LIFEPATH AREA PLAN ON AGING 2018-2021

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Planning and Service Area

LifePath primarily serves 30 towns including the 26 towns of Franklin County and the towns of Athol, Royalston, Phillipston and Petersham in Worcester County. Certain programs are also available in Hampshire, Hampden, and Berkshire counties.
Executive Summary

Mission and goals
LifePath’s mission to help elders live independently echoes the mission of its state parent, Executive Office of Elder Affairs, and federal parent, Administration for Community Living. EOEA’s mission includes “promoting independence, empowerment, and well-being of older adults,” while ACL adds helping elders “live where they choose.” This Area Plan outlines the steps to achieve our vision for elder aging supports in Franklin County and the North Quabbin.

LifePath’s work
With a staff of over 125 and volunteers of over 250 (71% of whom are elders), LifePath provides **over 40 programs and services** to serve this mission, including Meals on Wheels, Healthy Aging, SHINE Counseling, Protective Services, State Home Care Services, Personal Care Attendant Services and Family Care Services, among many others. We collaborate with other local and regional agencies to meet the needs of local elders and people with disabilities. See Attachment A: Brochure for a complete program listing.

Focus Areas
The coordinates focus areas for the entire country, and has identified specific areas that State and Local plans must include. LifePath, through the needs assessment conducted prior to this report, identified local focus areas that match the nationwide requirement with attention paid in specific areas.
### Administration for Community Living/Executive Office of Elder Affairs focus areas

<table>
<thead>
<tr>
<th>Older Americans Act core program</th>
<th>LifePath focus areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACL discretionary grants</td>
<td>Managing chronic disease, behavioral health issues, and dementia, including interfacing with health care partners for better coordination of clinical and home and community care and new business opportunities</td>
</tr>
<tr>
<td>Participant-directed/Person-centered planning</td>
<td>Promoting independence through person-centered planning</td>
</tr>
<tr>
<td>Elder justice</td>
<td>Protective services, coordination of legal services, and outreach</td>
</tr>
</tbody>
</table>

### Target Populations

While LifePath’s doors are open to anyone needing information or supports on aging, the Older Americans Act, the law that creates the Area Agency on Aging designation and provides funding for services and supports, identifies these priority populations:

1. Living alone (isolated) elders
2. Low income elders
3. Minority elder populations
4. Native American populations (where germane)
5. Rural elder populations (where germane)
6. Socially isolated populations (including limited English proficient elders)
Additional considerations
LifePath will also include the following in its planned efforts over the next four years:

1. Support aging in communities;
2. Prepare for evolving demographic trends;
3. Empower healthy aging;
4. Prevent injury, violence and exploitation;
5. Strengthen a “no wrong door” approach; and
## CONTEXT

### Needs Assessment Approach

LifePath undertook a needs assessment in the fall of 2016, seeking to understand the needs of elders and what had changed from previous assessments.

### Focus Groups

<table>
<thead>
<tr>
<th>Activity</th>
<th>Location</th>
<th>Target Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Focus group</td>
<td>Greenfield</td>
<td>LGBT elders</td>
</tr>
<tr>
<td>2. Focus group</td>
<td>Turners Falls</td>
<td>Rural, caregiver, low income</td>
</tr>
<tr>
<td>3. Focus group</td>
<td>Shelburne Falls</td>
<td>Rural, caregiver, low income</td>
</tr>
<tr>
<td>4. Focus group</td>
<td>Orange</td>
<td>Rural, caregiver, low income</td>
</tr>
<tr>
<td>5. Focus group</td>
<td>Athol</td>
<td>Rural, low income</td>
</tr>
<tr>
<td>6. Focus group</td>
<td>Greenfield, Elm Terrace Housing Site</td>
<td>Low income</td>
</tr>
<tr>
<td>7. Focus group</td>
<td>Greenfield</td>
<td>Elders</td>
</tr>
<tr>
<td>8. Focus group</td>
<td>Gill-Montague</td>
<td>Elders</td>
</tr>
<tr>
<td>9. Interviews</td>
<td>Phone</td>
<td>Minorities/consumers with language barriers</td>
</tr>
<tr>
<td>10. Interviews</td>
<td>Phone</td>
<td>Pantries, community meals and food bank</td>
</tr>
<tr>
<td>11. Listening session</td>
<td>Turners Falls</td>
<td>COA Chairpersons</td>
</tr>
</tbody>
</table>
12. **Stakeholder group** Turners Falls CAB
13. **Stakeholder group** Turners Falls Board
14. **Stakeholder group** Turners Falls Line Staff
15. **Stakeholder group** Turners Falls Program Directors
16. **Survey** Online & paper Elders & caregivers

The focus groups, interviews, and surveys were designed to reach a wide variety of people in the community and to cover a wide variety of topics; the focus groups were generally well-attended and the survey received 171 responses. With the exception of the phone interviews with recent immigrants and people for whom English is a learning language, participants self-selected, which could have skewed the results. The focus groups’ input varied widely depending on the location as needs and available services form senior centers vary by location. Seniors and staff enjoyed these conversations; their comments illuminated the elder situation, which this report attempts to convey. Focus group full reports are provided in Attachment L.

**Population-level data**
Research reports and census data were also reviewed for this report. Several newer online tools, such as Community Commons, were helpful in distilling data to the correct regional location and identifying differences in our area versus other parts of Massachusetts and the United States.

**Top Needs Identified via Needs Assessment**

<table>
<thead>
<tr>
<th>2014-2017</th>
<th>2018-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Transportation</td>
</tr>
<tr>
<td>Housing</td>
<td>Economic security</td>
</tr>
<tr>
<td>Social needs</td>
<td>Housing, especially upkeep</td>
</tr>
<tr>
<td>Benefits counseling/help with money</td>
<td>Accessing health care</td>
</tr>
</tbody>
</table>

Page 8
We are currently working on all of these priority areas and will continue to advance our capacity in emerging areas.

**Results**

**Demographics**

*RURALITY*
LifePath serves a population that is the most rural in Massachusetts, one of the most notable contrasts to other service areas.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Total Population</th>
<th>Total Land Area (Square Miles)</th>
<th>Population Density (Per Square Mile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>86,283</td>
<td>734</td>
<td>118</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>6,705,586</td>
<td>7,801</td>
<td>860</td>
</tr>
</tbody>
</table>

Focus group participants in the western part of F are frustrated that several local medical practices have closed. “[Now] you have to travel from Heath over 20 miles,” said one person.
People aged 65 and over make up 17% of the population here versus 15% in Massachusetts. This group will grow faster than in the state as a whole, since the group aged 55-64 is also 17% versus 13% in the state as a whole. Nationally, over the past 10 years, the population 65 and over increased by 30% and is projected to more than double by 2060.\(^1\)

In some towns, especially in the western part of the area, the population age 65 and up makes up more than 20% of the population, growing quickly, with those towns expected to double their elder populations in the next 8 years.

<table>
<thead>
<tr>
<th>Portion of population that will be aged 65 and up</th>
<th>2015 by 2025</th>
<th>2025 by 2030</th>
<th>2030 by 2035</th>
</tr>
</thead>
<tbody>
<tr>
<td>West County Towns</td>
<td>37%</td>
<td>52%</td>
<td>66%</td>
</tr>
<tr>
<td>Massachusetts(^2)</td>
<td>19%</td>
<td>34%</td>
<td>49%</td>
</tr>
</tbody>
</table>

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\(^2\) American Community Survey (September 19, 2017) [https://www.census.gov/programs-surveys/acs/](https://www.census.gov/programs-surveys/acs/)
**RACE & ETHNICITY**

This area of Massachusetts has less racial and ethnic diversity than other areas. However, the population is becoming more diverse.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Some Other Race</th>
<th>Multiple Races</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>94.2%</td>
<td>1.2%</td>
<td>1.5%</td>
<td>1.3%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>79.6%</td>
<td>7.1%</td>
<td>6.0%</td>
<td>4.4%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent Population Hispanic or Latino</th>
<th>Percent Population Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>3.9%</td>
<td>96.1%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>10.6%</td>
<td>89.4%</td>
</tr>
</tbody>
</table>

Advisory Board members, staff, and focus group participants alike worry that people with language barriers will be left behind.
**DISABILITY**
This area has a larger portion of the population with a disability than the state average.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent with a Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>14.9%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>11.5%</td>
</tr>
</tbody>
</table>

**VETERANS**
Veterans make up a greater share of the population here than in the state.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Veterans, % of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>9.8%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

**Social & Economic Factors**
We now have a much better understanding of the social determinants of health: people recognize that the doctor is just one player in a complex set of factors contributing to health outcomes.

**POVERTY**
In Massachusetts, six out of ten older adults living alone, and three out of ten living in two-person households, cannot afford the basic necessities of life such as food, housing in a safe community, and health care. In Massachusetts, 19.3% of elders live in poverty; 41.8% live “in the gap” between poverty and financial security, and 61.1% live below the Elder Poverty Index, ranking Massachusetts #2 of all states in elder economic insecurity (second to

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3 Jan Mutchler, Yang Li, and Ping Xu, “Living Below the Line: Economic Insecurity and Older Americans Insecurity in Massachusetts 2016” (September 2016). http://scholarworks.umb.edu/cgi/viewcontent.cgi?article=1013&context=demographyofaging
Mississippi). Decreases in fuel assistance and uncertainty of the continuation of safety-net programs have increased anxiety around financial security.

LifePath serves one of the poorest areas of Massachusetts, with Franklin County having consistently had the lowest average wages of all fourteen counties in MA since 2000. The poverty rate for elders in Franklin County is 5.8%.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent Population with Income at or Below 200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>29.9%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>24.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent Households Receiving SNAP Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>14.6%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>12.5%</td>
</tr>
</tbody>
</table>

Despite the improvement in the overall economy, elders are more concerned than ever about economic security as they age. Social Security constituted 90% or more of the income received by 33% of beneficiaries in 2014 nationwide. 

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4 Jan Mutchler, Yang Li, and Ping Xu, “Living Below the Line: Economic Insecurity and Older Americans Insecurity in Massachusetts 2016” (September 2017). http://scholarworks.umb.edu/cgi/viewcontent.cgi?article=1013&context=demographyofaging


Social Security cost of living increase was very low this year,” said one member of the Citizens Advisory Board.

**NUTRITION**

This region has a greater than average instance of low-income people having low food access. Some areas are designated “food deserts,” making it hard for elders to find healthy food.⁸

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent Low Income Pop. with Low Food Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>31.1%</td>
</tr>
<tr>
<td>Massachusetts⁹</td>
<td>17.1%</td>
</tr>
</tbody>
</table>

Food insecurity is on the rise across the state, with a 71% increase between 2003 and 2013.¹⁰ Over 2/3 of Franklin County residents eat less than the recommended amount of veggies; poor diet can lead to preventable chronic disease.¹¹

**SOCIAL ISOLATION**

“The loneliness is almost overwhelming,” said one survey respondent.

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We know that loneliness, a feeling that results when one’s social connections aren’t what they wish them to be, is associated with declining function and mortality.\textsuperscript{12} \textsuperscript{13} We know more about LGBT elders and how they tend to be more socially isolated and more vulnerable to health problems, and less likely to have children to care for them as they age. More research has been done into the value of home delivered meals to help people stay well and socially connected. \textsuperscript{14}

**FAMILY SUPPORTS**
According to LifePath staff, the “old Yankee stock” is diminishing in numbers, leaving a younger generation of elders, some of whom lack the informal supports their elders had. We understand the tremendous value of unpaid caregiving, and thus the need to support caregivers.

**Physical environment**

**INTERNET ACCESS**
Many areas in our service area are not served by broadband internet access, which is becoming more of a problem for seniors. More seniors want to know how to use technology to access information and to stay connected, and they say it’s important for their health, too: “I had major heart surgery; and due to some problems, had a thing implanted. There’s no cell phone or broadband; my wife had to drive me to Shelburne [daily] to transmit information. It was insane!”

**OPPORTUNITIES FOR PHYSICAL ACTIVITY**
Elders have fewer opportunities for physical activity here than elsewhere in Massachusetts.

\textsuperscript{13} Caitlin E. Coyle, PhD, “Social Isolation in Later Life: What is the problem and what can we do about it?” Center for Social and Demographic Research on Aging Gerontology Institute (June 9, 2017)
\textsuperscript{14} Kali Thomas and David Dosa, “Results from a Pilot Randomized Control Trial of Home-Delivered Meal Programs,” Center for Gerontology and Healthcare Research School of Public Health Brown University (March 2, 2015).
<table>
<thead>
<tr>
<th>Report Area</th>
<th>Establishments, Rate per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>12.7</td>
</tr>
<tr>
<td>Massachusetts(^{15})</td>
<td>17.4</td>
</tr>
</tbody>
</table>

Just over 22% of Franklin County residents are physically inactive (no leisure-time physical activity such as running, calisthenics, golf, gardening, or walking for exercise)\(^{16}\).

**TRANSPORTATION**

Public transportation is extremely limited in Franklin county and the North Quabbin. For many, there is still no good way to get around after they give up driving.

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Percent Population Using Public Transit for Commute to Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin*</td>
<td>1.4%</td>
</tr>
<tr>
<td>Massachusetts(^{17})</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

In any given year, 3.6 million Americans miss at a minimum one medical appointment due to a lack of transportation; missed appointments are associated with poorer health outcomes.\(^{18}\) Medical appointment attendance may depend on a friendly neighbor’s availability or public transportation that is inconvenient and that seniors often don’t feel secure using.

\(^{15}\) US Census Bureau, *County Business Patterns*. Additional data analysis by CARES. 2015. Source geography: County via Community Commons.


HOUSING
Massachusetts has a shortage of affordable housing units for low-income people. Here, 38 units exist for every 100 households who need affordable housing, creating severe housing cost burden on many people and rendering them unable to pay for other basic needs.19

“What is called ‘affordable housing’ often is not really affordable for elders,” said one elder. “Assisted Living is not an option for the average person.”

Health & Chronic Disease
Staff report that the elders they work with have increasingly complex health problems. “I don’t remember working with clients who had pic lines and feeding tubes in earlier years,” said one staffer at a focus group. A key concern is lack of services to meet behavioral health and substance abuse issues. The consequences of untreated conditions in this arena can be more severe for seniors than for younger people. The medical complexity of some consumers increased workloads without correlating increases in staff time.

For people aged 65 and up, the number with one or more chronic diseases is 90.7% and with two or more to 73.1%. 20 This area has bigger problems with asthma, smoking, and diabetes than in other areas of Massachusetts. Ten towns in the service area have among the highest rates of obesity for adults, with clear disparities in obesity by race and ethnicity.21

Yet, some people are living longer and better, too. Many seniors have committed to healthy lifestyles: Tai Chi, walking groups, and other wellness programs are

packed at senior centers and town halls around the service area, as well as Healthy Eating programs offered by LifePath’s Healthy Living program.

Clinical Care & Coordination

There are fewer dentists and primary care doctors per capita here than elsewhere in Massachusetts. 22

<table>
<thead>
<tr>
<th>Report Area</th>
<th>Dentists, Rate per 100,000 Pop.</th>
<th>Primary Care Physicians, Rate per 100,000 Pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Franklin County and North Quabbin</td>
<td>63.5</td>
<td>88.7</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>95.6</td>
<td>124.1</td>
</tr>
<tr>
<td>United States</td>
<td>65.6</td>
<td>87.8</td>
</tr>
</tbody>
</table>

Many local doctors have retired in recent years with new doctors not necessarily staying permanently. “Seniors like to have a relationship with doctors, you just get established then in two years, and they are gone. People feel the lack of relationships,” said a focus group participant.

As more elders have more illnesses, access to primary care, specialists, and especially care coordination among these players is needed more than ever before. “As an elder, I don't see the hospital being integrated with the local providers. I go to my endocrinologist who has her own separate account for me with my patient electronic medical record. Why don't I have one in the hospital that covers the doctors in the area?” asked one interviewee.

