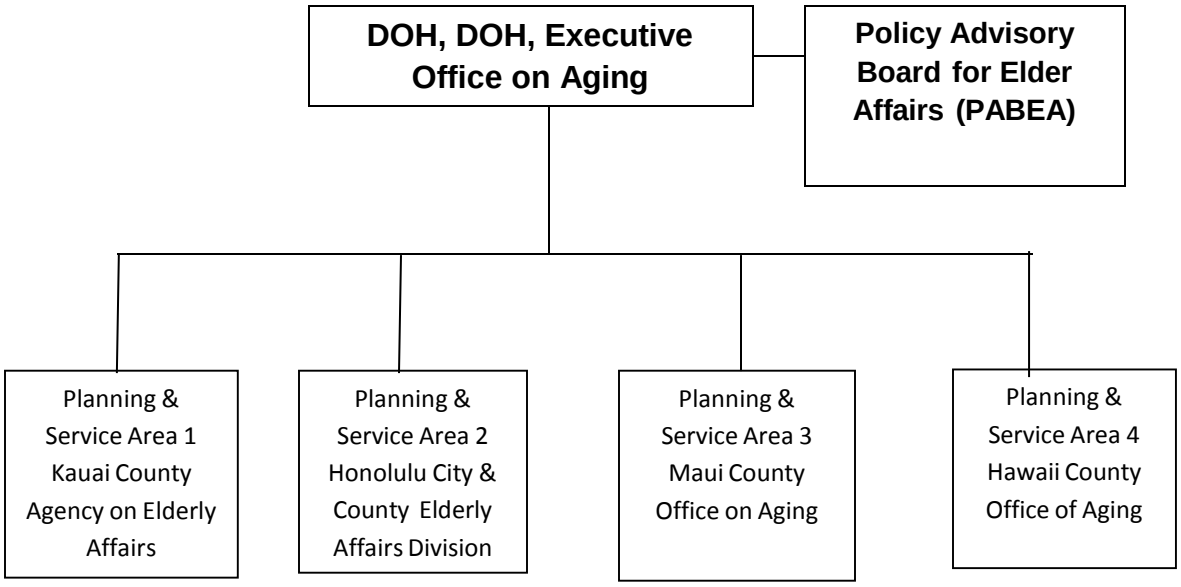
- Planning
- Policy and program development
- Advocacy
- Research
- Information and referral
- Coordination of services provided by public and private agencies for our elders and their families

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, Hawaii Revised Statutes, defines the purpose and functions of EOA and, in Section 4, established the Policy Advisory Board for Elder Affairs to assist the EOA Director by advising on the development and administration of the State Plan by representing the interests of older persons including grandparents raising grandchildren, and by reviewing and commenting on other State plans, budgets and policies that affect older persons.

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 by the EOA as Area Agencies on Aging (AAAs):

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

Nalani Aki, County Executive
Telephone: (808) 768-7705

Maui County Office on Aging (MCOA)
County of Maui
J. Walter Cameron Center
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, Director
Telephone: (808) 961-8600

The AAAs are responsible for implementing the OAA in their respective counties. Each AAA carries out a wide range of functions related to advocacy, planning, coordination, inter-agency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development and enhancement of comprehensive and coordinated community based systems which will enable older persons to lead independent, meaningful and dignified lives in their homes and communities as long as possible, as documented in their 4-Year Plans. Each AAA has an advisory council to advise the agency on the development and administration of the area plan, conduct public hearings, represent the interests of older persons, and receive and comment on all community policies, programs and actions which affect older persons.

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.

EOA receives formula funds based on population from the ACL, Administration on Aging under Title III and VII, and discretionary funds under Title IV, of the OAA. Based on the State's Intrastate Funding Formula, Title III and VII funds are allocated to the four AAAs. The EOA also receives funds from the State Legislature for aging services (Kupuna Care and other programs), which are allocated to the AAAs. The AAAs contract out both federal and State funds to service providers that deliver services at the local 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). The EOA also receives Title VII funds from the OAA and other federal grants to carry out elder rights and benefits programming. Furthermore, the EOA and the AAAs will better coordinate Title III services and programs with Title VI grantees in Hawaii by referring Native Hawaiians, via our Aging and Disability Resource Center (ADRC), to Title VI grantee provider, Alu Like, Inc., for the full range of services if they meet qualifications.

B. State Plan Purpose

Section 307(a) of the OAA requires that each state, to be eligible for grants under Title III, develop a State Plan on Aging that conforms to the criteria outlined by the Assistant Secretary for Aging. This extension plan complies with the requirements of the Older Americans Act, as amended in 2016 through P.L. 114-144 and the AOA Program

instruction, AoA-PI-14-01, which outlines the criteria set forth by the Assistant Secretary for Aging.

The 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) incorporated in its strategies, the needs, expectations and choices of older individuals as determined by the AAAs in the development of their area plans, and describes how Hawaii's systems of services and access to these services will meet the challenges of our aging population.

The 2017 – 2019 Hawaii State Plan on Aging (Extension of the 2015 – 2017 Hawaii State Plan on Aging) strategies are based on principles in the OAA, which form the direction over the next two 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, in its efforts to rebalance the system of long-term supports and services (LTSS), has outlined additional strategic principles and objectives in Choices for Independence, which will enable the Network to become more participant-directed. These additional strategic principles were also incorporated into the 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) strategies:

- Empower participants to make informed decisions about their care options;
- Help older adults at high 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 that relate to four federal, AoA goals, were also included in the plan strategies:

- Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term 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 their 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.

The purpose of the 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) is to set the direction for the period October 1, 2017 through September 30, 2019, for the development of a comprehensive and coordinated system of long term services and supports in accordance with all federal requirements, to serve Hawaii's older adults and persons with disabilities, and their caregivers.

C. Planning Process and Community Input

EOA, AAA, and the ACL discretionary grant programs namely the Hawaii Senior Medicare Patrol (SMP) and the Hawaii State Health Insurance Assistance Program (SHIP) staff met to develop the State goals for the 2015- 2017 State Plan that address the identified needs. Five goals emerged from the discussions (See Chapter III). EOA,

the AAAs, and the ACL grant programs then developed their plans for achieving the five goals.