22 US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File. 2015. Source geography: County via Community Commons.
Conclusion

In order to serve our diverse community effectively, we must support those with limited income, resources, and supports while remaining relevant to elders who have more resources. Armed with new knowledge, we set a course for our work for the next four years. 23

GOALS, OBJECTIVES, & STRATEGIES

Older Americans Act Core Programs

**Goal 1:** LifePath will ensure as many older persons and adults with disabilities as possible have the supports necessary to maintain their well-being and dignity.

**Objective 1.1:** Attend to concerns of isolation, malnutrition, and hunger among as many seniors as possible.

**Strategies:**

**Meals on Wheels** are provided short-term or long-term to homebound elders age 60 and older who are unable to prepare a nutritionally balanced noon meal for themselves and are unable to attend congregate hot lunches. Therapeutic meals are available for certain medical conditions and may be ordered by an elder’s health care provider. Frozen meals for weekend use are available.

The 55 volunteers who deliver Meals on Wheels ensure daily contact and a “wellness check” for elders who are alone during the day. We served 1,290 consumers last year and expect this number to continue to increase, if funding allows. LifePath for 25 years has held an annual event called the Walkathon to financially support Meals on Wheels. 42 people volunteered for the Walkathon last year and the event raised over $101,000.

**Senior Dining Centers and Luncheon Clubs** provide hot, noon meals for people age 60 and older. Elders can be joined for lunch by their spouse of any age or an individual with a disability who lives in the same household as the elder. The meals offered are at eight area Senior Centers and eight Luncheon Clubs. Dining Centers offer the opportunity to have a well-balanced meal (600-800 calories), no salt added. Non-sugar desserts are available. We served 499 consumers last year and expect that number to decrease as the demand shifts away from congregate meals and toward home-delivered. 45 people volunteer in this program.
Nutrition education sessions are offered twice annually by our in-house nutritionist at Dining Centers and Luncheon Clubs. Last year we did 34 education sessions and expect this number to stay about the same.

Nutrition consultations are available by phone or in person at home to consumers who receive in-home services from LifePath. Last year we served 21 people with nutrition consultations and expect this number to increase as we have made a concerted effort to generate referrals and have contracted with some health care providers to offer consults. The desired outcome of nutrition consultation is improved eating habits, which are shown to lead to positive weight changes and reduced malnutrition and the related health problems and premature death; we will begin measuring outcomes in the next year to evaluate program effectiveness.

Farmers’ Market Coupons valued at $25 are offered to qualifying seniors. They are distributed in the summer via local Brown Bag grocery supplementing programs. Last year we offered 525 coupon books, one per consumer, and expect this number to remain flat due to flat funding.

Meal preparation assistance may be available through Home Care service plans.

Rainbow Elders offers opportunities to lesbian, gay, bisexual, transgender, intersex, queer, questioning, and asexual elders plus their straight and younger allies to build connections and find resources. It organizes quarterly events for LGBTIQA older adults and allies. These events are free of charge, although donations are welcomed, and events are drug-, alcohol-, and fragrance- free. We currently have 370 subscribers to the mailing list and attracted 90 people to our largest event, though most events attract 20-40 people; we expect this number to grow.

Congregate Housing combines home care services and shared living space for elders or disabled adults. Security, companionship, support and home care services, help residents stay independent and active in the community. Congregate housing is a great option for people who don't want to live alone. Congregate housing: Winslow Wentworth - 18 units; Morgan Allen - 18 units.
**Supportive Housing** provides flexible supportive services to residents who reside in housing complexes for elders and persons with disabilities. LifePath works in collaboration with local housing authorities to assist and ensure residents can live safely and independently in their apartments. A full-time staff person is on site to work with residents. The goal of supportive housing is to allow those who already live in elder housing to stay there and get support when and how it is needed. Supportive Housing: Highland Village, Shelburne Falls - 46 units; Stoughton Place, Gill -14 units; Stratton Manor, Bernardston - 20 units; Squakheag Village, Northfield - 20 units; Elm Terrace Greenfield - 108 units.

**Benefits Counseling** helps homeowners and renters age 60 and older or persons with disabilities find resources to help them stay in their homes for as long as they choose. Benefits Counselors also help people apply for benefits that help them save money, like Fuel Assistance or SNAP. The program serves 250 consumers per year, and we expect this to remain flat unless funding increases. Over half of the calls last year needed nutrition assistance.

**Objective 1.2:** Address gaps in consumer services as identified by the needs assessment and federal and state priorities.

Strategies:

**Title III Subgrants:** LifePath, as the designated Area Agency on Aging for Franklin County and the North Quabbin, grants Title III monies to eligible Councils on Aging and other organizations for senior services through a biennial RFP process. In 2017, nine organizations received Title III subgrants totaling $44,403. We expect this number to decrease slightly due to decreased funding.

**Citizens Advisory Board** members advise our agency concerning Older Americans Act programs, community grantmaking and planning for elders, and nutrition services. Twelve people served on the Citizens’ Advisory Board last year, representing nine towns.
Outreach and collaboration with community partners such as COAs, VNAs, TRIAD, medical providers, assisted living, nursing facilities, and SCO and OneCare plans ensures we are connecting with a wide variety of constituents and leveraging the power of collaboration to meet mutual goals.

Outreach to those in the greatest social need is conducted (see Attachment B).

Outreach to Native American groups via tribal leadership of Pocumtuc, Nipmuc, and other local tribes as well as intertribal organizations.

The Good Life acts as the cornerstone of an awareness-building campaign that also includes social media and traditional media work. The Good Life reaches at least 23,000 people each week. We also offer an e-newsletter to over 1,500 subscribers and have a Facebook following of 830 people.

Continuous monitoring including outreach, satisfaction surveys, and quality assurance and improvement provides guidance for programmatic decisions and gaps in service.

Objective 1.3: Support unpaid caregivers

Strategies:

The Dementia Caregivers Support Groups (online and in-person) are for caregivers of people with memory disorders such as, but not limited to, Alzheimer's disease.

Options Counseling is a free service that provides information and support to consumers to assist them in decision making. Our professionally trained community options resource specialists work with consumers and families to address specific individual needs. Counseling, support groups, and caregiver training served 97 caregivers in 2016.

The Family Caregiver Program provides elder care advice in the caregiver’s home and information on programs and services at no charge.
**Respite Services** allow caregivers to take a much-needed break from their important work of caring. Many grants are available to fund ways for caregivers to "refresh and renew.” Respite served 3 caregivers in 2016.

**Information & Caregiver Resource Center (ICRC):** Our Resource Consultants are experts in available area programs and services that support elders and caregivers. They can help you determine what help an elder needs, how often it’s needed and how that help will be paid for. ICRC took 5,315 calls in 2016 and we expect this number to increase as the elder population increases.

**Caregiver Grants** offer caregivers and/or Grandparents Raising Grandchildren under the age of 18 an opportunity to refresh and renew away from their caregiving responsibilities. Grants can be used in many creative ways to meet the needs of caregivers and grandparents. They served 106 caregivers and reached an audience of 23,770 with information.

**Pay for Caregivers:** Caregivers can now get paid for providing care to a loved one (spouse excluded), friend or neighbor under the following LifePath programs: Home Care, Respite, Adult Family Care, Personal Care Attendant, and Caregiver Grants.

**Objective 1.4:** Provide in-home supports as needed (not OAA-funded)

Strategies:

LifePath offers many additional in-home supports, including but not limited to homemaking; personal care; grocery shopping; chores; personal emergency response systems; Adult Day programs; dementia coaching; Enhanced Community Options Program (ECOP); Community Choices; Elder Home Care and Community Based Waiver Program; Senior Care Options; PCA (which served 846 people last year); AFC (which served 146 people in 2016); Supportive Housing; Congregate Housing; Nursing; and medication monitoring, dispensing, oversight and administration. These supports are available through vendored services or consumer-directed options.
Promoting independence through person-centered planning

“At ACL, we believe that every person should be able to make choices and to control their own decisions, regardless of their age, disability, or illness.” - Edwin Walker, Deputy Assistant Secretary for Aging, and Bob Williams, Acting Commissioner, Administration on Disabilities Director, Independent Living Administration

Person-centered planning is the foundation of every conversation about every consumer, program, project, problem, or opportunity. The first question asked in any conversation is, “What are the consumer’s goals and wishes?” We seek to promote independence based on each individual’s vision of their path forward.

Goal 2: LifePath will work with elders and people with disabilities, their families and caregivers to identify options for independence that work for their unique situation; we will become more targeted in our interventions, tailoring them for both case management and service selection.

Objective 2.1: Reduce the negative impact of transportation barriers on health outcomes.

Strategies:

Rides for Health volunteer drivers make a difference to the individuals with whom they are matched by offering door-through-door assisted transportation for home care clients. In its second year of service, Rides for Health served 13 people with assisted transportation in 2016, and we aim to increase that by 50% next year. It currently has 4 volunteers and growing.
**Home Care** Consumers may be eligible for transportation (public, private, PT1) to be coordinated and paid for through their care plan. Case Managers often can facilitate ADA approval. Over 6,000 rides were provided in 2016.

**Objective 2.2:** Increase financial security for those at risk.

Strategies:

**The Money Management Program** assists elders and persons with disabilities who have difficulty writing checks or managing their basic living expenses for many reasons, including vision difficulties, memory difficulties, and physical disabilities. It also offers **Representative Payee** services to LifePath clients in certain cases. The Money Management program served 41 elders in 2016; we do not expect this to increase due to limited funding. 29 people serve as Bill Pay volunteers, 23 of whom are elders. In 2017, LifePath established outcomes for the money management program, and we will measure those outcomes in the next four years:

- Client has improved confidence in their ability to live at home, with sufficient funds for basic needs
- Client is protected from financial exploitation

**Emergency Needs Funding** can help prevent elders from suffering serious consequences, like the loss of a home, from a short-term financial strain.

**The SHINE Program** is a State Health Insurance Program that provides free, one-on-one health insurance information, counseling and assistance to Medicare beneficiaries of all ages. This can help seniors achieve financial savings by matching them with the insurance that most benefits them individually. SHINE served 3,231 people in 2016; we do not expect this number to increase, and in fact may dramatically decrease, as the FFY18 federal budget draft from the administration eliminates this program. 27 volunteers and 17 paid staff from other organizations serve as local SHINE counselors.
Benefits Counseling supports financial well-being by helping residents avail themselves of benefits through volunteer-based application and counseling assistance.

Objective 2.3: Connect elders to services appropriate for their unique situation.

Strategies:

Several programs exist specifically to make a “bridge” between elders and the services appropriate for them: Options Counseling, Benefits Counseling, Information & Caregiver Resource Center, and SHINE.

LifePath is a part of the Pioneer Valley Aging and Disability Resource Consortium (PVADRC), which creates a single, coordinated system of information and access for all persons seeking long-term services and supports, regardless of age, disability or income. Our agency participates in the No Wrong Door program, coordinating with other agencies to integrate access to services through a single, standardized entry process.

LifePath also assists other organizations, like Councils on Aging, to do this work, such as its work on age-friendly and aging in place programs in the West County health district, Village Neighbors (Shutesbury, Pelham, Leverett, Wendell, and New Salem) and Petersham Village.

LifePath employs Community Health Workers (CHWs) as part of a CHART 2 grant initiative funded through the Health Policy Commission. It helps connect people prone to emergency department or hospital use to community supports to help stabilize their situations and reduce re-admissions. CHWs use motivational interviewing and person-centered planning to assist with social determinants. CHWs work with each person flexibly. The aim is to reduce ED visits by 25% for persons who have had five revisits or more in 12 months or four inpatient readmissions in 12 months. LifePath and other partners involved in this project (with the hospital as the lead) are engaged in a project evaluation including a sustainability plan as the project is projected to end in spring. For the 227 individuals enrolled since the grant began, CHWs have helped reduce
readmissions and revisits through addressing housing, transportation, and behavioral health issues.

Clinical behavioral health and dementia support services through grants area available to support those with specific needs. Last year, the Dyer mental health grant program had an average of 18 people served per month, with 20 cases being completed throughout the year. Its desired outcome is to improve safety, physical and emotional well-being, and financial security of clients; we have begun measuring outcomes and will use the results to evaluate the program in the future.

Objective 2.4: Encourage and educate on good advance directive planning.

Strategies:

Health Care Proxies are the way a person’s wishes are honored even if they can’t communicate those wishes. LifePath has promoted health care proxies through working with the Honoring Choices model and made tools available to residents in our service area.

LifePath has a partnership with Hospice of Franklin County regarding advance directive planning.

Objective 2.5: Increasing civic and social engagement for better quality of life.

Strategies:

The Healthy Living program’s evidence-based workshops have been shown to increase social engagement for those who participate.

LifePath offers 12 standard volunteer positions, many of which are filled by elders who enjoy the social engagement and other benefits that volunteering offers. Over 250 people volunteer each year with LifePath. Volunteers can assist with Money Management, Benefits Counseling, Nutrition, Healthy living,
Rainbow Elders is focused on the needs of LGBTIQA elders. It offers opportunities and information to lesbian, gay, bisexual, transgender, intersex, queer, questioning, asexual, and aromantic elders, as well as their allies and the community at large. Rainbow Elders helps people build relationships, give and gain support, grow in knowledge and cultural competence, and advocate for human rights so that everyone can live and age with dignity. Living alone or requiring institutional care is more common among LGBTIQA elders. Dedicated services for this population are greatly needed. Rainbow Elders offers programming that allows individuals to meet other members of their community, tell life stories, and grow in their identity. Social events offered by the group include:

- **Breakfasts and Picnics**: Get acquainted, share experiences, and reflect upon LGBTIQA identities.

- **Annual Intergenerational Gathering co-presented by various LGBTIQA community groups**: Creative activities bring community members together to share the unique and common threads across generations.

- **Seminars** on a range of topics, including LGBTIQA legal and financial concerns, as well as discussions of specific gender and/or sexual identities.

They also offer education to COAs, nursing facilities, and assisted living facilities on the LGBT elder experience and how to become more welcoming.

**Objective 2.6**: Assist elders with their aging-in-place wishes.

**Strategies:**

Pets are an integral part of the lives of many seniors; some seniors may buy food for their pet before food, medicine, or other necessities for themselves. Recognizing this, LifePath recently launched a pet support program made
possible through a modest grant from a foundation. In one elder’s words, “If you’re not pet-friendly, you’re not senior-friendly.” In its first few months of operation, the pet program served 5 people, and will continue as long as the grant is sustained.

**Options Counseling** is another example of person-centered planning at work. By meeting with seniors individually, counselors can help them access services that meet their specific needs and wishes.

LifePath will expand its **emergency needs moneys and home repair funds** to homeowners who want to remain at home safely, as we are stewarding allocations for two endowments. Minor home repair is cited as a significant need in our area. Through an endowment from the Church Street Home Fund managed by the Community Foundation of Western MA and the Durkee Trust, home repair programs have served 49 households so far this year; we expect this figure to increase once a full year is included and as awareness of programs increases.

**Objective 2.7:** Build capacity to operate with a person-centered philosophy.

**Strategies:**

LifePath hosts a **Diversity Committee** made up of staff members. Their goal is to increase the understanding of the issues faced by various groups of people in the community. They recommend specific trainings and offer a film series open to all staff on issues such as race, disability, disease, gender, and more.

**Managing chronic disease, behavioral health issues, and dementia**

**Goal 3:** LifePath will empower consumers to stay active and healthy with a high quality of life, as defined by the consumer, for as long as possible.
Objective 3.1: Empower individuals to improve their own health outcomes and promote healthy habits through education.