The 2015 – 2017 Hawaii State Plan on Aging was reviewed by the public and government officials. An early draft of the plan was posted on the Hawaii ADRC website for the public to review. Notice of the plan's posting and the information session schedule were posted on EOA's website, printed in the local newspapers on all the Hawaiian Islands, as well as distributed by email to advocates, community organizations, and service providers for older adults and persons with disabilities. The plan was presented to the public in two WebEx sessions and in-person to the EOA Policy Advisory Board for Elder Affairs. More than 30 individuals attended these sessions and/or offered comments. A revised plan was then submitted for review to the director of the Department of Health and the Governor's Office.

Due to EOA recent staff shortages and to enhance implementation of a comprehensive and coordinated system of long term services and supports for Hawaii's older adults and individuals with disabilities as set forth by the 2015-2017 Hawaii State Plan on Aging, EOA requested approval from AoA to develop a two-year extension plan to the current 2015 - 2017 Hawaii State Plan on Aging. Upon receiving approval from the ACL Region 9 Representative, EOA is submitting this 2017-2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) for approval by the Assistant Secretary for Aging. The 2017 - 2019 Hawaii State Plan on Aging does not change any of the goals and objectives of the 2015 - 2017 Hawaii State Plan on Aging. Rather, the extension plan just extends the completion date of some of the existing objectives contained in the 2015-2017 Hawaii State Plan on Aging.

The 2017 - 2019 Hawaii State Plan on Aging (Extension of the 2015 - 2017 Hawaii State Plan on Aging) was reviewed by the EOA Director, EOA staff, and members of the Policy and Advisory Board of Elder Affairs (PABEA). A draft of the plan was posted on the Hawaii ADRC website for the public to review. Notice of the plan's posting and the information session schedule were posted on EOA's website. The plan was presented to in-person to the EOA Policy Advisory Board for Elder Affairs. More than XX individuals attended these sessions and/or offered comments. A revised plan was then submitted to the director of the Department of Health and the Governor's Office for review and 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. HAWAII'S AGING POPULATION AND OAA'S TITLE III PROGRAMS

In developing our plan, we reviewed data from the American Community Survey (ACS) and Title III programs, as well as studies that looked at the older adult population in Hawaii. We compared the characteristics of persons 60 years and older and their utilization of Title III programs in Hawaii to those nationally between 2011 and 2015. In this chapter, we present the findings from this review.

A. Cost of Growing Old

In the next few years, the number of persons 60 years and older will continue to rise as more baby boomers enter their retirement years. By 2020, most of the baby boomers, i.e. those born between 1946 and 1964, will have celebrated their 60th birthday. By then, it is projected that about a quarter (25.8%) of Hawaii's population will be 60 years or older, 2.6 percentage points more than that projected for 2015 (Table 1).

Table 1. Population Distribution Projections for the United States and Hawaii by Age Groups, 2015 and 2020.

AGE GROUP	2015		2020	
	United States[1]	Hawaii[2]	United States[1]	Hawaii[2]
Total Population	100.0%	100.0%	100.0%	100.0%
55 – 59 years old	6.8%	6.9%	6.5%	6.3%
60 years and older	20.8%	23.5%	23.2%.	25.8%
60 – 64 years old	5.9%	6.5%	6.3%	6.5%
65 – 74 years old	8.6%	9.6%	9.9%	11.0%
75 – 84 years old	4.3%	4.8%	5.0%	5.6%
85 years and older	2.0%	2.6%	2.0%	2.7%

[1]Source: United States Census Bureau
[2]Source: State of Hawaii Department of Business, Economic Development and Tourism

The growing number of older adults is likely to put a severe strain on the State's resources for LTSS. The Centers for Disease Control and Prevention estimated the health care costs for persons 65 years and older to be three to five time larger than the costs for persons younger than age 65 (CDC, 2013a.). Ninety-five percent (95%) of the health care costs for older adults are spent on treating chronic diseases.

Chronic diseases, as well as the natural outcome of the aging process, may result in life impairing difficulties. As Table 2 shows, the proportion of individuals with life impairing difficulties, in Hawaii and in the nation as a whole, rose with age. The increase

Table 2. Percent of Non-Institutionalized Civilians with Life Impairing Difficulties in the United States and Hawaii for Selected Age Groups for the Years 2011 – 2015.

AGE GROUP	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Self-Care Difficulties										
35 to 64 years old	1,7 (9,144)	2.0 (10,842)	1.7 (8,614)	1.8 (9,636)	1.7 (8,881)	2.5 (3,033,445)	2.5 (3,002,965)	2.5 (3,019,976)	2.5 (3,033,009)	2.5 (3,038,400)
65 to 74 years old	3.5 (3,681)	4.2 (4,636)	3.9 (4,683)	3.5 (4,409)	3.4 (4,515)	4.7 (1,038,609)	4.6 (1,102,568)	4.5 (1,118,176)	4.5 (1,173,525)	4.4 (1,207,383)
75 years and older	9.9 (9,245)	12.6 (11,906)	12.8 (12,587)	16.7 (16,345)	15.4 (15,328)	14.1 (2,511,587)	14.0 (2,527,124)	14.0 (2,569,924)	13.9 (2.611,858)	13.6 (1,610,940)
Independent Living Difficulties										
35 to 64 years old	2.9 (15,410)	3.6 (18,890)	3.3 (17,007)	3.4 (17,936)	3.0 (15,824)	4.5 (5,468,335)	4.5 (5,455,962)	4.5 (5,495,953)	4.5 (5,561,027)	4.5 (5,561,027)
65 to 74 years old	6.7 (7,053)	7.8 (8,679)	7.8 (9,381)	6.8 (8,575)	6.2 (8,313)	8.2 (1,819,980)	8.1 (1,926,659)	7.8 (1,952,876)	7.9 (2,050,570)	7.6 (2,086,336)
75 years and older	26.1 (24,346)	29.0 (27,280)	28.7 (27,371)	31.2 (30,507)	28.4 (28,254)	26.2 (4,671,568)	26.0 (4,700,470)	25.7 (4,739,188)	25.5 (4,798,443)	25.2 (4,824,113)

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Tables B18106 and B18107.