Strategies:

The Healthy Living program offers evidence-based workshops to seniors who wish to become better advocates of their own health. Nine people volunteer as workshop leaders. Workshops offered by the Healthy Living program:

- My Life, My Health — Chronic Disease Self-Management
- Chronic Pain Self-Management
- Diabetes Self-Management
- Healthy Eating for Successful Living in Older Adults
- Tai Chi for Healthy Aging
- A Matter of Balance — Falls Prevention

The Healthy Living program was the subject of an outcomes measurement project in 2014 which established desired outcomes and indicators; the framework and results for the first two years are included as Attachment N.

Through another foundation grant, LifePath will expand its dementia and behavioral health training for field staff and counseling for caregivers. Understanding the specific needs of people with these conditions is essential for person-centered practice. LifePath will also conduct specialized capacity building to serve persons with other disease-specific concerns and harder-to-serve populations. One tool currently being taught is Motivational Interviewing, which helps people succeed in meeting their goals by tapping into their internal motivation for change.

The Good Life offers free education on nutrition, exercise, and healthy lifestyles.

The Mass in Motion program enables people to participate in making their communities more healthy-choice-friendly through training them how to conduct
walk audits, hold walking groups in their towns, and promote existing walking routes. LifePath’s work includes subgrants to COAs, training, and promotion of walking trails in the area and healthy lifestyles.

**Objective 3.2:** Partner with other organizations for better care coordination

**Strategies:**

Health care providers and community-based service providers have a shared objective around the health of elders. LifePath plans to expand partnerships with health care providers and seek new business opportunities to better meet the needs of elders, especially those with chronic disease, behavioral health conditions, and/or dementia.

**The Healthy Living program** will expand its medical partnerships and make its programs available regularly in the largest medical providers in the community. These workshops are highlighted as priority projects in the Community Health Improvement Plan for Franklin County and the North Quabbin, which we participated in developing. They are also funded in part by the Community Benefits Advisory Council at Baystate Franklin Medical Center, which links the hospital to community-based services, and supports community organizations with grant funding for health programs, and on whose advisory council we will continue to have representation. Ultimately, we hope to make a strong case for reimbursement of these workshops by insurers.

LifePath partners with Baystate Franklin Medical Center in its **CHART** program to reduce preventable readmissions and work toward the goal of care in the most appropriate setting. LifePath supplies care transitions assistance for discharging patients and two community health workers who assist with supports for patients who are at risk for readmission. We will seek continued funding for the CHART program, which identifies people who frequently re-visit the emergency
department or have stays in the hospital and seeks out non-medical interventions that are effective at preventing re-hospitalization such as benefits assistance, housing search, mental health/substance abuse treatment, home care services, and Meals on Wheels.

LifePath will work to improve care transitions for consumers through active participation in case planning and resource provision in all home- and community-based programs. For example, an Options Counselor goes to the hospital to meet consumers. We will continue to support the care transitions program, Senior Care Options, One Care, and other care coordination programs.

We will expand a partnership with **Hospice of Franklin County** to continue the care coordination for seniors through the end of life.

LifePath is an affiliated partner in the Care Alliance of Western MA which has applied to MassHealth to become a LTS Community Partner.

Finally, we have pursued **technological capacity** to prepare for expanded contracts with health care providers. We will seek to become connected electronically to medical provider databases through the Mass HIWay, PatientPing, and other platforms for better care coordination, integration, and referrals for services through real-time notifications of admissions, discharges, and care transitions.

**Objective 3.3:** Support those with dementia and their caregivers.

Strategies:

Enhanced dementia work will include **dementia coaching** and working with the **Alzheimer’s Music Project**, a model program born here in Western Mass that delivers customized iPods with consumers’ favorite music, shown to delight people and relieve some of the negative mood symptoms experienced by people with dementia. The music project received 78 referrals last year, and we were able to provide iPods to many of those.
LifePath will offer **Savvy Caregiver**, an evidence-based, professional-level training for non-professional caregivers of people with dementia. We plan to offer three Savvy Caregiver workshops in the first year of service.

**Objective 3.4:** Advance our preparedness to work with dementia and behavioral health populations.

Strategies:

Franklin County’s **Hoardig Task Force** builds connections and resources needed to help people whose behavioral health problems have put their housing at risk.

**Advanced training on dementia end behavioral health** will be offered to field staff.

**Objective 3.5:** Partner with other organizations to ensure elder needs are included in community priorities.

Strategies:

The Executive Director participates in the **Community Benefits Advisory Council**, which advises the local hospital on community priorities, funding decisions, and the Community Health Needs Assessments with the goal of reducing health disparities, promoting community wellness, and improving access to care for vulnerable populations.

The Planner participates in a **Community Health Improvement Plan** for the years 2017-2020, which identifies priority health needs and disparities and the factors that contribute to them; builds on our strengths by identifying current resources in the community to address priority health issues; identifies the most effective strategies for addressing the priority health needs; reduces gaps and duplication in services; and increases our collective ability to secure resources to improve health in our region. After identifying priority areas based on each agency’s expertise, the group relied on the What Works for Health database from the Robert Wood Johnson Foundation to identify the strategies (policies,
programs, and practices) with the strongest evidence of effectiveness that address each of the priority areas and then to narrow and prioritize that list, culminating in the development of the final plan.

**Objective 3.6:** Build capacity for value measurement and articulation.

**Strategies:**

LifePath has been gradually adding outcomes measures to individual programs. This involves creating a logic model for each program, including identifying desired outcomes, and then creating a measurement tool.

Furthermore, its Planner participates in the statewide home care association’s [Long-Term Services and Supports Outcomes subcommittee](#), whose objective is to identify statewide measureable objectives that can be used to evaluate effectiveness and demonstrate value.

LifePath in conjunction with Mass Home Care’s LTSS Outcomes subcommittee is working on a project to create reports in the new [HAR](#) system to evaluate outcomes for home care and other programs. One data analysis volunteer serves to create the reports needed for project and other reporting activities in the agency.

**Protective services, coordination of legal services, and outreach**

**Goal 4:** LifePath will support the protection of fundamental social and legal rights of elders, especially those who are most vulnerable.

**Objective 4.1:** Identify and respond to reports of elder abuse.

**Strategies:**
LifePath operates a **Protective Services** department that handles reports of elders who may be experiencing abuse or neglect by others or for elders who may be unsafe because of an inability to care for themselves. Last year 391 investigations in Franklin County and 395 in Berkshire County were completed. We expect this number to increase in the coming years.

It also conducts outreach and coordination related to potential victims of elder abuse.

**Objective 4.2**: Raise awareness of elder abuse.

**Strategies:**
LifePath conducts **marketing campaigns** defining elder abuse and educating the public on what to do when they suspect abuse, including a postering campaign, including restrooms to reach potential victims of abuse.

It conducts mandated reporter trainings for new CNAs (3 last year); financial exploitation training for various groups (1 last year); and protective services training for first responders, COAs, and other groups (2 last year). LifePath also does community education in conjunction with World Elder Abuse Awareness Day (June 15).

It conducts internal trainings on a variety of topics including hoarding, trauma, patient-centered counseling, and more (7 last year).

It also conducts **advocacy** to fund and support elder abuse prevention and services.

**Objective 4.3**: Provide legal assistance to low-income elders.

**Strategies:**
LifePath contracts with Community Legal Aid to offer the **Elder Law Project** through its Title III subgrant process; this program provides legal assistance and representation to the neediest elders.
It also refers many people to outside legal services through its **Information & Referral** center. We maintain strong working relationships with the Franklin County Bar Association and local elder law attorneys.

**Objective 4.4:** Advocate for residents of nursing and rest homes.

**Strategies:**

LifePath operates the **Long-term Care Ombudsman program**, whose purpose is to advocate for residents of nursing and rest homes. The Ombudsman program director also provides education to the community on residents’ rights and other issues pertaining to nursing and rest home residents. Seven volunteers serve as Ombudsmen.

**Objective 4.5:** Educate consumers on insurance, benefits, and financial security.

**Strategies:**

People can prevent legal issues from arising with good information, assistance, and education, as provided by the **SHINE, Benefits Counseling, and Money Management programs**. We use the Good Life and other publications to educate on these issues and raise awareness of pitfalls and scams.

**QUALITY MANAGEMENT ACTIVITIES**

LifePath has a Quality Assurance Plan for FY2018, outlining in detail the leadership, responsibilities, goals and objectives, standards and implementation details and how outcomes will be evaluated to assure quality services. The Plan is attached as Attachment O. The Management Team functions as the Continuous Quality Assurance Committee (CQAC) with guidance from the Board of Directors. The QA and Contracts Manager sends out surveys to consumers, surveys colleagues outside the agency about their experiences with LifePath programs.
and staff members, and surveys case managers about vendors. All client services programs and one community services program were surveyed in FY2017. In FY18, we plan to further define program impact by developing and measuring metrics and outcomes.

Title III sub-grants and in-house programs are monitored annually through a personal visit from the Title III Grants Monitor, during which required practices, records, client evaluations, and financial systems are reviewed. Care is taken to try to observe the funded activity in action, when possible, in the course of the visit. Reports on each program are submitted to the State Planner, including suggestions for improvement in meeting standards for Title III, and any required corrective actions are noted. Results of these reports are reviewed by the Citizens Advisory Board and the Board of Directors of LifePath. The Planner, who also reviews monthly NAPIS and Expense Report forms from sub-grantees, offers ongoing technical assistance to sub-grantees. Title IIIC programs annually review consumer satisfaction using EOEA standardized nutrition survey tools.

LifePath meets periodically with Council on Aging Directors from the 30 Towns to work on joint projects and share news of new programs and changes in services. Many volunteers of LifePath are located in the Senior Centers to make them more available to area elders in the large geographical area we serve, and we offer trainings in these programs to COA Directors and their staff. Feedback from the COA’s at the quarterly meetings helps us to improve the programs.

LifePath plans to work with the Franklin County Council of Governments to offer workshops on Aging in Place and Age-Friendly initiatives.

LifePath participates in the Mass Home Care LTSS Outcomes Subcommittee, which aims to create standard measures for quality management across all agencies.
ATTACHMENT A: AREA PLAN ASSURANCES AND AFFIRMATION

For Federal Fiscal Year 2018, the Area Agency on Aging makes the following assurances as required by the Older Americans Act of 1965 as amended, and all relevant regulations:

1) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2)(C), 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, outreach, information and assistance, 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. ((a)(2))

(2) Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan. ((a)(4)(A)(i))

(3) Each area agency on aging shall 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:

(A) specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in the area served by the provider;
(B) to the maximum extent feasible, provide services to low-income minority individuals and older individuals residing in rural areas in accordance with their need for such services; and

(C) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals and older individuals residing in rural areas within the planning and service area. ((a)(4)(A)(ii))

(4) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall:

(A) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(B) describe the methods used to satisfy the service needs of such minority older individuals; and

(C) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i). ((a)(4)(A)(iii))

(5) 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:

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

(E) older individuals with limited English-speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in (A) through (F), and
the caretakers of such individuals, of the availability of such assistance.  
((a)(4)(B))

(6) 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.  
((a)(4)(C))

(7) 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, with agencies that develop or provide services for individuals with disabilities.  
((a)(5))

(8) 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.  
((a)(9))

(9) 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. 
((a)(11))

(10) 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. 
((a)(13)(A))

(11) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency:

(A) 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

(B) the nature of such contract or such relationship. 
((a)(13)(B))

(12) 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. 
((a)(13)(C))

(13) 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. 
((a)(13)(D))

(14) 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. 
((a)(13)(E))

(15) 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. ((a)(14))

(16) Each area agency on aging shall 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. ((a)(15))

The undersigned acknowledge the Area Plan Assurances for Federal Fiscal Year 2018 and affirm their Area Agency on Aging’s adherence to them.

LifePath, Inc
(Area Agency on Aging)

Regina E. Curtis (Signed)
9/21/17 Regina E. Curtis
(Date) (Chairperson of Board of Directors)

Catherine Fournier (Signed)
Sept 26, 2017 Catherine Fournier
(Date) (Chairperson of Area Advisory Council)

Marie Martuccia (Signed)
9-31-2017 Marie Martuccia
(Date) (Area Agency on Aging Executive Director)
ATTACHMENT B: AREA AGENCY ON AGING INFORMATION REQUIREMENTS

Section 306 (a)(4)(A)(i)

Describe the mechanisms and methods for assuring that the AAA 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;

Each sub-grant awarded by LifePath outlines priority populations to be served which includes the individuals in greatest economic and social need and elders needing assistance with health programs. Specific Objectives in the FY2017 Plan which assist elders in greatest economic need are the Community Legal Aid providing the Elder Law Project; the Benefits Counseling Program; emergency funds; Farmers Market Coupons; Home Repair services; Home Delivered Meals and wellbeing checks on 500 homebound elders each weekday; 16 Title III Dining Centers/Luncheon Clubs; providing emergency frozen and shelf stable meals, fuel, fans and other assistance to area elders as needed; serving on the area Community Action sponsored Hunger Taskforce and participating in the Belly Bus Campaign; explaining benefits and how to access them through print and radio and local access television; providing Dementia and Memory Disorders Support Group; identifying risk levels of consumers at assessment and reassessment; seeking special funds from donors, foundations or corporations to fund elder emergency food, fuel, caregiver and home heating needs, providing respite awards and practical skills trainings to caregivers; providing two sub-grants for Grandparents parenting groups; providing quarterly social gatherings for LGBTIQA elders; and providing education on available elder services to Native American elders and their caregivers.

(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;

The LifePath service area is the most rural of any Area Agency on Aging area in the state, according to all Federal Standards on rurality. Title III B, D and E sub-grants are planned in FFY 2018 to better provide service across the large geographical area. Transportation in FY18 will be purchased for clients for demand/response service, taxi services, private car MedRide services out of county, and our own Rides for Health volunteer assisted transportation service. This door through door service was a priority in terms of unmet needs uncovered in the focus groups held for the Area Plan FY2014-2017.

LifePath serves one of the poorest areas in the state; a Basic Benefits Counseling and Application Assistance Program provides trained volunteers (and trains some COA staff) to meet with elders at home or in community settings to assist them to access fuel assistance, SNAP benefits, housing repair grants and loans and any other benefits they are eligible for, in
order to free up more of their limited income to be available to pay bills. The service will continue to be refined and offered in the coming years, seeking additional grants and support from United Way of Franklin County.

LifePath has few minority elders. Low income minority individuals are scattered throughout the population and are reached and served in the same way we serve the general population. We continue to use translation and interpreting services as needed to address language needs.

LifePath uses local media extensively to reach rural elders with news of our programs in local newspapers delivered to their homes and TV and radio programming. Our website was redesigned to better serve the elders and their caregivers who reach us via computer, and we completed a Search Engine Optimization project, which allows people seeking our services to better find us using search (and in fact we receive calls from people all over Massachusetts searching for services). Facebook has also been added as a way to communicate with the public. Outreach to community gatherings is conducted regularly and callers and visitors are received at the Information and Caregiver Resource Center every weekday.

LifePath is planning to continue quarterly breakfasts or evening social events including educational and intergenerational exchange topics for LGBTQIA elders under its Rainbow Elders program, which has over 360 people on its mailing list. Rainbow Elders also offers a panel describing the lived experience and has given presentations to community groups.