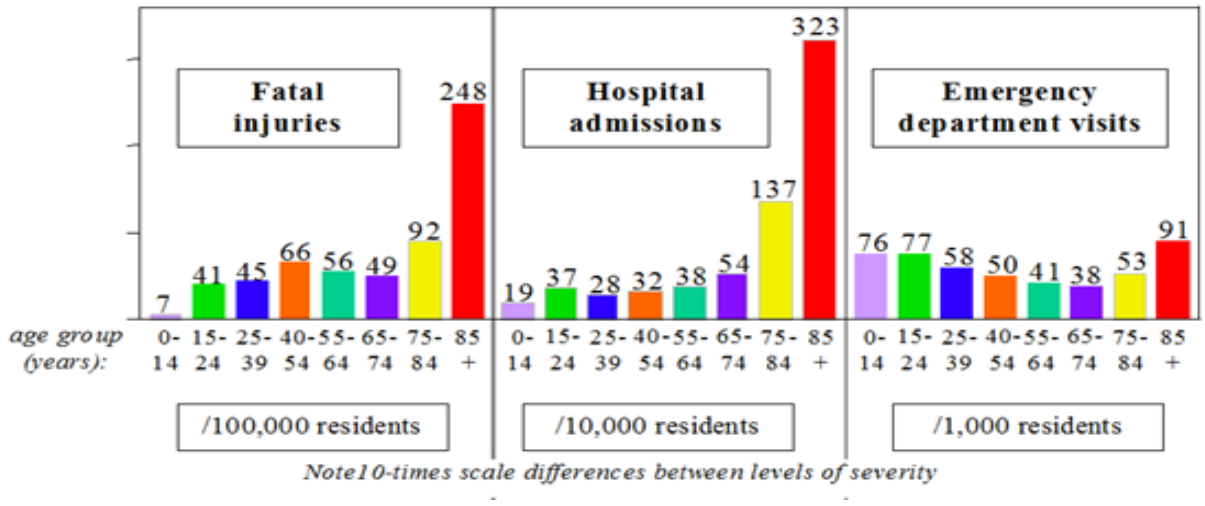
[a] Self-care difficulty is having difficulty bathing or dressing.

[b] Independent living difficulty is having difficulty doing errands alone because of a physical, mental, or emotional condition.

was particularly sharp among those 75 years and older. He and Larsen (2014) reported that in the 75 and older age group, the incidence was particularly high among those 85 years and older. They found that while 55% of persons between the ages of 75 and 84 reported having no disabilities and 16.5% reported having three or more disabilities, among those 85 years and older, the proportion reporting no disabilities fell to 27.5% and the proportion with three or more disabilities rose to 41.5%.

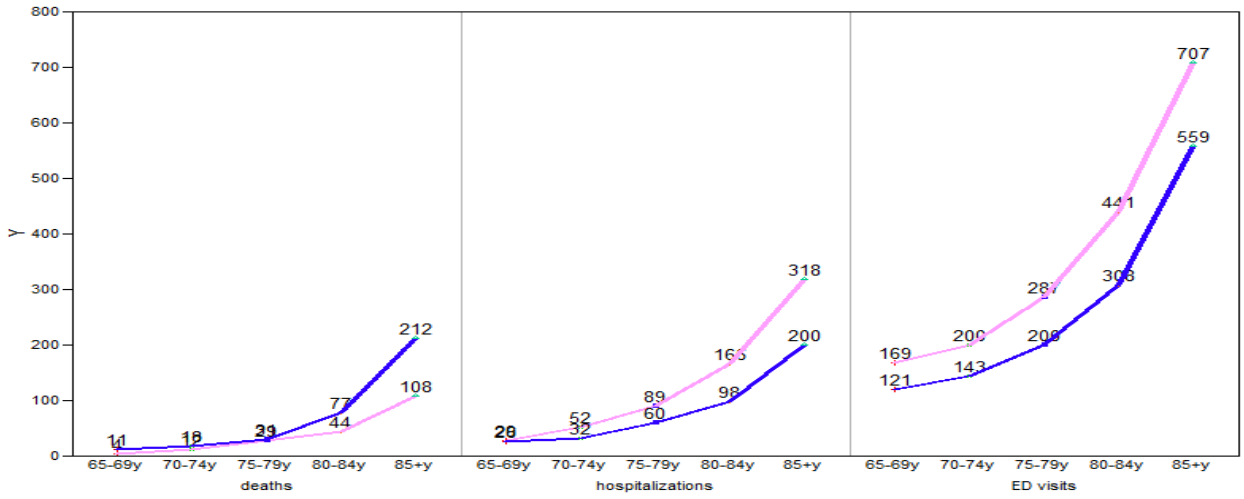
Accidents and injuries add to the costs for caring for older adults. As Figure 1 shows, injuries in Hawaii, across all levels of severity, occurred more often among those ages 75 and older, with the rate increasing more rapidly among those 85 years and older. Figure 2 shows injuries from falls also rising more rapidly with age.

Figure 1. Annual Rates of Injuries among Hawaii Residents, by Severity and Age Group, 2008-2012.



Source: Galanis, Dan. Hawaii Department of Health, Injury Prevention Program. January 23, 2014 PowerPoint presentation.

Figure 2. Rates of Injuries from Falls among Senior Residents of Hawaii, by Gender and Level of Severity, 2008-2013.



Male ---- Female ----

Source: Galanis, Dan. Hawaii Department of Health, Injury Prevention Program. January 23, 2014.

Older adults are also more often the subject of reports investigated by the Hawaii Adult Protection Services (APS). Although, as Table 3 shows, persons 60 and older made up only slightly more than a fifth of the 2011–2015 population, persons they were involved in 78% of APS's 2013 investigations (Kano, 2014). A disproportionate number of those cases, 58%, involved persons 80 years and older, much larger than their proportion among persons 60 years and older (See Table 4).

Table 3. Population Distribution for the United States and Hawaii by Age Groups for the Years 2011 to 2015. (In Percent)

AGE GROUP	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
54 years and younger	72.2	71.9	71.6	71.2	70.8	74.5	73.9	73.4	72.9	72.4
55 – 59 years old	6.7	6.6	6.7	6.5	6.8	6.5	6.6	6.7	6.7	6.7
60 years and older	21.1	21.5	21.7	22.3	22.4	19.0	19.5	19.9	20.4	20.9
60 – 64 years old	6.3	6.4	6.0	6.2	5.8	5.7	5.7	5.8	5.9	6.0
65 – 74 years old	7.7	8.0	8.6	8.9	9.3	7.2	7.6	8.0	8.3	8.6
75 – 84 years old	4.7	4.4	4.5	4.4	4.4	4.2	4.2	4.3	4.3	4.4
85 years and older	2.5	2.7	2.5	2.7	2.8	1.9	1.9	1.9	1.9	1.9
Total	100	100	100	100	100	100	100	100	100	100

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table B01001.

Unless something is done to reduce the incidence of functional limitations among older adults, the problem of providing older adults with the services they need will escalate in Hawaii in 10 years. The results in Table 3 indicate that Hawaii is likely to be one of the states that will be hardest hit by the demands the aging baby boomers will place on resources. The table shows Hawaii has a slightly larger percentage of older adult population than the nation and this trend, as Table 1 showed, is expected to extend for the duration of this 2017 to 2019 plan extension.

Table 4. Age Distribution of Persons 60 Years and Older in the United States and Hawaii for the Years 2011 to 2015. (In Percent)

AGE GROUP	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
60 – 64 years old	30.0	29.8	27.8	28.0	25.9	30.2	29.4	29.0	28.9	28.8
65 – 74 years old	36.6	37.4	39.7	40.1	41.8	37.9	39.3	40.1	40.7	41.2
75 – 84 years old	22.1	20.5	20.9	19.6	19.9	22.3	21.8	21.4	21.2	20.9
85 years and older	11.3	12.4	11.6	12.3	12.4	9.6	9.5	9.5	9.3	9.2
Total	100	100	100	100	100	100	100	100	100	100

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table B01001.

B. Older Adults in Hawaii are Healthier

Despite having a larger proportion of older adults than the nation, the effects of the baby boomers may possibly be mitigated by Hawaii having a generally healthier older adult population than the nation. Using the responses to a question in the Behavioral Risk Factor Surveillance System (BRFSS) on general health status, a CDC study (2013b) concluded that Hawaii had the highest "healthy life expectancy" in the nation for persons age 65.[2] The study estimated that women in Hawaii who were 65 years old between 2007 and 2009 had a healthy life expectancy of 17.3 years and a life expectancy of 23.2 years compared to the national rates of 14.8 and 20.3 years, respectively. Males in Hawaii were estimated to have a healthy life expectancy of 15.0 years and a life expectancy of 19.3 years after age 65. Nationally, the rates for males were 12.9 and 17.7 years, respectively.

The better health of the older adults in Hawaii relative to the nation may also account for the lack of a gender difference in the youngest older adult age group in Table 5. In the 2011 to 2015 five-year period, there is a noticeable gender difference in the United States in all three age 60 and older age groups. In contrast, the gender difference in Hawaii does not show up until the 65 and older age groups.

[2] The question used was "Would you say that in general your health is excellent, very good, good, fair, or poor?". Persons who responded "fair or poor" were categorized as "unhealthy" and those who answered "excellent, very good, or good" were categorized as "healthy".

The better health status of older adults in Hawaii may also explain the functional limitations found in Table 2 between Hawaii residents and those in the rest of the nation. The table showed a smaller proportion of Hawaii residents under 75 years old reported having self-care difficulties (e.g., difficulty bathing or dressing).

Table 5. Sex Distribution of Persons 60 Years and Older in the United States and Hawaii for 2011 – 2015. (In Percent)

SEX AND AGE GROUP	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Male										
60 years and older	45.7	45.9	46.1	46.3	45.7	44.9	44.9	45.0	45.1	45.2
60 – 64 years old	48.9	49.5	50.0	50.7	47.6	47.9	47.9	47.9	47.9	47.9
65 – 74 years old	48.3	48.2	48.3	48.1	48.4	46.6	46.7	46.8	46.8	46.7
75 years and older	39.9	40.0	39.9	40.1	40.7	39.4	39.7	40.0	40.2	40.5
Female										
60 years and older	54.3	54.1	53.9	53.7	54.3	55.3	55.1	55.0	54.9	54.8
60 – 64 years old	51.1	50.5	50.0	49.3	52.4	52.1	52.1	52.1	52.1	52.1
65 – 74 years old	51.7	51.8	51.7	51.9	51.6	53.4	53.3	53.2	53.2	53.3
75 years and older	60.1	60.0	60.1	59.9	59.3	60.6	60.3	60.0	59.8	59.5

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table B01001.

Table 2 also showed that, among those 75 years and older, a slightly larger proportion of Hawaii residents reported having independent living difficulty and, more recently, self-care difficulties. However, given that residents of Hawaii live longer, the median age of its oldest age group is likely to have been higher and thus more likely to have infirmities. This may also explain the finding in Table 6 that shows a higher incidence of cognitive impairments among Hawaii residents 65 years and older, since the risk of cognitive impairments increases with age.

The results from ACS show no notable difference in the socio-demographic characteristics of older adults in Hawaii between 2009 - 2011 and 2011 - 2013. They do, however, reveal differences between the national statistics and those in Hawaii. The results show racial composition of Hawaii's older adults differs from the nation's (Table 7). Hawaii has a smaller proportion of whites and African Americans, and a larger proportion of Asian, Native Hawaiians and Other Pacific Islanders, and persons of two or more races. The results showed that nearly 8 out of 10 persons 60 years and older in the United States were white, non-Hispanics; whereas in Hawaii, less than 3 out of 10 persons were white.

Table 6. Persons with Disabilities in the United States for the years 201 to 2015 by Age Group

AGE GROUP AND DISABILITY	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
18 to 64 years old										
Hearing	1.8	1.9	1.7	2.9	1.6	2.1	2.0	2.1	2.1	2.0
Vision	2.3	1.2	1.4	1.3	1.2	1.8	1.8	1.9	1.9	1.9
Cognitive	3.5	3.4	3.3	3.6	3.1	4.3	4.3	4.4	4.4	4.5
Ambulatory	3.7	4.0	3.3	3.8	3.6	5.2	5.2	5.2	5.2	5.1
Self-Care	1.4	1.5	1.3	1.3	1.4	1.9	1.9	1.9	1.9	1.9
Independent Living	2.6	2.8	2.8	2.9	2.6	3.6	3.6	3.6	3.7	3.7
65 years and older										
Hearing	15.1	15.0	15.2	16.4	15.4	15.0	14.7	15.2	15.0	14.8
Vision	5.4	5.8	5.8	5.3	4.7	6.8	6.5	6.8	6.7	6.5
Cognitive	10.1	10.5	12.7	12.2	10.3	9.4	9.3	9.2	9.1	9.0
Ambulatory	21.0	21.1	22.0	22.9	20.4	23.6	23.1	23.3	23.0	22.6
Self-Care	6.5	8.0	7.8	9.3	8.5	8.9	8.7	8.5	8.4	8.2
Independent Living	15.8	17.5	17.0	17.5	15.7	16.2	15.8	15.4	15.4	14.9

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table S1810.