Section 306 (a)(5)

Include information detailing how the AAA will:

(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;

LifePath works closely with the local Independent Living Center, Stavros, Inc., as a member of the PVADRC, and to mutually refer clients to each other’s’ programs. The Personal Care Attendant Program covers all towns in the five western Mass ASAP areas, providing assessment and skills training to chronically disabled individuals to hire the help they need and works closely with Mass Rehab Commission. LifePath holds a contract with DDS and serves many people with intellectual disability in the Adult Family Care Program. In addition, LifePath Congregate and Supportive Housing sites include residents with disabilities. Subgrants are made to United ARC of Franklin and Hampshire Counties and to Valuing Our Children in Athol for Grandparents Parenting programs. In the case of United ARC, intellectual impairment in the child or the grandchild is the disability which can present issues for
Grandparent caregivers. LifePath runs a Support Group for caregivers of people with Alzheimer’s or other dementias. One of the 2017 Title III sub-grants is for a program incorporating evidence-based fitness. Additional Title IIID funds are used for the Healthy Living program which teaches Falls Prevention; and Diabetes, Pain, or Chronic Disease Self-Management, and Healthy Eating. SHINE serves Medicare beneficiaries of all ages and younger beneficiaries are generally persons with disabilities.

Section 306 (a)(6)
Describe the mechanism(s) for assuring that the AAA will:

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

LifePath conducts QA activities for its programs and surveys participants regularly to gauge client satisfaction with services. Focus groups and public hearings are held in forming the goals and objectives of the Area Plan. On an ongoing basis, meetings are held with the Citizens Advisory Board, whose members are elected by local meal sites, and with Councils on Aging in the service area to gather their views on our services. The Money Management Program Advisory Council provides input to the ongoing improvement of the Money Management Program and support for the program volunteers. A majority of the Board of Director members are appointed by the local Councils on Aging and provide feedback on LifePath services provided at the Senior Centers, such as SHINE or Benefits Counseling or Healthy Aging evidence based programs. Participants at our dining centers and luncheon clubs provide feedback to site managers and their feedback is communicated to the caterer. Services are developed, changed or refocused in the development of the Area Plan and in programs or services to reflect this input whenever possible. QA activities will continue throughout the four years of the plan, especially client satisfaction surveys which are required of every sub-granted and in-house Older Americans Act funded program. The Board of Directors receives all QA reports, consumer satisfaction survey results, and program and audit reports.

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

There is ongoing attention to policy matters impacting elders locally, in Massachusetts, and at the national level and advocating on these issues is ongoing.

LifePath serves as an advocate and focal point for elders in the service area in its participation in area organizations’ Boards of Directors and Advisory Boards and in its cooperation with area Councils on Aging. LifePath will directly contact town officials or state or federal legislators.
concerning any budgetary, regulatory, or policy proposals that directly and negatively impact elders and regularly publishes an insert section in local media called The Good Life in which local elder issues are explored in depth. Focus groups and public hearings were held with area elders to help develop the new Area Plan. LifePath conducts outreach to elder advocates here and in the community to ask them to send advocacy messages to their representatives on federal, state and local issues that will impact area seniors. Rainbow Elders takes on advocacy specific to the needs of LGBTIQA elders.

Section 306 (a)(7)
Include information describing how the AAA will:

(7) provide that the area agency on aging shall, consistent with this section, facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care.

LifePath offers a number of services beginning with I&R, Options Counseling and Caregiver Services to educate and assist elders and persons with disabilities. Programs operate using a model of person-centered planning and consumer choice, through vendored services, such as State Home Care, and/or consumer directed care.

The Long-Term Care Home Ombudsman Program provides Elder Rights trainings to local organizations and interprets long term care rights of elder residents and regulations of facilities to staff of local rest homes and nursing homes. LifePath provides counseling and assistance with discharge planning, work with families and care planning to elders and persons with disabilities through the Nursing Facility Initiative and CSSM in area skilled nursing facilities. LifePath cooperates with the Stavros Center for Independent Living and other area ASAP/AAA agencies in the Pioneer Valley ADRC in providing and collaborating around options counseling, targeted discharge planning, SHINE Counseling, and training of staff. LifePath will continue to participate in area collaborations with post-acute workgroups including hospitals, nursing facilities, certified home health agencies, patient centered medical homes, ACOs, and others to prevent re-hospitalizations, serve dually eligible SCO and One Care members (last year, 185 and 58, respectively), work on smoother care transitions and other projects. Bi-monthly meetings on risk management include internal staff, vendors and Hospice staff. LifePath partners with TRIAD as well as VNAs to refer clients. The Executive Director
participates in the Community Benefits Advisory Council in partnership with the local hospital. The Planner participates in a Community Health Improvement Plan (CHIP).

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals;

LifePath is in its sixth year of providing the Healthy Living Program as a direct service which offers Diabetes, Chronic Pain, and Chronic Disease Self-Management; A Matter of Balance Falls Prevention; and Healthy Eating for Successful Living. LifePath has operated as a leader for the Western MA Healthy Aging Coalition and will continue to do so, with the Director of the Healthy Aging Program chairing the regular Healthy Aging Coalition meetings at which members share techniques, ideas and resources in Western MA to further the goal of making a variety of evidence based programs available to area elders. LifePath is a partner and receives funding through the Healthy Living Center for Excellence at ESMV and Baystate Franklin Medical Center. LifePath trains Program leaders and organizes workshops for participants. All sub-grants (one) under Title IIID to Councils on Aging and other local agencies for FFY2017 have been approved by the state planner as “evidence-based:” YMCA EnhanceFitness.

LifePath assessment staff check for elder safety in their review of the home environment and recommend changes to enhance the client’s safety or health, for example, by arranging for grab bars and ramps to be installed or recommending a personal emergency response system, etc. Options counselors are trained in the Coleman 30 day Care Transitions Intervention and a mental health grant through a foundation may bring additional evidence-based interventions into practice locally. LifePath also has a dementia coach, offers Savvy Caregiver (evidence-based caregiver training), and a biweekly support group.

Section 306 (a)(10)
Describe the procedures for assuring that the AAA will:

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

LifePath monitors each sub-grantee annually to assure that grievance postings, explaining how participants who believe they have been denied services may file a grievance, are posted at the program site or given to participants in writing. Grievance procedures are also explained at intake to elders receiving services in Home Delivered Meals and are posted at local meal sites.
Elders who call asking about the possibility of filing a grievance have the process explained and are assisted in filing.

Section 306 (a)(17)
Describe the mechanism(s) for assuring that the AAA will:

(17) Include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery.

LifePath has coordinated activities that will occur during a disaster with emergency managers in all 30 towns of its service area and neighboring communities in western Mass and maintains a Non-Emergency Town Grid that is used instead of 911 to connect to town emergency personnel to coordinate information and activities during emergencies/disasters. LifePath personnel meet with long range emergency planning groups at the Franklin County Council of Governments and the Athol Hospital as meetings are scheduled, to explain our role with clients during emergencies. MEMA/FEMA officials also attend.

LifePath serves on the Western Mass COAD (Community Organizations Active in Disasters) and chairs the Care Subcommittee. The COAD provides a communication mechanism for activating organizations to provide assistance after a disaster, thus preventing gaps or duplications in services (ensuring emergency managers have the services they need and only those they need).

LifePath seeks funds through grant proposals to Farnsworth Trust, Boynton Fund, Katherine Pierce/ Little Necessities and other foundation and corporate supporters annually in order to provide emergency food, fuel, fans and other assistance to area elders. We also participate in the Hunger Taskforce of Franklin County with Community Action, Community Meals, the Survival Center, food pantries, the Western MA Food Bank and other food providers to assist with food collections to increase food available to low income elders and their families. Each year, LifePath delivers Farmers Market Coupons to area low income elders, teaming up with area Brown Bag Food Bank distributions at local Senior Centers.

Elders accessing our programs are warned about hyperthermia and hypothermia at the appropriate season and are given written tips and provided equipment and assistance to help avoid these conditions.

The agency maintains and Emergency Response and COOP plans to ensure continuity of business operations and participation in assisting elders following any type of emergency situation, including HR resources and 24/7 on-call staff.
ATTACHMENT C: ORGANIZATIONAL CHART
## ATTACHMENT D: AAA CORPORATE BOARD OF DIRECTORS – FORM 1

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Identify Officers by Title</th>
<th>City/Town of Residence</th>
<th>Membership Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanie Bernstein</td>
<td></td>
<td>Bernardston</td>
<td>Franklin County Regional Housing &amp; Redevelopment Authority (retired)</td>
</tr>
<tr>
<td>Ruth Black</td>
<td></td>
<td>Athol</td>
<td>Retired--formerly in banking</td>
</tr>
<tr>
<td>Jaye BonSignor</td>
<td></td>
<td>Northampton</td>
<td>Retired - Director of Lathrop Home</td>
</tr>
<tr>
<td>Denise Coyne</td>
<td>Treasurer</td>
<td>Greenfield</td>
<td>Greenfield Savings Bank</td>
</tr>
<tr>
<td>Regina E. Curtis</td>
<td>President</td>
<td>Warwick</td>
<td>Greenfield Community College</td>
</tr>
<tr>
<td>Russell Dean</td>
<td>Secretary</td>
<td>Turners Falls</td>
<td>Retired--formerly in banking</td>
</tr>
<tr>
<td>Michelle Di Lisio</td>
<td></td>
<td>Greenfield</td>
<td>Semi-retired, self-employed Psychotherapist</td>
</tr>
<tr>
<td>Judith Fonsh</td>
<td></td>
<td>Leverett</td>
<td>Farren Care Center - retired</td>
</tr>
<tr>
<td>Donna Jeanloz</td>
<td></td>
<td>Erving</td>
<td>Software Pricing Partners</td>
</tr>
<tr>
<td>Jim Geisman</td>
<td></td>
<td>Greenfield</td>
<td>Business Owner</td>
</tr>
<tr>
<td>Alfred Ohlson</td>
<td></td>
<td>New Salem</td>
<td>Retired Law Enforcement Officer</td>
</tr>
<tr>
<td>Sonnya Peters</td>
<td></td>
<td>Turners Falls</td>
<td>Retired</td>
</tr>
<tr>
<td>Deb Taylor</td>
<td></td>
<td>Athol</td>
<td>Retired--former LSW</td>
</tr>
<tr>
<td>Evelyn Walsh</td>
<td>Vice President</td>
<td>Turners Falls</td>
<td>Retired--formerly in public finance</td>
</tr>
<tr>
<td>Peter Wingate</td>
<td></td>
<td>Hadley</td>
<td>Energy Director Community Action</td>
</tr>
</tbody>
</table>

- **80%** Percentage of the Board that are 60+ years of age.
- **6.6%** Percentage of the Board that are minority persons.
- **6.60%** Percentage of the Board that are 60+ and minority persons.
## ATTACHMENT E: AAA ADVISORY COUNCIL MEMBERS – FORM 2

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Identify Officers by Title</th>
<th>City/Town of Residence</th>
<th>Membership Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constance Blakley</td>
<td></td>
<td>New Salem</td>
<td>Elected</td>
</tr>
<tr>
<td>Clifford Fournier</td>
<td>Chair</td>
<td>Orange</td>
<td>Elected</td>
</tr>
<tr>
<td>Beverly Demars</td>
<td></td>
<td>Gill</td>
<td>Elected</td>
</tr>
<tr>
<td>Nicole Graves</td>
<td></td>
<td>South Deerfield</td>
<td>Elected</td>
</tr>
<tr>
<td>Theresa Allen</td>
<td></td>
<td>Leverett</td>
<td>Member-at-Large Leverett</td>
</tr>
<tr>
<td>Bill Johnson</td>
<td></td>
<td>Bernardston</td>
<td>Member-at-Large Bernardston</td>
</tr>
<tr>
<td>Clyde Perkins</td>
<td></td>
<td>Warwick</td>
<td>Elected</td>
</tr>
<tr>
<td>Susan Sprung</td>
<td></td>
<td>Greenfield</td>
<td>Member-at-Large Greenfield</td>
</tr>
<tr>
<td>Beverly Leonard</td>
<td></td>
<td>Orange</td>
<td>Member-at-Large Orange</td>
</tr>
<tr>
<td>Nora Bixby</td>
<td></td>
<td>Bernardston</td>
<td>Elected</td>
</tr>
</tbody>
</table>

| 100%                 | Percentage of the Advisory Council that are 60+ years of age. |
| 0%                   | Percentage of the Advisory Council that are minority persons. |
| 0%                   | Percentage of the Advisory Council that are 60+ and minority persons. |

* Membership must be more than 50 percent older (60+) persons.
## ATTACHMENT F: AAA FOCAL POINTS DOCUMENT

<table>
<thead>
<tr>
<th>Focal Point Name</th>
<th>Town</th>
<th>Senior Center/ Council on Aging</th>
<th>Community Center</th>
<th>Nutrition Meal Site</th>
<th>SHINE Site</th>
<th>Adjacent Housing</th>
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<tr>
<td>ATHOL HOSPITAL</td>
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</tr>
<tr>
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<td>Charlemont</td>
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<tr>
<td>COLRAIN COMMUNITY CHURCH</td>
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<td>COMMUNITY HEALTH CENTERS OF FR</td>
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</tr>
<tr>
<td>SHELURNINE SENIOR CENTER</td>
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<td>LifePath</td>
<td>Turners Falls</td>
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## ATTACHMENT G: AAA TITLE III-B FUNDED SERVICES – FORM 4A

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>Title III Funding Category</th>
<th>Direct Service Status</th>
<th>NAPIS Code # (1-121)</th>
<th>Title III Award</th>
<th>Non-Title III Exp.</th>
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<tbody>
<tr>
<td>Community Legal Aid</td>
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<td>11</td>
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<td>Athol COA</td>
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<td>Bernardston COA</td>
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<td>Heath, Town of</td>
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<td>Warwick COA</td>
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<td>Long-Term Care Ombudsman</td>
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<tr>
<td>Escorted Transportation</td>
<td>B</td>
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<td>10</td>
<td>$3,576</td>
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<tr>
<td>Money Management</td>
<td>B</td>
<td>Y</td>
<td>50</td>
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Priority services: A - access; I - inhome; L - Legal; O - other.

**Total**

$70,613 $60,258
## ATTACHMENT H: AAA TITLE III-C,D,E ANDE OMB FUNDED SERVICES – FORM 4B

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>Title III Funding Category (C/D/E/OMB)</th>
<th>Direct Service Status (Y/N)</th>
<th>NAPIS Code # (1 to 121)</th>
<th>Evidence-Based Program In Use</th>
<th>FFY2018 FUNDING -</th>
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<tbody>
<tr>
<td></td>
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<td>Title III Award</td>
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<tr>
<td>Nutrition Home Delivered Meals</td>
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<td>Nutrition Congregate Meals</td>
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<td>Admin A</td>
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<tr>
<td>Caregiver Respite</td>
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<td>Healthy Living</td>
<td>D</td>
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<td>CDSMP</td>
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<td></td>
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<tr>
<td>Long-Term Care Ombudsman</td>
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<td>Y</td>
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<td>45,553</td>
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<td>-</td>
</tr>
<tr>
<td>Bernardston COA</td>
<td>D</td>
<td>N</td>
<td>115</td>
<td>YMCA EnhanceFitness</td>
<td>5,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>17,049</td>
</tr>
<tr>
<td>United ARC</td>
<td>E</td>
<td>N</td>
<td></td>
<td></td>
<td>4,498</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,727</td>
</tr>
<tr>
<td>Valuing Our Children</td>
<td>E</td>
<td>N</td>
<td></td>
<td></td>
<td>3,871</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9,856</td>
</tr>
<tr>
<td>Shelburne COA</td>
<td>E</td>
<td>N</td>
<td></td>
<td></td>
<td>3,551</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>1,370</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>534,377</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,279,936</td>
</tr>
</tbody>
</table>
**ATACHMENT I: AAA TITLE III-E FAMILY CAREGIVER BREAKOUT – FORM 5**

Based on the FFY2018 Title III-E Planning Budget Total (refer to FFY2018 Title III-E column on Projected Budget Plan tab), provide percentage (%) estimates for the services listed.