Table 7. Race Distribution of Persons 60 Years and Older in the United States and Hawaii for the Years 2011 to 2015. (In Percent)

RACE/ETHNICITY	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
One Race	89.5	90.1	89.0	88.6	88.5	98.9	98.9	98.9	98.9	98.9
White	28.3	27.8	28.1	28.0	27.9	83.8	83.5	83.2	82.8	82.4
African American	0.5	0.6	0.7	0.7	0.7	9.1	9.2	9.3	9.4	9.5
American Indian/ Alaska Native	0.2	0.2	0.1	0.2	0.2	0.5	0.5	0.5	0.6	0.6
Asian	53.8	55.0	53.4	53.2	52.8	3.8	3.9	4.0	4.2	4.3
Native Hawaiian/ Other Pacific Islander	5.7	6.1	5.9	6.1	6.4	0.1	0.1	0.1	0.1	0.1
Some other race	0.9	0.4	0.8	0.5	0.6	1.7	1.7	1.8	1.8	1.9
Two or more races	10.5	9.9	11.0	11.4	11.5	1.1	1.1	1.1	1.1	1.1
White Alone, not Hispanic or Latino	27.2	26.6	27.0	27.1	26.9	78.3	77.9	77.5	76.9	76.4

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table S0102.

Table 8 reveals two other noticeable differences between older adults in Hawaii and the rest of the nation. While 4 out of 10 older adults lived alone nationally, 3 out of 10

did so in Hawaii. It also shows that the percentage of older adults who spoke English less than "very well" was twice that of the nation, approximately 18% compared to approximately 9 percent nationally.

Table 8. Social Demographic Characteristics of Person 60 Years and Older in the United States and Hawaii for the Years 2011 – 2015. (In Percent)

SOCIAL DEMOGRAPHIC CHARACTERISTICS	HAWAII					UNITED STATES				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Householder living alone	30.4	31.0	31.9	31.8	31.7	40.2	40.1	40.0	40.0	39.9
Responsible for grandchildren	2.3	2.1	1.9	2.4	1.6	1.5	1.6	1.6	1.6	1.5
Civilian veteran	19.3	20.2	18.8	17.3	17.9	21.1	20.3	18.4	17.5	16.6
With a disability	28.0	29.3	29.5	30.4	28.3	31.6	31.2	31.8	31.5	31.0
Speak English less than "very well"	17.9	18.2	18.3	17.5	18.5	8.4	8.5	8.5	8.7	8.9
Live below 100% of the poverty level	8.6	7.7	7.6	9.0	8.3	9.5	9.8	9.9	9.9	9.5

Source: U.S. Census Bureau, 2011 to 2015 American Community Survey, Table S0102.

Thus, although Hawaii, with its larger older adult population, would appear to be a state likely to be hardest hit by the challenges associated with the aging of the baby boomers, having a relatively healthier older adult population may, to some extent, obviate Hawaii from some of these challenges. If true, then improving the general health of the Hawaii's older adults may help to delay and reduce the demand for health and home care services.

C. Hawaii's Title III Programs Serve At-Risk Older Adults

Between 2011-2015, the AAAs served an average total of 53,976 clients. The "total" is a duplicate count of every contact made with an older individual, such as phone calls and contacts made at health fairs, as well as service delivery to registered participants. The average number of unduplicated participants for Title III Cluster 1 and 2 services was 7,926.[3] The 7,926 registered clients is slightly less than a tenth of the average number of persons 60 years and older with one or more disabilities for the years 2011 to 2015 (87,859).[4] This coverage is slightly less than the 14% coverage

[3] Cluster 1 include personal care, homemaker, chore, home delivered meals, adult day care, and case management. To receive these servers, persons need have some difficulty caring for themselves. Cluster 2 services include congregate meals, nutrition counseling, and assisted transportation. Persons receiving congregate and home delivered meals services need to be nutritionally at risk.
[4] U.S. Census Bureau, American Community Survey 5-Year Estimate. Table S0102.

rate nationally.[5, 6]

Table 9 shows the utilization of some of the Title III services by registered participants. The table shows the most widely used Title III programs to be nutrition services. The average annual number of clients who participated in the congregate meal program was nearly 3 times larger than the most frequently used non-meal service, case management (3,528 versus 1,239 clients). The table also shows that, although the meal programs were the most widely used, many of the non-meal programs were as intensely used. For example, clients who used adult care services used on average 210 hours per year and those who used respite and personal care services used on average 79 and 67 hours, respectively, while those who received congregate and home delivered meals received 141 and 61 meals, respectively. Because the AAAs have had difficulty finding licensed dietitians, utilization, both in terms of participants and units, was lowest for nutrition counseling.

Hawaii's Title III programs are being successfully targeted to those at risk for nursing home care. Altshuler and Schimmel (2010) identified several high-risk predictors of nursing home placement. These included lower income, poorer health, older, and less family support.

Comparing the results in Table 8 and 10 to the State numbers reported in the earlier tables, Title III participants had more risk factors for nursing home placement than other older adults in the State. The proportion of persons with incomes below the poverty level was approximately 3 times higher among program participants than among persons 60 years and older in the State and a slightly higher percentage of program participants than older adults in the State lived alone (see Tables 8 and 10).

[5] The unduplicated count of registered clients for Title III Cluster 1 and 2 services for the nation was derived the Aging Integrated Database, State Profile tables. Because the database did not have the 2015 numbers the national average of registered clients was based on the numbers for 2011 thru 2014.
[6] The coverage rates are rough estimates. The question in the ACS asks about only 2 of the activities of daily living (ADLs) and a person needs to have only 1 limitation to be counted. In contrast, Cluster 1 services are targeted at those with 2 or more ADLs. On the other hand, the Title III participant count includes Cluster 2 services that do not screen for ADLs. However, to the extent that these problems apply to both Hawaii's and the national counts, the rankings is unlikely to be affected, i.e., Hawaii having a lower coverage rate.

Table 9. Average Utilization of Selected Title III Support Services, FFY 2012 to FFY 2016

SUPPORT SERVICES	AVERAGE		
	Participants Served (FFY 2012 to FFY 2016	Units of Service[a] (FFY 2012 to FFY 2016	Average Units Per Client
Adult Day Care	207	43,647	210 Hours
Case management	1,239	23,152	19 Hours
Chore	311	2,199	7 Hours
Homemaker	637	15,292	24 Hours
Personal Care	1,005	67,820	67 Hours
Home Delivered Meals	2,886	408,055[b]	141 Meals
Congregate Meals	3,528	215,105[b]	61 Meals
Assisted Transportation	120	3,840[c]	32 Trips
Transportation	NA	166,234[c]	NA
Nutrition Counseling	88	90[d]	1 Session
Respite	218	17,176	79 Hours

Source: Hawaii State Performance Reports for Title III Programs

[a] Units in hours except when otherwise noted.

[b] Units in meals

[c] Units in one-way trips

[d] Units in sessions

Table 10: Characteristics of Title III Participants, Federal Fiscal Years 2012 to 2016

CHARACTERISTICS	FEDERAL FISCAL YEAR				
	2012	2013	2014	2015	2016
Percent minority participants	70.5%	72.4%	72.9%	74.7%	74.9%
Percent rural participants	63.1%	63.7%	61.7%	61.4%	61.1%
Percent below poverty	24.2%	24.6%	26.2%	26.5%	24.3%
Percent living alone	36.4%	33.8%	35.1%	36.2%	35.7%
Percent of persons at high nutrition risk	32.6%	32.8%	34.3%	35.3%	38.3%
Number of Cluster 1 and 2 participants	8,162	8,239	7,509	7.176	7,555

Source: Hawaii State Performance Reports for Title III Services.

Table 11 reveals that approximately 85% of the program participants reported having at least one limitation in activities of daily living (ADL) and more than half having 3 or more ADLs.[7] This is significantly higher than the approximate 30% of older adults in the State who reported having a disability. (See Table 8.)

[7] ADLs are difficulties in performing basic self-care tasks, such as grooming, toileting, bathing, dressing, feeding, etc.

Table 11. Number of Activities of Daily Living Disabilities (ADLs) Reported by Cluster 1 Clients, Federal Fiscal Years 2012 to 2016

Number of ADLs	FEDERAL FISCAL YEAR				
	2012	2013	2014	2015	2016
0 ADL	14.6%	13.5%	15.6%	15.2%	14.1%
1 ADL	7.0%	7.2%	7.6%	8.6%	8.0%
2 ADL	22.4%	20.2%	20.0%	20.4%	15.6%
3 or more ADLs	53.2%	56.8%	53.8%	52.7%	58.7%
ADL missing	2.8%	2.1%	3.0%	3.0%	3.6%
Number of Cluster 1 Clients (All Ages)	4,845	4,713	4,215	4,207	4,600

Source: Hawaii State Performance Reports for Title III Services.

Finally, Table 12 shows about 4 out of 10 Title III participants in the most recent years were 85 years or older, a proportion that has been steadily, if only slightly, rising in the observed period. In contrast, only about 2 out 10 persons 60 years and older in Hawaii were 85 years or older. Multiplying the percentage of 85 and older participants to the total number of participants will show that the number of 85 and older participants has been fairly constant at about 3,000 over the past 5 years. Thus, the rising proportion of 85 and older participants resulted from having fewer younger Title III participants.

Table 12. Age Distribution of Participants Receiving Title III Cluster 1 and 2 Services, Federal Fiscal Years 2012 to 2016.

Age Group	FEDERAL FISCAL YEAR[1]				
	2012	2013	2014	2015	2016
60 to 74 years old	28.5%	28.9%	27.5%	26.9%	27.0%
75 to 84 years old	31.8%	31.2%	31.0%	31.1%	30.6%
85 years or older	37.9%	38.2%	40.0%	40.2%	40.4%
Missing	1.7%	1.7%	1.5%	1.7%	2.0%
Number	8,162	8,239	7,509	7,176	7,555

[1]Column percentages do not sum to 100.0%.
Source: Hawaii State Performance Reports for Title III Services.

Utilization of Title III services is a picture of how the AAAs have procured for the selected services and may not be a complete measure of the needs in the community. However, as we move towards a holistic person-centered approach through a comprehensive intake and assessment process by the ADRC, these statistics and the needs of older adult in Hawaii will be reflected in the utilization of services.

III. EOA's STRATEGIES TO ACHIEVE GOALS AND POTENTIAL BARRIERS

All goals, objectives, and strategies outlined in this extension 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. This 2017 - 2019 Hawaii State Plan on Aging keeps the goals and strategies of the current 2015 - 2017 Plan but extends the completion dates all the objectives that needs additional time to be met.

EOA will continue to pursue a three-pronged strategy over the next 2 years to address the identified issues. Goal 1 will continue to seek to improve the wellness and health maintenance practices of older adults. Goals 2, 3, and 4 will seek to improve persons with disabilities and persons 60 years and older access to the LTSS services they need to remain in the community and under Goal 5, we will seek to ensure the security and safety of older adults.

Due to shortages in staffing and funding constraints some of the objectives in the current 2015 - 2017 Hawaii State Plan on Aging are currently being worked on but may not be completely accomplished by September 30, 2017. After a comprehensive review of the status of the objectives in the current Plan on Aging, EOA determined which objectives needed completion dates to be extended. This 2017 - 2019 Hawaii State Plan identifies and extends the completion dates for objectives that EOA needed additional time to complete. The Objectives that are <u>UNDERLINED</u> under the "Goals, Strategies, and Objectives" Section below have been assigned a new completion date.

A. Goals, Strategies, and Objectives

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

Staying physically active and exercising can prevent diseases and disabilities (NIH Senior Health, 2015). It may also reduce health care costs. A 2015 CDC study estimated that inadequate levels of physical activity accounted for 11.1% of the total health expenditure. Studies have also found that social activity helps to reduce or delay the onset of cognitive and physical limitations (Alden, 2011; James et al., 2011).

Strategy 1-1: Utilize Title IIID funds for to expand the existing wellness and health maintenance evidence-based interventions.

Objective 1-1:1 By September 30, 2017, provide Stanford's Chronic Disease Self-Management Education (CDSME) to 400 additional older individuals and persons with disabilities.

Objective 1-1:2 By September 30, 2019, recruit and train forty (40) additional CDSME Master Trainers and Lay Leaders.

Objective 1-1:3 By September 30, 2017, add two new EnhanceFitness sites on Kauai and Maui.

Strategy 1-2: Continue to provide ongoing support to the Healthy Aging Partnership for Medicare reimbursement for Stanford's Diabetes Self-Management Program.

Objective 1-2:1 By September 30, 2018, assist one AAA to attain accreditation.

Objective 1-2:2 By September 30, 2018, ensure that the accredited AAA has been recognized and is eligible to receive Medicare reimbursement

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.

Objective 1-3:1 By September 30, 2018, determine the feasibility for providing nutrition counseling remotely.