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wages/Personnel costs of AAA staff involved in Family Caregiver Support Program services (counseling, support groups, training, assess assistance and information outreach and other specific caregiver services).</td>
<td>51%</td>
</tr>
<tr>
<td>Contracted respite services.</td>
<td>0%</td>
</tr>
<tr>
<td>Contracted supplemental services.</td>
<td>0%</td>
</tr>
<tr>
<td>Contracted services that include: counseling, support groups, caregiver training, access assistance and information outreach.</td>
<td>27%</td>
</tr>
<tr>
<td>Other (explain below)</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100%</td>
</tr>
</tbody>
</table>

**Other (detail):**

- Administrative costs
- Mileage/Travel
- Other Program Support
- Direct Caregiver Support
### ATTACHMENT J: PROJECTED BUDGET PLAN – FFY2018

<table>
<thead>
<tr>
<th>Area Plan</th>
<th>Title III-B</th>
<th>Title III-C-1</th>
<th>Title III-C-2</th>
<th>Title III-D</th>
<th>Title III-E</th>
<th>Ombudsman</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin</td>
<td>Supp Svs</td>
<td>Cong. Nutr Svs</td>
<td>HDM Nutr Svs</td>
<td>Evi-Based Svs</td>
<td>Caregiver Svs</td>
<td>Services</td>
</tr>
</tbody>
</table>

#### Federal Planning Award:

<table>
<thead>
<tr>
<th></th>
<th>FFY 2017 Title III Estimated Continuation</th>
<th>FFY 2018 Title III Income</th>
<th>FFY 2018 Total Title III Income</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$70,147</td>
<td>$106,262</td>
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<td></td>
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<td>$208,061</td>
<td>$ 328,285</td>
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<td>$76,534</td>
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<tr>
<td></td>
<td></td>
<td>$6,553</td>
<td>$13,107</td>
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</table>

#### Other Income:

<table>
<thead>
<tr>
<th></th>
<th>NSIP</th>
<th>4,500</th>
<th>40,500</th>
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</thead>
<tbody>
<tr>
<td>NSIP Commodity Credit</td>
<td>4,593</td>
<td>41,336</td>
<td></td>
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<tr>
<td>Other Federal (non-Title III or NSIP)</td>
<td>-</td>
<td>15,938</td>
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<tr>
<td>Program Income (Client Contributions)</td>
<td>-</td>
<td>26,135</td>
<td></td>
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<tr>
<td>State Home Care</td>
<td>-</td>
<td>-</td>
<td>604,037</td>
</tr>
<tr>
<td>State Elder Lunch</td>
<td>-</td>
<td>-</td>
<td>159,257</td>
</tr>
<tr>
<td>State - Other</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-Federal Inkind</td>
<td>60,258</td>
<td>-</td>
<td>17,049</td>
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<tr>
<td>Local</td>
<td>4,665</td>
<td>-</td>
<td>118,880</td>
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<tr>
<td>Other</td>
<td>45,205</td>
<td>659</td>
<td>10,168</td>
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#### Total Other Income:

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<thead>
<tr>
<th></th>
<th>$49,870</th>
<th>$60,917</th>
<th>$1,145,898</th>
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<tr>
<td></td>
<td>$17,169</td>
<td>$26,121</td>
<td>$34,554</td>
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#### Total Available Income:

<table>
<thead>
<tr>
<th></th>
<th>$120,017</th>
<th>$167,179</th>
<th>$2,326,109</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$29,454</td>
<td>$102,655</td>
<td>$80,107</td>
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#### Budgeted Expenditures:

<table>
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<tr>
<th></th>
<th>Wages and Salaries</th>
<th>$65,770</th>
<th>$20,457</th>
<th>$58,571</th>
<th>$108,903</th>
<th>-</th>
<th>$39,708</th>
<th>$44,482</th>
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<tbody>
<tr>
<td></td>
<td>Payroll Taxes/Fringe Benefits</td>
<td>$21,046</td>
<td>$6,546</td>
<td>$18,743</td>
<td>$34,849</td>
<td>-</td>
<td>$12,707</td>
<td>$14,234</td>
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<tr>
<td>Mileage/Travel</td>
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<td>417</td>
<td>1,929</td>
<td>17,365</td>
<td>-</td>
<td>409</td>
<td>5,352</td>
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<tr>
<td>Occupancy Costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Equipment Purchase/Rental/Maintenance</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

#### Total Budgeted Expenditures:

<table>
<thead>
<tr>
<th></th>
<th>$120,017</th>
<th>$167,179</th>
<th>$2,326,109</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$29,454</td>
<td>$102,655</td>
<td>$80,107</td>
</tr>
</tbody>
</table>

---

**Signature of Area Agency on Aging Planner:**

**Signature of Area Agency on Aging Fiscal Manager:**

**Signature of Area Agency on Aging Executive Director:**

Date: 9/25/17
ATTACHMENT K: ANNUAL REPORT

The latest annual report can be accessed at https://lifepathma.org/about/annual-report.
ATTACHMENT L: FOCUS GROUP REPORTS

1.

AAA LifePath Date: January 19, 2016

Facilitator Name: Jennifer Putney Total Participants* 8

Location: Green Fields Market Meeting Room 144 Main Street, Greenfield MA 01301
Start time: 2PM End time: 4PM

Vulnerable (target) population (Check applicable items):

Race: __x_ Majority ___ Black ___ Nat Am/PI ___ Asian ___Am Ind ___ Multi racial/Other

Ethnicity: ___ Spanish/Latino

Language: ___ Linguistic minority: specify

Economic need: __x_ Low income elders ___ Low income minority elders

Social need: ___ Abused, neglected, exploited ___ Frail elders ___ Low vision
___ Alzheimer’s/dementia ___ Grandparents ___ Mental/behavioral
___ Caregiver support ___ Housing concerns ___ Mobility
___ Cognitive impairmen ___ Isolated elders ___ Nutrition - meals
___ Cultural ___ Legal services ___ Rural elders
___ Disabled elders ___ LGBT ___ Workforce
___ Other:

Methodology/strategy: Small public gathering/focus group

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Maintain independence*
2. Leisure and recreation, social gathering activities
3. Spirituality
4. Long-term services and supports, affordable
5. Housing/Affordable*, accessible, alternative senior housing, diverse, LGBT-welcoming, LGBT-
exclusive, maintenance
6. Transportation, reliable and affordable, to medical care
7.
8. Safety and security, fear of discrimination in institutions
9. Social isolation, community engagement
10. Health care*, medical, Health insurance

We hosted and recruited for an LGBT housing focus group for the The Massachusetts LGBT Aging Needs Assessment (M’LANA) Coalition for a study on Housing Needs of LGBT Older Adults in Massachusetts. We requested the notes from the focus groups and received this response:
LifePath Area Plan on Aging 2018-2021

“I needed to thoroughly review our Institutional Review Board (IRB) documents for guidance on how best to respond to your request... Given the vulnerability of older LGBT adults, we have taken several precautions to protect their identities. Each focus group had a small number of participants (4-8). As a result, it would be possible to infer the participants’ identities (even without their names) if we release a separate report for each community. To protect their confidentiality, we need to release the results as a summary of major themes from all 7 focus groups. Our preliminary analysis has revealed that participants’ needs and concerns are remarkably similar across communities; therefore, the summary report will provide meaningful and helpful information.”

This report is based on the general preliminary report issued by M’LANA.

2.

AAA LifePath

Date: March 2, 2016

Facilitator Name: Jessica Payne

Total Participants* 16

Location: Greenfield Savings Bank Community Room Turners Falls, MA

Start time: 10:00 End time: 11:30

Vulnerable (target) population (Check applicable items):

Race: _16__ Majority __ Black ___ Nat Am/PI ___ Asian ___Am Ind ___ Multi racial/Other

Ethnicity: ___ Spanish/Latino

Language: ___ Linguistic minority: specify

Economic need: _x__ Low income elders ___ Low income minority elders

Social need: ___ Abused, neglected, exploited ___ Frail elders ___ Low vision

___ Alzheimer’s/dementia ___ Grandparents ___ Mental/behavioral

___ Caregiver support ___ Housing concerns ___ Mobility

___ Cognitive impairment ___ Isolated elders ___ Nutrition - meals

___ Cultural ___ Legal services ___x_ Rural elders

___ Disabled elders ___x__ LGBT ___ Workforce

___ Other: ___

Methodology/strategy: focus group

List the needs and issues vocalized/identified:

Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Health Care: more providers and geriatric specialists; benefit from minute clinics and nurse practitioners; need help navigating insurance coverage and the healthcare system; the insurance system, pharmaceutical industry and politics acting as a barrier to care. Older adults need support navigating the system, determining what is covered and how to access the highest quality care. High deductibles discourage older adults from accessing needed medical care, and high costs discourage older adults from filling needed prescriptions. Through stories about insurance refusing to pay for needed medications, participants alluded to the control insurance and pharmaceutical companies exert over care. Participants generally agreed that there was a need for more providers, especially geriatric specialists, in the area and improved continuity of care to address multiple chronic conditions most elders deal with. Many general practitioners have retired or left the area, and they have not been replaced. Participants would like to see improved clarity about follow up and more education about self-management; continued access to urgent care and more minute clinics; greater access to information and access to alternative medicine options; Participants would like to see use of infolines, and patient portals; and improved ways to access

Page 61
help navigating the healthcare system and insurance industry. “There are special health needs relative to older bodies.” “We need our physicians to be clearer on the orders you get when you leave a hospital or ER. Patients need to be able to understand these. When you’re discharged from hospital you may be groggy from whatever medication you were given…No one is coordinating your care. This lack of coordination of care results in people going to the ER when they otherwise wouldn’t need to do that.” Elders of color are an “invisible group” with multiple health care needs.”

2. Leisure and recreation: opportunities to socialize, sense of community, senior center programs are a benefit. Participants agreed that isolation is detrimental to health in general and mental wellbeing in particular, and that human interaction in itself is therapeutic.

3. Mental and behavioral health: support with mental health and transitioning into being older adults, attention to issues of addiction, and education about follow up and self-care; Many experience a stigma around growing older, and struggle to connect with and get support from their peers and others in their community. “We have support groups for diabetes, but we don’t have any support groups for elders dealing with mental health issues.” Senior centers, support groups, and other venues allow older adults to come together and learn how to adapt to growing older. As we grow older, we are not necessarily prepared to cope with retirement or chronic illness. Participants also expressed concern about the ways the opioid crisis and substance abuse impacts elders and the need for increased attention and support in this area. “A lot of focus has been on young people with opiate drugs and that sort of thing, but I know a lot of older people with addiction issues. As they get older, especially if they retire, they indulge in more and more alcohol drinking, which can lead to depression... Addiction with seniors is a hugely different story than it is with a 22-year-old in terms of how it is visualized, recognized...Addiction among elders needs to be addressed and treated.”

4. Language/communication barriers: benefit from access to online information,

5. Transportation: better access to transportation; lack of transportation makes medical care more difficult; Participants would like to see improved access and information about transportation

6. Economic security

7. Social isolation: Participants would like to see more opportunities to participate in support groups and other venues for socialization, including outreach to those who don’t tend to leave home. “A lot of problems, including mental health, are from lack of socialization, after people stop working...People are shell shocked once they leave work. It was their social life, and they didn’t even know it”

This focus group consisted of 16 adults aged 60 years or older who were recruited through flyers distributed at senior facilities/agencies, emails, and Facebook postings. The focus group addressed needs, access and barriers to receiving healthcare among elders, with emphasis on overall health, mental health, life changes, and homecare, and also addressed circumstances and barriers for accessing primary and emergency care and medication.

3.

AAA  LifePath ________________________________ Date: 6/22/16

Facilitator Name: Kim Gilhuly ____________________________ Total Participants*16 _______

Location: Shelburne Senior Center, 7 Main Street, Orange, MA 01370 Start time: 10:30 __ End time: 12:00 ______

Vulnerable (target) population (Check applicable items):
Race:  _x_ Majority _____ Black _____ Nat Am/PI _____ Asian ____ Am Ind _____ Multi racial/Other
Ethnicity:  _____ Spanish/Latino
List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Long term services and supports: foot care; better marketing of LifePath services;
2. Nutrition
3. Health Care; need inexpensive dentists; Lack of doctors in Franklin County – you have to travel from Heath over 20 miles; we need gerontologists, our needs are different than someone dealing with kids or younger adults; Lack of longevity of doctors, seniors like to have a relationship with doctors; Ability to have doctor to have good communication with a senior, if they talk quickly or use vocabulary outside our normal vocabulary, it’s difficult; appointments too short; physicians having to type as they talk is off-putting, scribes are great; emergency services not that good, lack of EMTs, long wait time; not enough resources for hearing aids, so people do without them, which can lead to depression and other problems; long waits for primary care appointments; home visits would be helpful; hospital docs and primary care don’t communicate; long waits at ER unless you take an ambulance which costs $1,000; elders avoid the ER at all costs; urgent care and minute clinics are great; town nurse is great; better patient education after doctor and hospital visits with new diagnoses; better checking in after new diagnosis; larger print on pharmacy printouts; clearer medication information;
4. Transportation; going to physicians for medical facilities outside of Franklin County;
5. Language/communication barriers*: Lack of broadband internet is an enormous barrier for health (“I had major heart surgery; and due to some problems, had a thing implanted. I have to talk to doctor in NH. There’s no cell phone or broadband, my wife had to drive to Shelburne to transmit information. It was insane!” “My doctor asked me – do you have digital camera (in order to take a picture of something that was bothering her). Well, I have a digital camera, but I have dial up internet, so I can’t send a picture. “, can’t get online reports, make appts; phone lines unreliable; getting information they need; doctors’ offices phone menus can be confusing; lack affordable hearing aids causes communication problems
6. Access to social services: some seniors are afraid if they tap into services it will lessen the services they already receive; pride prevents people from accessing services; disaster preparedness
7. Economic: affording health care (copays, especially for specialists, and deductibles)
8. Exercise: here people drive everywhere instead of walking
9. Education: Life Path has a great chronic disease management course; Lack of education and support about safer sex practices; Requirement for a certain level of participation is a barrier to getting education (“I got my town a grant for education – they required 10 participants. People who were in charge of running it wouldn’t guarantee it would be 10 participants so the education didn’t happen. That makes me sad because I’m happy if one person shows, if I get 4 I got a full house! Regulations to have education for services, info, you put a number on it of 10 in the hill towns, that’s not going to happen.”)
11. Mental and behavioral health: Access to MH services, and mental health doctors who understand and want to work with seniors; Substance abuse treatment needs for some folks, especially alcoholism (especially when opioid crisis has taken front seat); substance problem may prevent someone from seeking health care

12. Social isolation: senior centers can alleviate loneliness; programs targeted to men, making male companions more comfortable with dementia “My husband’s friends stayed away”

13. Housing: home repair (COA Grant is great), help with home safety issues (TRIAD is very helpful); dedicated senior housing; home sharing matching

14. Leisure and recreation: more LGBT activities

15. Caregiver support: support groups for memory loss and loved ones, especially men

AAA ___________________________ Date: 6/28/16

Facilitator Name: ______Kim Gilhuly Total Participants* 10_____

Location: Orange Council on Aging, 135 E. Main Street, Orange, MA 01370
Start time: 10:30 End time: 12:00

Vulnerable (target) population (Check applicable items):
Race: ___x_ Majority ___ Black ___ Nat Am/PI ___ Asian ___Am Ind ___ Multi racial/Other
Ethnicity: ___x__ Spanish/Latino
Language: ___ Linguistic minority: specify____________________________
Economic need: ___x_ Low income elders ___ Low income minority elders
Social need: ___ Abused, neglected, exploited ___ Frail elders ___ Low vision
___ Alzheimer’s/dementia ___ Grandparents ___ Mental/behavioral
___x_ Caregiver support ___ Housing concerns ___ Mobility
___ Cognitive impairment ___ Isolated elders ___ Nutrition - meals
___ Cultural ___ Legal services ___x_ Rural elders
___x_ Disabled elders ___ LGBT ___ Workforce
___ Other: ________________________________

Methodology/strategy: Focus Group

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Transportation*: Better transportation to the doctors; RTA bus not always available/ fixed routes only/ elders can’t walk to
2. Long-term services and supports: Someone to do nails and hair/ list of names referral list would be very
<table>
<thead>
<tr>
<th>LifePath Area Plan on Aging 2018-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Access to social assistance services: Seniors don’t know about existing services, lack of marketing, don’t know how to use services; Difficulty navigating system to gain benefits; insurance issues can prevent seniors from getting health care; Resource manual needed listing all services available, care coordination; Fuel assistance makes a big difference</td>
</tr>
<tr>
<td>4. Leisure and recreation: lots of isolation out there, unaware of positive activities; seniors are so pre-occupied with current crisis</td>
</tr>
<tr>
<td>5. Nutrition: Bus transportation stops at 2:00 PM/ Farmer’s Market ends at 6:00 PM; SNAP benefits insufficient to purchase healthy food – Farmer’s Market doesn’t accept SNAP benefits</td>
</tr>
<tr>
<td>6. Economic: Can’t afford health care costs</td>
</tr>
<tr>
<td>7. Health care: elders may use emergency room when doctors are closed, an urgent care center would be helpful, more availability of regular appointments, shorter waits at emergency room, don’t want to be transferred out of Athol hospital; Outreach &amp; education, work together to resolve crisis (medical, addiction) more holistic approach necessary; more home visiting; more geriatricians; adult day health</td>
</tr>
<tr>
<td>8. Social isolation: Socialization support, physical, emotional contact very important; Incentives needed for volunteers to socialize with seniors/ create great tool to identify what senior needs; friends can also be isolated, can’t get to see one another</td>
</tr>
<tr>
<td>9. Education: LifePath Chronic Disease Management in Turner's Fall very educational</td>
</tr>
<tr>
<td>10. Mental and Behavioral: Depression, isolation, living in deplorable conditions, fear of leaving the house, embarrassment because of physical limitations, stigma, self-medication with alcohol, opioids, Private insurance coverage lacking for dispensing machines, Life Line system; opportunities to celebrate good things; MDZ machines for protecting against substance abuse</td>
</tr>
<tr>
<td>11. Language/communication: More information about services needed; Getting seniors more connected to computers to converse with friends, families</td>
</tr>
<tr>
<td>12. Caregiver support*: More money needed to pay care-takers for seniors – one on one is what elderly need; inability to use public bathrooms (gender neutral family bathrooms needed), Support group to relate/ vent / celebrate successes/ positive things happening; relief from exhaustion and disconnectedness that can happen as a caregiver</td>
</tr>
<tr>
<td>13. Housing*: affordable; assisted living; elderly housing; first floor apartments; Grants needed to handicap bathrooms, ramps, adaptable equipment; home repair</td>
</tr>
</tbody>
</table>

This session had several attendees who were under 60 providing care for elders. Several of these caregivers expressed that the stress of providing care can be extraordinary at times. One woman who was under the age of 30 spoke about caring for her own children plus her grandfather who was an amputee as being exhausting; she mentioned that the stigma of being elderly and disabled had severely limited his circle of friends leaving the family to provide all the elder’s needs.

AAA LifePath
Date: 11/30/16
Facilitator Name: Lynne Feldman
Total Participants*9
Location: Athol Senior Center Start time: 10:00 End time: 11:15
Vulnerable (target) population (Check applicable items):
Race: ___x_ Majority ___ Black ___ Nat Am/PI ___ Asian ___Am Ind ___ Multi racial/Other
Ethnicity: ___x__ Spanish/Latino
Language: ___ Linguistic minority: specify______________________________

Economic need: ___x_ Low income elders ___ Low income minority elders
Social need: ___ Abused, neglected, exploited ___ Frail elders ___x__ Low vision
___ Alzheimer’s/dementia ___x__ Grandparents ___ Mental/behavioral
___ Caregiver support ___x__ Housing concerns ___x__ Mobility
___ Cognitive impairment ___x__ Isolated elders ___ Nutrition - meals
___ Cultural ___x__ Legal services ___ Rural elders
___x__ Disabled elders ___ LGBT ___x__ Workforce
___ Other: _____________________________

Methodology/strategy: Small public gathering/focus group

List the needs and issues vocalized/identified: Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Staying active and wellness promotion /Exercise programs x
2. Nutrition /congregate meals, home meals x
3. Transportation*, especially evening and to other towns, medical appointment, social activities x
4. Economic (financial) security x
5. Access to social assistance services /Coordination between county services (area lies on county border), reduced paperwork and travel burden, Outreach and information
6. Social isolation /Support groups*, Volunteers or ministers for home visiting x
7. Legal services* x
8. Recreation activities x
9. Civic engagement/volunteer opportunities /Engagement in town democracy (voting, transportation to attend town meetings)
10. Learning and development /Computer skills training
11. Safety/security/snow removal, public safety, coping with fear of crime, becoming comfortable with someone being in their home to provide services, fear of scams*
12. Housing /Home repair
13. Mental health/supports to cope with the loss of an adult child
14. Caregiver/money Management, respite, personal care, training on dementia for caregivers and people in the community, support groups, discussion groups

Elders in this group have noticed these changes in their peers:
1. Older people are living longer.
2. Family no longer can or will provide the informal support that families once did, hence the need for more services. Some elders are seeing their children make less than they did, so they can’t ask for them to care for them. Some family have more self-serving values that prevent them from providing care. Some informal supports can’t provide care because they are geographically more separated than in previous generations.
6. 

AAA  LifePath  

Date:  12/8/16  

Facilitator Name:  Lynne Feldman  
Total Participants*  7  

Location:  Elm Terrace Supportive Housing, Greenfield  
Start time:  10:00  
End time:  11:15  

Vulnerable (target) population (Check applicable items):  
Race:  _x__ Majority  ___ Black  ___ Nat Am/PI  ___ Asian  ___ Am Ind  ___ Multi racial/Other  
Ethnicity:  ___ Spanish/Latino  
Language:  ___ Linguistic minority:  specify  
Economic need:  _x__ Low income elders  ___ Low income minority elders  
Social need:  _x__ Abused, neglected, exploited  _x__ Frail elders  _x__ Low vision  
_x__ Alzheimer’s/dementia  _x__ Grandparents  _x__ Mental/behavioral  
_x__ Caregiver support  _x__ Housing concerns  _x__ Mobility  
_x__ Cognitive impairment  _x__ Isolated elders  _x__ Nutrition - meals  
_x__ Cultural  _x__ Legal services  ___ Rural elders  
_x__ Disabled elders  _x__ LGBT  ___ Workforce  
___ Other:  

Methodology/strategy:  Small public gathering-focus group  

List the needs and issues vocalized/identified:  
Among the listed needs and issues identified, place an asterisk next to top three needs identified.  

1. Transportation*; (options and flexibility) (shopping for necessities, gifts) (medical) (complexity of system)  
   (important for independence) (PT1 form is invaluable; they don’t strand you there) (some people use 911 for transportation)  

2. Language/communication barriers: Interpreters for people who are not English speaking  

3. Health care*, quality medical care, (fewer primary care physicians available), In-home health care, Access to community health centers (they took are of people who have no insurance--always find a way) (access to free dentures) (dealing with red tape), In-home counseling  

4. Maintain independence: housekeeping, Home maintenance, laundry (machines that are working)  

5. Access to social assistance services*; navigating programs that don’t talk to one another, SHINE counselors, (helping with how veteran status impacts eligibility); Assistance with end-of-life services (living in a congregate house feels comfortable on this front), Workers at senior housing who are warm and approachable, Information about activities for people who have just moved in, Help with “legalese”, Social security Appointments at our convenience instead of theirs  

6. Learning and development: Healthy Living evidence-based workshops  

7. Staying active and wellness promotion: Exercise at senior centers and senior housing (bicycle, treadmill);
accessible exercise programs for non-English speakers

8. Housing; Affordable housing

9. Economic security: Livable monthly income

10. Leisure and recreation: Pets, Ability to attend activities (tenants associations, meal programs, coloring group); Library services (volunteer program that brings in books, tapes and videos since getting there is a problem)

11. Social isolation: Companionship, community rooms at housing sites for socialization

7.

AAA__LifePath_________________________Date: 6/23/16___________________________

Facilitator Name: Rachel Stoler________________________________________Total Participants*10___

Location: __________Greenfield Senior Center Start time: __________End time: __________

Vulnerable (target) population (Check applicable items):
Race: ________Majority ________Black ________Nat Am/PI ________Asian ________Am Ind ________Multi racial/Other
Ethnicity: ________Spanish/Latino
Language: ________Linguistic minority: specify______________________________
Economic need: ________Low income elders ________Low income minority elders
Social need: ________Abused, neglected, exploited ________Frail elders ________Low vision
            ________Alzheimer’s/dementia ________Grandparents ________Mental/behavioral
            ________Caregiver support ________Housing concerns ________Mobility
            ________Cognitive impairment ________Isolated elders ________Nutrition - meals
            ________Cultural ________Legal services ________Rural elders
            ________Disabled elders ________LGBT ________Workforce
            ________Other: ________________________________

Methodology/strategy: Focus Group

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Nutrition: Hard to access local foods in winter; hard to cook for one person; no daily lunch at Greenfield senior center; food banks/brown bags have limited choice (too much peanut butter and tuna); food banks/brown bags sometimes have too much processed food and low-quality food; Meals on Wheels not always great food; knowledge on how to cook produce would be helpful; elders will try new things when risk of wasting money is low; some seniors go to multiple grocery stores to get the best prices on different items

2. Transportation: inconvenient public transportation (“You have to wait for 2 hours at Stop and Shop!”); lack of benches along walking routes; Saturday hours in public transit are needed (“otherwise your life just stops on Friday.”); carpooling or collaborative transportation group would be helpful;

3. Economic: hard to always afford local and organic foods; reliance on food banks or Sherriff’s department,
In 2015, Mass in Motion Franklin County received expanded funding from the Centers for Disease Control and Prevention to address the increasing incidence of diabetes and heart disease. Through this grant funding, Partnership for Youth (PFY) staff are implementing strategies to increase people’s access to healthy food and opportunities for active living through policy, systems, and environment change.

PFY staff took responsibility for conducting focus groups with seniors, residents of low income housing units, and youth. They designed the focus group protocol, with guidance provided by the Massachusetts Department of Public Health, the USDA “food security” framework, and input from key community stakeholders.

Focus group questions addressed community member’s knowledge about healthy and local food, factors influencing their food purchasing and consumption, and their perspectives regarding solutions to improve their access to healthy and local food.

8.

AAA  LifePath  Date: 7/12/16
Facilitator Name: Rachel Stoler  Total Participants*  9
Location: Gill-Montague Senior Center  Start time:  End time:
Vulnerable (target) population (Check applicable items):
Race:  ___ Majority  ___ Black  ___ Nat Am/PI  ___ Asian  ___ Am Ind  ___ Multi racial/Other
Ethnicity:  ___ Spanish/Latino
Language: ___ Linguistic minority: specify
Economic need: ___ Low income elders  ___ Low income minority elders
Social need: ___ Abused, neglected, exploited  ___ Frail elders  ___ Low vision
 ___ Alzheimer’s/dementia  ___ Grandparents  ___ Mental/behavioral
 ___ Caregiver support  ___ Housing concerns  ___ Mobility
 ___ Cognitive impairment  ___ Isolated elders  ___ Nutrition - meals
 ___ Cultural  ___ Legal services  ___ Rural elders
 ___ Disabled elders  ___ LGBT  ___ Workforce
 ___ Other:
Methodology/strategy: Focus group
List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Transportation: public transport is difficult (“Round trip to Stop & Shop is almost a full day project. Must make appointment for senior bus.”); bus is too hard for people with certain limitations; bus is often late; wayfinding signs too small
2. Economic: reliance on food pantries
3. Nutrition: nutrition information is confusing, changing all the time; for one person, harder to cook, hard not to waste food, harder to eat healthy; too expensive to buy organic; farm stands don’t take food stamps; prepared foods at the grocery stores could be healthier.

In 2015, Mass in Motion Franklin County received expanded funding from the Centers for Disease Control and Prevention to address the increasing incidence of diabetes and heart disease. Through this grant funding, Partnership for Youth (PFY) staff are implementing strategies to increase people’s access to healthy food and opportunities for active living through policy, systems, and environment change.

PFY staff took responsibility for conducting focus groups with seniors, residents of low income housing units, and youth. They designed the focus group protocol, with guidance provided by the Massachusetts Department of Public Health, the USDA “food security” framework, and input from key community stakeholders.

Focus group questions addressed community member’s knowledge about healthy and local food, factors influencing their food purchasing and consumption, and their perspectives regarding solutions to improve their access to healthy and local food.

9.

AAA LifePath
Date: 7/7-7/21/16
Facilitator Name: Jessica Payne Total Participants*8
Location: Telephone Start time: End time:

Vulnerable (target) population (Check applicable items):
Race: _x_ Majority ___ Black ___ Nat Am/PI _x__ Asian ___Am Ind ___ Multi racial/Other
Ethnicity: _x_ Spanish/Latino
Language: _x_ Linguistic minority: specify: Arabic, Korean, Moldovan, and Spanish

Economic need: ___ Low income elders ___ Low income minority elders
Social need: ___ Abused, neglected, exploited ___ Frail elders ___ Low vision
___ Alzheimer’s/dementia ___ Grandparents ___x__ Mental/behavioral
___ Caregiver support ___ Housing concerns ___x__ Mobility
___ Cognitive impairment ___ Isolated elders ___x__ Nutrition - meals
___ Cultural ___ Legal services ___ Rural elders
___ Disabled elders ___x__ LGBT ___ Workforce
___ Other: ___

Methodology/strategy: Phone interviews

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Economic: assistance paying for over-the-counter medications
2. Transportation*: medical visits; other trips; can’t afford gas for car
3. Health care*: home physical and occupational therapies needed to recover from injuries/ailments so the rest of the body/mind does not suffer; paperwork burden prevents health providers from offering certain treatments; providers focus on acute patients; physicians have no relationship to patient; hospitals do not nurture relationship with patient; “the way for me to trust in my phlebotomist is to have a 10% cushion in our contact time that is solely for relationship building. The individual provider of care is being turned into an algorithm from the outside.”; “I’ve been unhappy with my PCP and I had to go to about four practices. I ended up with a lady who spent my first appointment not touching me, because we spent 45 minutes building a relationship, talking about my experiences in healthcare, my understanding of my situation. And the second time I went to see her it was the same thing. Only at the end, she made a suggestion about my health. It’s that comprehension of my needs that keeps me coming back, even when other things go wrong. “; elders need education on how to make use of the health care system; health care managers to guide them step by step, to learn how to “push”; long wait times to see specialists are a problem; doctors don’t have time to respond to patient questions; bilingual care; cultural stigmas can prevent people from seeking care, especially men, but education could help this; health education could be provided by nurses in housing projects; hospital not integrated with local providers (e.g. endocrinologist has own separate electronic medical record from the hospital); education, outreach, and cultural competence are all needed to help people navigate the system; assistance understanding medications.