Objective 1-3:2 If feasible, by September 30, 2019, implement a pilot program to have nutrition counseling provided remotely.

Objective 1-3:3 By September 30, 2019, work with the AAAs to develop a plan to implement new service models for providing for congregate and/or home delivered meals.

Strategy 1-4: Encourage more older adults to serve as volunteers in the OAA grant programs.

Objective 1-4:1 By September 30, 2019, develop procedures to formalize the exchange of "best practices", expertise, and experiences on older adult volunteer recruitment between the Long-Term Care Ombudsman Program (LTCOP), Senior Medicare Patrol (SMP), and Hawaii SHIP programs.

Goal 2: Forging partnerships and alliances that will give impetus to meeting Hawaii's greatest challenges of the aging population.

EOA will take advantage of the expertise and resources of other organizations serving older adults by working together to coordinate services and improve service efficiency and quality. These partnerships and alliances will create better coordination and target services, thereby using our limited resources more efficiently.

In planning and forging partnerships, we will coordinate among agencies that advocate for persons with disabilities and those who advocate for older adults to address the ongoing needs of both populations and all payers while taking into consideration the commonalities and the differences of each population.

EOA will work with the new partner organizations to develop and implement the No Wrong Door vision in Hawaii. The vision of a No Wrong Door approach is to develop the current ADRCs into a fully coordinated, integrated and person-centered system of LTSS for all individuals of all ages, all disabilities, and all payers.

EOA will also seek to have the AAA and their provider staff become better able to serve two populations that face special challenges—persons with Alzheimer's and other related dementia and persons of Hawaiian ancestry. The rise in the number of older adults will be accompanied by a rise in the number of persons with dementia. Tilly and her colleagues (2014) found that 15% of older adults living in the community with at least one limitation in daily activity has dementia. The Alzheimer's Association reported that in 2011, nearly 90% of persons 60 years and older in Hawaii who reported having memory problems had not consulted a medical doctor, the highest percentage of the 22 states administering the BRFSS cognitive impairment module. Finally, focusing on Native Hawaiians is important since they have had more health and socio-economic risk factors than any other ethnic group in Hawaii.

Strategy 2-1: *Have individuals in need of 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.*

Objective 2-1:1 By September 30, 2019, have Memorandums of Agreements (MOAs) with the following entities, Department of Human Services- MedQuest Division, Department of Health's Developmental Disabilities Division and Behavioral Health, Office of Veterans Services, Vocational Rehabilitation, and the AAAs.

Objective 2-1:2 By September 30, 2019, improve coordination with the MOA entities by implementing cross training of the Doors.

Objective 2-1:3 By September 2019, have mechanisms in place to share data across the MOA entities.

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.

Objective 2-2:1 By April 1, 2016, develop a MOA with the Alzheimer's Association for the provision of dementia-capable training for AAA staff, their providers, and participants.

Objective 2-2:2 By September 30, 2019, have 90% of AAA and service provider staff competent in working with persons with Alzheimer's and related dementias.

Objective 2-2:3 By September 30, 2019, in partnership with the Alzheimer's Association and the AAAs, develop a plan to educate AAA participants on brain health and risk factors for dementia.

Strategy 2-3: Improve access to culturally sensitive services for older adults of Hawaiian ancestry.

Objective 2-3:1 By September 30, 2018, renew the MOA with the State's OAA provider to indigenous people (Title VI), Alu Like, Inc. that incorporates the referral processes between Alu Like and the ADRC operational model.

Objective 2-3:2 By September 30, 2017, an additional 10% of older adults of Hawaiian ancestry shall have received information and assistance and options counseling from the ADRCs statewide.

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.

EOA will have a state-wide fully functioning ADRC (See Appendix G). In the next two years, EOA will concentrate on completing the components of the ADRC 5-Year Plan. A component of the ADRC will be a participant-directed service option for qualify participants. In addition, EOA will strengthen the linkages between the ADRC and other programs that serve older adults and persons with disabilities. EOA will also seek to make the ADRC more accessible to persons of limited English proficiency (LEP) who make up 18% of the 60 and older population and to the visual and hearing impaired.

Strategy 3-1: Review the ADRC 5-Year Plan for components that need to be met and incorporated into the No Wrong Door implementation plan.

Objective 3-1:1 By December 31, 2015 develop a revised implementation plan to incorporate the components of the 5-Year Plan that have yet to be addressed.

Objective 3-1:2 By December 31, 2015, integrate the No Wrong Door implementation plan into the development of the ADRC.

Strategy 3-2: Strengthen the linkage between the ADRC and the OAA grant programs.

Objective 3-2:1 By September 30, 2019, train SMP and Hawaii SHIP staff on the use of the client referral system in the State consolidated database.

Objective 3-2:2 By September 30, 2019, implement the client referral system in the consolidated database between the ADRC and the SMP and Hawaii SHIP programs.

Strategy 3-3: Monitor the performance of participant-directed coaches, assessors, and the fiscal management service.

Objective 3-3:1 By September 30, 2018, identify performance indicators that will be used to monitor quality of services provided by the coaches, assessors, and the fiscal management services.

Objective 3-3:2 By September 30, 2017, the State consolidated database will be able to provide provider-specific and aggregate quality assurance reports regarding participant-directed services.

Strategy 3-4: Implement EOA's Language Access Plan which is currently being reviewed by the State Attorney General (See Appendix E).

Objective 3-4:1 By June 30, 2016, EOA will have assessed the language access needs of its current and potential customers.

Objective 3-4:2 By February 28, 2017, EOA will have developed written policies and procedures that ensure that LEP individuals have meaningful access to agency programs and activities.

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.

Older adults and persons with disabilities prefer to receive care in the comfort of their homes rather than institutional care. To make this possible, it is important that they have access to high-quality LTSS, such adult day care, assisted transportation, attendant care, case management, chore, home-delivered meals, homemaker, transportation, and

personal care. It is also important to extend this support to their caregivers, most of whom have assumed their responsibilities with little or no training.

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.

Objective 4-1:1 By December 31, 2015, have a resource listing of service providers for persons with disabilities that is also accessible to persons with disabilities.

Objective 4-1:2 By September 30, 2016, perform a review of AAAs procedures for keeping service provider resource listing current.

Objective 4-1:3 By September 30, 2019 coordinate with the AAAs to develop procedures to address the implementation of Cost Share as outlined in the OAA, Section 315(a).

Strategy 4-2: Coordinate with Medicaid for older adults who may benefit from access to needed LTSS through Medicaid.

Objective 4-2:1 By September 30, 2019, coordinate with Medicaid to draw down Medicaid Administrative federal financial participation funds.

Goal 5: Optimizing the health, safety, and independence of Hawaii's older adults.

As in-home support services become more accessible, it is likely that older adults will choose to live in their homes or in the care of their families or other less formal settings. However, such arrangements may make identifying cases of abuse, neglect, and exploitation more difficult. This goal seeks to increase the likelihood that, no matter where older adults in Hawaii choose to live, be it in their homes or in more formal care settings, their health and security will not be in jeopardy.

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.

Objective 5-1:1 By September 30, 2019, LTCOP will update a memorandum of agreement or understanding with EOA and the Department of Health to be consistent with policies and procedures with Hawaii Revised Statutes 359, Sections 21-25 and the Older Americans Act, as amended, which reflect recent recommendations made by the Administration on Aging/Administration of

Community Living, the National Association for State Ombudsman Programs, and the National Association of State United for Aging and Disabilities.

Objective 5-1:2 By September 30, 2019, LTCOP will reconvene the partnerships with EOA, the AAAs, APS, legal assistance programs, e.g., University of Hawaii Elder Law Program, the Police Department, the Attorney General's Office, the Legislature, Department of Commerce and Consumer Affairs, financial institutions, CMS, Health Care Association of Hawaii, and other provider organizations, health care professionals and their respective associations, the media, and other essential community stakeholders to be part of a multi-disciplinary state-wide coalition that will meet quarterly to focus on elder abuse, neglect, and exploitation.

Strategy 5-2: LTCOP will put into place measures that will allow it to expeditiously respond to reports of suspected mistreatments of older adults.

Objective 5-2:1 By December 31, 2015 LTCOP will be able to respond to all complaints related to long term care facilities within 72 hours.

Objective 5-2:2 By September 30, 2019, LTCOP will have posters up in all nursing homes, assisted living facilities, adult residential care homes, expanded adults residential care homes, community care foster family homes, and the ADRCs with information on how to contact LTCOP if a resident feels his/her rights have been violated.

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 particular attention to the hard-to-reach populations.

Objective 5-3:1 By September 30, 2016, SMP will have partnered with the State Library for the Blind and Physically Handicapped to transcribe key resources into Braille and create audiotapes.

Objective 5-3:2 By September 30, 2019, SMP will develop 10 education kits that will include PowerPoints or talking-point cheat sheets, fact sheets, skits, and interactive activities.

Objective 5-3:3 By September 30, 2017 SMP will have partnered with The National Resource Center on Lesbian, Gay, Bisexual, and Transgender Aging (LGBT); the State of Hawaii Civil Rights Commission; and other LGBT advocates to plan and implement outreach to LGBT older adults and cultural competency training for SMP staff and volunteers.

Objective 5-3:4 By September 30, 2017, SMP will work with the Office of Language Access (OLA) and the Disability and Communication Access Board to develop a language access plan that identified the limited English proficient population and persons with disabilities that it will target and the vital documents to be translated or incorporated in a video format.

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, Area Agencies on Aging, Hawaii SHIP, and the State LTCOP.

Objective 5-4:1 By September 30, 2016 SMP will have evaluated the composition of the SMP Hawaii Advisory Council and decided whether to invite new and former representatives from the Office of Inspector General/U.S. Department of Health and Human Services, Federal Bureau of Investigation, the Honolulu Police Department, the State HIPAA Office, AARP and other entities that would support SMP's efforts to carry out its mission.

Objective 5-4:2 By September 30, 2017 SMP will have collaborated with partners and stakeholders to plan a statewide campaign aimed at educating seniors, their families, and caregivers to recognize health-care related scams and avoid falling victim to fraud.

B. Potential Barriers to the Proposed Strategies

There are several potential barriers that may make it difficult for the timely accomplishment of some of these goals.

Lack of Funding: Goal 1 (wellness and health maintenance activities) and Goal 3 (fully functioning ADRC) will need additional funding to implement successfully. In the case of the wellness and health maintenance activities, we will continue to look for grants and contributions. For both initiatives, we will also seek the support of the Hawaii State Legislature.

Breakdown in Communication: Goal 2 involves developing partnerships and alliances with entities EOA has not worked with before. As with any relationship, but more so when it involves new partners, there is the possibility of miscommunication or misunderstandings. To reduce the likelihood that this will happen, it will be very important for all parties in the partnership to understand what each party's roles and responsibilities will be.

Compliance with State and Federal Requirements: Organizations have their own compliance requirements that may or, more likely, may not align with other partner organizations. This may make it difficult for some organizations to link to the ADRC. To preserve the partnerships, it is important that the parties are sensitive to these restrictions and look for other ways to smooth referrals and share information between organizations.

IV. OUTCOMES AND PERFORMANCE MEASURES RELATED TO THE GOALS

The anticipated outcomes as of September 30, 2019, as it relates to our goals and objectives are:

- 75% (300 of 400) older adults who participated in evidenced based wellness and health maintenance interventions will be faithful to training regimen 3 months after completing the program.
- 95% (12 of 13 partner organizations) will report satisfaction in working with EOA to address the LTSS needs of older adults and find an added benefit to the collaboration for the implementation of the integrated NWD network that streamlines access to LTSS.
- 100% (4 ADRC sites) will demonstrate competence in working with older adults with dementia and their families and in connecting them to LTSS.
- 90% (7,303 of 8,115) adults and persons with disabilities requesting LTSS service will have received the services requested.
- 90% (9 out of 10) the elderly justice objectives will have been met by September 30, 2017.

V. 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 quarterly to ensure that services are being delivered in a timely fashion to those at high risk of potential institutionalization.

- EOA will perform annual monitoring of a defined program area to ensure that the program is being implemented as stated in the service standards.

Continuous Improvement: Once all the AAAs are a fully functioning ADRC and the EOA has the consolidated database, the State and the AAAs will develop quality and performance measures from elements in the database and report programs will be written to enable both the State and the AAAs to produce performance reports. 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 problem areas:

- Identify the problem and vet the problem with our service providers who are the AAAs.
- Review the problem and the federal and State statutory rules that may have been violated. Provide necessary technical assistance.
- Complete a thorough review and provide finding and recommendations.
- Require the AAAs to submit a corrective action plan.
- Monitor the corrective action plan (CAP) to ensure that it has been implemented.
- Verify the CAP against the data.
- If resolved, submit a close out report to the AAAs.