4. Caregiver needs: Affordable respite care

5. Nutrition: trouble providing enough nutrition for 4 grandchildren in her care (food stamps is not enough); nutrition education is needed, especially how to incorporate the information we receive in our doctor’s visit into our lives;

6. Access to social assistance services: need health insurance; interpretation; paperwork can be a barrier to getting things like healthy insurance; wait times can be too long for elders;

7. Spiritual: many immigrants have strong religious beliefs, so connecting elders with churches would be beneficial

8. Leisure and rec: for working immigrants, finding free time and time to spend with family is hard; companionship

9. Long-term services and supports: home based care; housecleaning; handles in the bathroom; cooking; personal care

10. Exercise

11. Mental health: needs associated with trauma and war, Alzheimer’s, depression, dementia, depression, loneliness and isolation; there are no therapists who are bilingual; sadness at being separated from family; support groups are needed;

12. Communication: senior center and nursing should have people that speak Spanish; English classes at senior centers; “People need cultural competency to deal with the cultural piece here. In our [Latin, Puerto Rican] culture we are more aggressive and assertive so we need people who understand our culture. Maybe the hospital could have classes that address the culture of the Maldovans, other Spanish speaking people. Close relationships are really important for us, and family. We need people who use eye contact and really relate to us. There is an Indian doctor I know, and they seem more similar to us and I talk with elders about that, that they could see him and feel more comfortable. It’s how Indian people relate. When I see him I ask how his family is, and we do that, that’s how we relate. Most immigrants love this, especially when we don’t have our family here or are by themselves. Sometimes white people don’t understand this and they lack a personal touch. We need more outreach to people for the senior center. Many people don’t know about it. I don’t know if their outreach is inclusive. I don’t know if elders who aren’t white feel welcome there.

13. Security: fear of being arrested
10.

<table>
<thead>
<tr>
<th>AAA</th>
<th>LifePath</th>
<th>Date: 12/27-12-31/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitator Name:</td>
<td>Lynne Feldman</td>
<td>Total Participants*:4</td>
</tr>
<tr>
<td>Location:</td>
<td>Phone</td>
<td>Start time:</td>
</tr>
</tbody>
</table>

Vulnerable (target) population (Check applicable items):
- Race:  
  - x Majority  
  - ___ Black  
  - ___ Nat Am/PI  
  - ___ Asian  
  - ___ Am Ind  
  - ___ Multi racial/Other

- Ethnicity:  
  - ___ Spanish/Latino

- Language:  
  - ___ Linguistic minority: specify

- Economic need:  
  - x Low income elders  
  - ___ Low income minority elders

- Social need:  
  - ___ Abused, neglected, exploited  
  - ___ Frail elders  
  - ___ Low vision  
  - ___ Alzheimer’s/dementia  
  - ___ Grandparents  
  - ___ Mental/behavioral  
  - ___ Caregiver support  
  - ___ Housing concerns  
  - ___ Mobility  
  - ___ Cognitive impairment  
  - ___ Isolated elders  
  - ___ Nutrition - meals  
  - ___ Cultural  
  - ___ Legal services  
  - ___ Rural elders  
  - ___ Disabled elders  
  - ___ LGBT  
  - ___ Workforce  
  - ___ Other:

Methodology/strategy:  
- Phone interviews with stakeholders—representatives of local meal programs and food pantries.

List the needs and issues vocalized/identified: (If more space is needed, use the back of this sheet.)
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

Example: Need Area – Maintain independence
  Issue – TV cable, cell phone or computer not functioning; don’t know how to reconnect or reset.

| 1. Nutrition: see below | 11. |

*If advocates/representatives, list organizations and number of elders being represented:
These food pantries represent hundreds of seniors.
I interviewed representatives from four food pantries and meal programs.

- Stone Soup Café serves about 32-44 elders each Saturday, or 40% of total customers
- Northfield Food Pantry serves about 36 households with elders and several more that have people age 50-60 who are disabled, or 80% of total customers
- United Arc Food Pantry serves 40% elders, mostly “walking poor”
- Community Action! Center for Self-Reliance Food Pantry (Greenfield and West County) served 255 elders 65 and older last year, which is around 8% of their customers.

Overall, all interviewees felt that there was steady demand for services from elders. There was a lot of variance in the portion of elders served, from small (8% at the Center for Self-Reliance) to 80% at Northfield Food Pantry; Northfield noted they have a strong relationship with the senior center. Most felt that word of mouth was the best
way to market their services. One pantry, United Arc, is closing permanently in February 2017. A few noted that there is a stigma associated with community meals and food pantries which they felt sometimes kept elders away. Some said they have especially high demand for items that SNAP does not cover such as over-the-counter medicine, detergents, etc.

11.

AAA__LifePath ____________________________________________ Date: __11/9/16________
Facilitator Name: __Lynne Feldman______________________________________________Total Participants*7____
Location: __LifePath________________________________________Start time: __10:00____ End time: __11:30____

Vulnerable (target) population (Check applicable items):
Race: _____ Majority _____ Black _____ Nat Am/PI _____ Asian _____ Am Ind _____ Multi racial/Other
Ethnicity: ___x__ Spanish/Latino
Language: ___ Linguistic minority: specify_______________________________
Economic need: ___x__ Low income elders _____ Low income minority elders
Social need: ___x__ Abused, neglected, exploited ___x__ Frail elders ___x__ Low vision
___x__ Alzheimer’s/dementia ___x__ Grandparents ___x__ Mental/behavioral
___x__ Caregiver support ___x__ Housing concerns ___x__ Mobility
___x__ Cognitive impairment ___x__ Isolated elders ___x__ Nutrition - meals
___x__ Cultural ___x__ Legal services ___x__ Rural elders
___x__ Disabled elders ___x__ LGBT ___x__ Workforce
___ Other: _______________________________________________________________

Methodology/strategy: ___Listening session____

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Nutrition, getting people to accept help
2. Economic security; people running out of retirement savings, failure to plan to retirement, need for financial planning and education
3. Mental and behavioral health: lack of sense of purpose (Life Reimagined from AARP helps with this), depression, anxiety
4. Health care: lack of local support groups for chronic disease, worry about loss of insurance
5. Transportation: flexible 1:1 transportation, regionalized transportation, Uber
6. Access to social services: fuel assistance, help affording medications
7. Social isolation
8. Personal safety: falling while alone at home
9. Health care: education on chronic disease

*If advocates/representatives, list organizations and number of elders being represented: 100’s of elders

This group of COA directors and chairpersons talked about the changing needs of elders. The session was held as part of a regular meeting agenda. They noted that more people are living into their 90’s and require more and different types of support.

12.

AAA LifePath

Date: 10/19/16

Facilitator Name: Lynne Feldman

Total Participants* 11

Location: LifePath Office, Turners Falls

Start time: 1:00

End time: 2:15

Vulnerable (target) population (Check applicable items):

Race: 

__x__ Majority ___ Black ___ Nat Am/PI ___ Asian ___ Am Ind ___ Multi racial/Other

Ethnicity: 

__x__ Spanish/Latino

Language: 

___ Linguistic minority: specify

Economic need: 

__x__ Low income elders ___ Low income minority elders

Social need: 

___ Abused, neglected, exploited ___ Frail elders ___ Low vision

___ Alzheimer’s/dementia ___ Grandparents ___ Mental/behavioral

___ Caregiver support ___ Housing concerns ___ Mobility

___ Cognitive impairment ___ Isolated elders ___ Nutrition - meals

___ Cultural ___ Legal services ___ Rural elders

__x__ Disabled elders ___ LGBT ___ Workforce

___ Other:

Methodology/strategy: Small public gathering/ Input gathering for Needs Assessment

List the needs and issues vocalized/identified:

Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Transportation*; within county, North Quabbin, shorter wait times, better coordination between agencies, door-to-door, more volunteer programs

2. Housing*, Small home repair, yard maintenance

3. Access to social assistance services; Orange senior center no longer functioning well enough make connections for elders; elder locator; Information about services

4. Language/communication barriers; translation service awareness; general service awareness and promotion

5. Staying active and wellness promotion, Exercise programs, especially for men

6. Safety and security, Privacy

7. Health care; Hospital transitions; Care Coordination; example, person missed repeat colonoscopy with a bad
outcome; she was waiting for the MD to call to tell her what to do and the MD did not follow up. Education on the right questions to ask at the doctor.

9. Housing, “truly” affordable; affordable assisted living
10. Long-term services and supports, Housework, personal care
11. Socialization opportunities; activities, shopping trips; peer counseling; counselors to visit frailest and sickest at home
12. Nutrition; Meals at senior centers, home delivered meals, cooking classes
13. Caregiver support; Caregiver outreach
14. Learning and development; Education on chronic disease
15. Economic (financial) security; Social security cost of living increases

*If advocates/representatives, list organizations and number of elders being represented:
Over 1700 persons served by LifePath

13.

AAA  LifePath ___________________________ Date: 12/15/16 and 4/20/17
Facilitator Name: Lynne Feldman ______________________ Total Participants* 12
Location: LifePath, 330 Montague City Rd. Turners Falls Start time: 2:00 End time: 2:15

Vulnerable (target) population (Check applicable items):
Race: _x__ Majority    ___ Black   ___ Nat Am/PI   ___ Asian   ___ Am Ind   ___ Multi racial/Other
Ethnicity: _x__ Spanish/Latino
Language: ___ Linguistic minority: specify__________________________
Economic need: __x_ Low income elders  ___ Low income minority elders
Social need: ___ Abused, neglected, exploited   ___ Frail elders    ___ Low vision
___ Alzheimer’s/dementia   ___ Grandparents    ___ Mental/behavioral
___ Caregiver support    ___ Housing concerns  ___ Mobility
___ Cognitive impairment   ___ Isolated elders    ___ Nutrition - meals
___ Cultural   ___ Legal services   ___ Rural elders
___ Disabled elders   ___ LGBT   ___ Workforce
___ Other:____________________

Methodology/strategy: Listening session

List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Transportation*: still a top issue, though some headway has been made. Hard for older people to get to specialist in Springfield and back.
2. Learning and development*: More need for technology support and training. Technology requirements are higher. Can’t mail the commonwealth a check for more than $5000. Hard to keep up with systems changes. Medicare. Government is always changing.

3. Economic Insecurity*: Rising costs putting stress and strain on budgets of older. Financial insecurity. HI, food, fuel. Decline in public support. Fuel assistance used to be 1500, now 350. Uncertainty of continuation of medicate and SS.


5. Home repair: Home repair and upgrade tasks–handyman services, moving air conditioners (Peter); changing light bulbs. A way for people to find adaptive equipment --children of elders would benefit from this

6. Caregiver: caregiver-specific information

7. Nutrition: Grocery shopping – volunteer matching program? Collaboration with groceries? Hannaford’s used to do shopping in the store by staff. PeaPod and Amazon Fresh—how many elders know about this and can use a computer? Market Basket has many motorized shopping carts. They may have companion shopping. Food City or Fosters may be open to a conversation.

*If advocates/representatives, list organizations and number of elders being represented:
Over 1700 persons served by LifePath

14.

AAA__LifePath_________________________________________Date: 12/5/16

Facilitator Name: Lynne Feldman__________________________Total Participants*11_________

Location: LifePath____________________________Start time: 10:00 End time: 11:15

Vulnerable (target) population (Check applicable items):
Race:    __x__ Majority    __x__ Black   __x__ Nat Am/PI  __x__ Asian   __x__Am Ind   __x__ Multi racial/Other
Ethnicity:  _x__ Spanish/Latino
Language:  __x__ Linguistic minority: specify________________ Spanish, Russian, Moldovian
Economic need: __x__ Low income elders  __x__ Low income minority elders
Social need:  __x__ Abused, neglected, exploited  __x__Frail elders  __x__ Low vision  
  __x__ Alzheimer’s/dementia  __x__ Grandparents  __x__ Mental/behavioral
  __x__ Caregiver support  __x__ Housing concerns  __x__ Mobility
  __x__ Cognitive impairment  __x__ Isolated elders  __x__ Nutrition - meals
  __x__ Cultural  __x__ Legal services  __x__ Rural elders
  __x__ Disabled elders  __x__ LGBT  __x__ Workforce

Other:

Methodology/strategy: Small public gathering; Focus Group
List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

<table>
<thead>
<tr>
<th>Need/Issue</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transportation</td>
<td></td>
</tr>
<tr>
<td>2. Maintain independence /Affordable in-home foot and hair care</td>
<td></td>
</tr>
<tr>
<td>3. Safety and security/Snow removal</td>
<td></td>
</tr>
<tr>
<td>4. Mental and behavioral health resources*</td>
<td></td>
</tr>
<tr>
<td>5. Mental and behavioral health/Substance abuse resources, especially when formal treatment ends</td>
<td></td>
</tr>
<tr>
<td>6. Social isolation /Socialization opportunities, for example daily check in or companion program</td>
<td></td>
</tr>
<tr>
<td>7. Caregiver support /Respite options, especially for middle class</td>
<td></td>
</tr>
<tr>
<td>8. Maintain independence /Adaptive equipment, especially handicap ramps</td>
<td></td>
</tr>
<tr>
<td>9. Maintain independence /Medication management</td>
<td></td>
</tr>
<tr>
<td>10. Language/communication barriers /Affordable high-speed internet</td>
<td></td>
</tr>
<tr>
<td>12. Learning and development/Technology/computer skills training</td>
<td></td>
</tr>
<tr>
<td>13. Language/communication barriers /Use of native languages on forms, brochures, and resource documents</td>
<td></td>
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<tr>
<td>14. Long-term services and supports /Paid family caregivers</td>
<td></td>
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<tr>
<td>15. Maintain independence /More workers and more diversity in workers*</td>
<td></td>
</tr>
<tr>
<td>16. Transportation/Escorted transportation</td>
<td></td>
</tr>
<tr>
<td>17. Spirituality/Home visits from ministers or transportation to church</td>
<td></td>
</tr>
</tbody>
</table>

*If advocates/representatives, list organizations and number of elders being represented:

LifePath – More than 1700 persons served by LifePath

The staff at LifePath serve all walks of elders with varying needs. The staff has noticed a few changes in the population:
1. An increase in younger seniors who are sicker and needier (feeding tubes, PIC lines), many with comorbidities, many with behavioral, mental, or substance abuse problems
2. An increase in younger seniors who have fair health, but who seek out any and all services available to them
3. An increase in minority populations

This group is alarmed at the lack of available workers. Workers can be selective about their clients in this environment, so the more rural and harder to serve clients are harder to match with workers. The staff also noted that clients wait for services while physicians’ offices take weeks or months to submit paperwork. They noted that many of the gaps mentioned (transportation, ramps, shoveling) lead to social isolation, a risk factor for other problems.

15.

AAA LifePath

Facilitator Name: Lynne Feldman

Total Participants* 4

Location: LifePath

Start time: 10:00
End time: 11:00

Vulnerable (target) population (Check applicable items):
List the needs and issues vocalized/identified:
Among the listed needs and issues identified, place an asterisk next to top three needs identified.

1. Staying active and wellness promotion: increased demand for exercise programs
2. Health Care: Seeing a need for pain management (demand for solutions/answers, more active approach)
3. Access to social assistance services: senior centers are critical; wave of people aging in to the system could create a barrier; people who have long been marginalized/living in poverty are now aging into senior services and often needing lots of services; LTC facilities become a “catch-all” for people for whom no other solution exists (substance abuse, newly out of rehab, for example); outreach for LifePath and other services is needed; we all provide resources on everything under the sun for the people we work with and this value is not captured; some people think we are only for low-income people.
4. Transportation; transportation to/from nursing homes is needed; comfort, safety, convenience, availability could all be improved upon; older people don’t feel safe/secure using the bus
5. Housing; some elders must stay in nursing homes longer than they need/want due to lack of appropriate housing; housing for medically-intensive mental illness sufferers;
6. Mental/behavioral health*; people with personality disorders or challenging behaviors can be hard to serve (match with workers, clients); younger seniors with complex mental/behavioral health needs are more common
7. Nutrition: younger seniors aren’t interested in congregate meals, may be too busy/active; other younger seniors are coming in with complex medical, financial, social issues needing home-delivered
8. Language/communication: seniors don’t answer their phones anymore because often they can be relentlessly pursued by telemarketers, scammers, which has an isolating effect as legitimate callers have trouble reaching them; increased demand for technology
9. Social isolation: outreach is critical; senior centers do this, but how healthy are senior centers?
This group of LifePath Program directors discussed the changing needs of elders they serve at a regular staff meeting.

### AAA LifePath

**Facilitator Name:** Lynne Feldman  
**Total Participants:** 187

**Date:** 12/6/16-1/12/17

**Location:** Print/Online

**Start time:**  
**End time:**

**Vulnerable (target) population (Check applicable items):**

- **Race:**
  - _x_ Majority    ___ Black   ___ Nat Am/PI   ___ Asian   ___ Am Ind   _x__ Multi racial/Other

- **Ethnicity:**
  - ___ Spanish/Latino

- **Language:**
  - _x_ Spanish

- **Economic need:**
  - _x_ Low income elders   ___ Low income minority elders

- **Social need:**
  - _x_ Abused, neglected, exploited   ___ Frail elders   ___ Low vision
  - _x_ Alzheimer’s/dementia   ___ Grandparents   ___ Mental/behavioral
  - _x_ Caregiver support   ___ Housing concerns   ___ Mobility
  - _x_ Cognitive impairment   ___ Isolated elders   ___ Nutrition - meals
  - _x_ Cultural   ___ Legal services   ___ Rural elders
  - _x_ Disabled elders   ___ LGBT   ___ Workforce
  - ___ Other: ____________________________

**Methodology/strategy:** Survey

List the needs and issues vocalized/identified:

Among the listed needs and issues identified, place an asterisk next to top three needs identified.

<table>
<thead>
<tr>
<th>1. Health*:</th>
<th>6. Transportation:</th>
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<tbody>
<tr>
<td>Hearing loss 10</td>
<td>Affording it 12</td>
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<tr>
<td>Managing chronic pain 10</td>
<td>Finding it 14</td>
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<tr>
<td>Memory loss 8</td>
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<td>Physical disability 9</td>
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<td>General health 24</td>
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<table>
<thead>
<tr>
<th>2. Economic*:</th>
<th>7. Accessing assistance:</th>
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</thead>
<tbody>
<tr>
<td>Affording copays 7</td>
<td>Fuel/heating 16</td>
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<tr>
<td>Managing your money/debt 14</td>
<td>Understanding eligibility/options 31</td>
</tr>
<tr>
<td>Tax preparation 25</td>
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</tbody>
</table>

| 3. Mental: Coping with a recent loss 7 | 8. Long-term services and supports |
### LifePath Area Plan on Aging 2018-2021

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Balance/falls 39</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Leisure:</th>
<th>10. Housing*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging in social activities 23</td>
<td>Home modification/repair/upkeep 17</td>
</tr>
<tr>
<td>Finding more affordable housing 14</td>
<td>Repairs/upkeep 38</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How old are you?</th>
<th>How many people live in your household?</th>
</tr>
</thead>
<tbody>
<tr>
<td>55-60 years old</td>
<td>1</td>
</tr>
<tr>
<td>61-70 years old</td>
<td>2</td>
</tr>
<tr>
<td>71-80 years old</td>
<td>3</td>
</tr>
<tr>
<td>81-90 years old</td>
<td>4</td>
</tr>
<tr>
<td>Over 90 years old</td>
<td>5</td>
</tr>
<tr>
<td>Under 55 years old</td>
<td>6</td>
</tr>
<tr>
<td>Grand Total</td>
<td>Grand Total 103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your household monthly income?</th>
<th>What is the primary language you speak?</th>
</tr>
</thead>
<tbody>
<tr>
<td>below $1,010</td>
<td>English 139</td>
</tr>
<tr>
<td>$1,011 - $2,199</td>
<td>Spanish 1</td>
</tr>
<tr>
<td>$2,200 - $3,300</td>
<td></td>
</tr>
<tr>
<td>$3,301 - $4,400</td>
<td></td>
</tr>
<tr>
<td>$4,401 - $5,500</td>
<td></td>
</tr>
<tr>
<td>over $5,501</td>
<td></td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>Grand Total 141</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is your gender?</th>
<th>How would you describe yourself? (Race/Ethnic Heritage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>none of the above 1</td>
</tr>
<tr>
<td>Male</td>
<td>Prefer not to answer 3</td>
</tr>
<tr>
<td></td>
<td>White 139</td>
</tr>
<tr>
<td></td>
<td>White/American Indian 1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>Grand Total 144</td>
</tr>
</tbody>
</table>

Page 80
Comments from respondents
at this point at 80 I feel good, enjoy church and related activities. Meal site when in MA. I’m able to drive & go to plays, musical events. God is good!
Expand public transportation to area towns
I actually do quite well at this moment (I have severe Rheumatoid Arthritis and receive disability income). It is rather stressful to live where I am not wanted (a former sister-in-law and her husband), but we are all holding on and waiting for my name to come up on housing. Some of what I have responded to in this survey is either current or anticipated issues. Once I am in housing, I don’t see how I will be able to live on disability income. I believe I can do some kinds of work, but only part time. I have had Oct-Dec full of medical appointments, including two cataract surgeries, in the hopes I will feel better and be in housing soon and perhaps look for part-time employment. I don’t want to sound desperate or fearful, but I have been anxious about my future and actually do feel quite alone and invisible too often, although being new to the area, I am slowly making friends and that's extremely helpful. I have just finished up meeting with a clinical psychologist since about August and feel ok to stop our sessions, knowing that I can call if I need her help. I don’t want to wait until things are desperate to begin research and understand what I need and where I might go. I also have an interest in helping others in the meanwhile. Driving in stormy/snowy condition bothers me, but I do have my own vehicle and manage fine so long as I don’t have to go out in bad weather. I also was a participant in a recent program you offered for living with chronic pain. Thank you very much.
I already have enrolled with LifePath
I foresee needing assistance as we get older and health deteriorates, particularly in my spouse's situation, and would like an idea of resources available now and, more importantly, in the years ahead. We both have conditions that will have physical impacts.
I play bridge at the Sr. Center
Keep up the good work!
loneliness is almost overwhelming
Low cost affordable housing with opportunities to live in mixed age group/ also diversify how we see aging. Its an adventure and no necessarily one of decline.
Meals at new Greenfield senior center
might use more convenient public transportation
no but thanks!
No help needed
Work to end the moratorium on installation of new gas-burning heating units! This is a huge problem when an old house has few other options.
ATTACHMENT M: BROCHURE

Information & Caregiver Resource Center (ICRC)

The ICRC is the first stop on the way to your solution. Resource Consultants help you by providing expert advice on available area programs, services, and resources. Tell us your specific needs so we can help you learn about your options.

Volunteer Opportunities

Use your skills and passion to serve our senior citizens and persons with disabilities. Meet new people and enjoy new experiences, while giving back to the community. Any number of days or hours that fit your schedule would be of help.

Giving Opportunities

We appreciate the donors who honor our mission in so many ways, from gifts to our annual appeals and community fundraisers to personal gifts and gifts in honor of loved ones. Planned gifts such as bequests and in-kind donations are needed and valued.

Support for Elders

You want to remain in the place that you love. We’ll help you stay there. Our services can help you:

- Understand and choose your care options
- Obtain in-home care and other supports
- Better manage your care with case management assistance
- And more!

"My mother-in-law had a stroke and needed a lot of care. They provided someone to be with her and got her the care she needed—the respect she deserved. She was able to stay home because of the care they gave."

Support for Caregivers

You care so wholeheartedly and do so much, but sometimes it’s hard to do it all. We’ll help you find peace of mind.

Our services can help you:

- Take a break from your caregiving duties with support for your loved one
- Learn more about providing care for your loved one as well as yourself
- Find support from other caregivers
- And more!

"You asked my father for a long time, and that helped me. It’s so wonderful that you get people to do such a kindness."

Support for People with Disabilities

You need support that meets unique needs. We’ll give you information so you can make the best choice.

Our services can help you:

- Live with a caregiver or on your own
- Receive right amount of in-home support for your needs
- Stay in your community
- And more!

"What you and the organization you work for did for me and my son goes far beyond helping someone in need. You gave us hope, like my son said, that things will get better."

Updated February 2020

Adult Family Care | Benefit Counseling | Caregiver Grants | Case Management | Community Choices | Community Nursing Facility Screening | Congregate Housing | Morgan Allen & Windsor Waverly Retirement | Consumer Directed Long-Term Care Waiver | Dementia Caregiver Support Group | Diversion Centers & Respite Château | Enhanced Community Options | Elder Protective Services | Family Caregiver Support | Generic Support Coordination | Home Care Options | The Good Life | Grandparents Raising Grandchildren Support | Healthy Living | Home Care Services | Information & Caregiver Resource Center | Long-Term Care Ombudsman | Long-Term Care Planning | Medicare Options Counseling | Personal Care Attendant | Private Care Management | Rainbow Elders | Respite Services | Rides for Health | Shared Living | SHINE: Serving the Health Insurance Needs of Everyone | Silverline Directory of Resources | Supportive Housing | Tim’s Terrace | Highland Village | Squashbush Village | Stoughton Place | Stratton Manor
## ATTACHMENT N: HEALTHY LIVING OUTCOMES FRAMEWORK AND RESULTS

<table>
<thead>
<tr>
<th>Activities &amp; Interventions</th>
<th>Outcomes</th>
<th>Outcome Indicators</th>
<th>Results to date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>End-of-Workshop:</strong> Data collection takes place during and immediately at the end of the 6-8 week workshop.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All Healthy Living Program Workshops</strong></td>
<td>Participants are satisfied with workshop content</td>
<td>#/% of participants who are satisfied with workshop content</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>Participants are satisfied with workshop leaders</td>
<td>#/% of participants who are satisfied with workshop leaders</td>
<td>100%</td>
</tr>
<tr>
<td><strong>My Life, My Health: Chronic Disease Self-Management</strong></td>
<td>Participants are more confident in management of their chronic condition.</td>
<td>#/% of participants who report greater confidence in managing their condition and/or have set goals for themselves</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>Participants have greater knowledge of their chronic condition and how to manage it.</td>
<td>#/% of participants who report greater knowledge of how to manage their condition (e.g. effective breathing, exercises, activity, eating, communication)</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Chronic Pain Self-Management</strong></td>
<td>Participants are more confident in management of their chronic pain.</td>
<td>#/% of participants who report greater confidence in managing their pain and/or have set goals for themselves</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Participants have greater knowledge of their chronic pain and how to manage it.</td>
<td>#/% of participants who report greater knowledge of how to manage their pain</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Diabetes Self-Management Program</strong></td>
<td>Participants are more confident in management of their diabetes.</td>
<td>#/% of participants who report greater confidence in managing their diabetes and/or have set goals for</td>
<td>60%</td>
</tr>
<tr>
<td>Activities &amp; Interventions</td>
<td>Outcomes</td>
<td>Outcome Indicators</td>
<td>Results to date</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------</td>
<td>--------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| **Healthy Eating for Successful Living in Older Adults** | Participants have greater understanding of what it means to have a healthy diet:  
  a) Understanding of food label reading  
  b) Awareness of nutritious diet options | #/% of participants who report greater understanding in the areas described at left | 91% |
<p>| | Participants are more confident that they can improve their health/eating habits | #/% of participants who report greater ability to improve health/eating habits | 73% |
| <strong>A Matter of Balance – Falls Prevention</strong> | Participants have less fear of falling | #/% of participants who report that they are less afraid of falling | 90% |
| <strong>All Healthy Living Program Workshops</strong> | • Participants have increased sense of wellness. | • #/% of participants who report an increased sense of wellness | Not enough data yet |
| | • Participants have increased their activity levels | • #/% of participants who report increased activity (frequency and/or duration) | Not enough data yet |
| <strong>Activities &amp; Interventions</strong> | | | |
| <strong>Outcomes</strong> | | | |
| <strong>Outcome Indicators</strong> | | | |
| <strong>Results to date</strong> | | | |</p>
<table>
<thead>
<tr>
<th>Program</th>
<th>Improvement</th>
<th>Percentage Reporting Improvement</th>
<th>Data Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Life, My Health: Chronic Disease Self-Management</td>
<td>Participants become more social/engaged in their communities</td>
<td>#/% of participants who report more active participation in social/community activities</td>
<td>Not enough data yet</td>
</tr>
<tr>
<td>Chronic Pain Self-Management</td>
<td>Participants become more social/engaged in their communities</td>
<td>#/% of participants who report more active participation in social/community activities</td>
<td>Not enough data yet</td>
</tr>
<tr>
<td>Diabetes Self-Management Program</td>
<td>Participants' A1C score has shown improvement.</td>
<td>#/% of participants who report that their' A1C score has shown improvement</td>
<td>Not enough data yet</td>
</tr>
<tr>
<td>Healthy Eating for Successful Living in Older Adults</td>
<td>Participants are practicing skills learned in the workshop learned:</td>
<td>#/% of participants who report they are practicing skills learned [see left]</td>
<td>Not enough data yet</td>
</tr>
<tr>
<td></td>
<td>a) Reading food labels more regularly</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Are making better food choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participants have made progress toward a healthy weight</td>
<td>#/% of participants who report progress toward target weight</td>
<td>Not enough data yet</td>
</tr>
<tr>
<td>A Matter of Balance – Falls Prevention</td>
<td>Participants have increased their exercise (specific to Fall Prevention workshop curriculum)</td>
<td>#/% of participants who report they are practicing exercises from the workshop</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Participants are empowered and experience less interference (from fear of falling) in normal social activities</td>
<td>#/% of participants who report that they &quot;have a plan&quot; for what to do in case of a fall; have confidence in their strength and ability to protect self</td>
<td>50%</td>
</tr>
</tbody>
</table>
ATTACHMENT O: QUALITY ASSURANCE PLAN

Introduction: LifePath, Inc. maintains a commitment to Quality Assurance and to meeting the requirements set forth by MassHealth and the Executive Office of Elder Affairs. Continuous Quality Assurance is carried out through an organized framework for improvement.

Leadership and Organization: The Management Team functions as the Continuous Quality Assurance Committee (CQAC) with guidance from the Board of Directors. The CQAC provides leadership and direction to the Continuous Quality Assurance Team (CQAT).

The Continuous Quality Assurance Team is comprised of the Director of Client Services, the Quality Assurance and Contracts Manager, and representation from the Client Services Program Directors.

Responsibilities: The CQAC reviews the Quality Assurance Plan annually and set new goals and measurable objectives for the upcoming year. The Executive Director reviews QA activities with the Board of Directors and reports outcomes and findings back to the Board of Directors on an ongoing basis. The CQAT will carry out the following responsibilities:

<table>
<thead>
<tr>
<th>QA ACTIVITIES—Part I</th>
<th>QUALITY IMPROVEMENT—Part II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construct and modify QA tools</td>
<td>Develop Quality Improvement Plan standards</td>
</tr>
<tr>
<td>Establish CQA performance measures</td>
<td>Implement Quality Improvement Plan</td>
</tr>
<tr>
<td>Develop CQA activities</td>
<td>Train staff and improve systems</td>
</tr>
<tr>
<td>Create a CQA implementation schedule</td>
<td>Evaluate Quality Improvement Plan outcomes</td>
</tr>
<tr>
<td>Determine roles and responsibilities</td>
<td>Determine next steps</td>
</tr>
<tr>
<td>Implement CQA</td>
<td>Define program impact by developing metrics and outcomes</td>
</tr>
<tr>
<td>Analyze and quantify outcomes and findings</td>
<td></td>
</tr>
<tr>
<td>Report findings to CQAC and applicable departments</td>
<td></td>
</tr>
</tbody>
</table>

Goals and Objectives: The Continuous Quality Assurance members implement the following quantitative and qualitative measurements to assess process and outcomes:

- Timeliness: Consumers are served in program- prescribed timelines
  - Measure timeframes for responding to calls
  - Measure compliance with completing assessments
  - Measure timelines for completing documentation and follow-up
  - Measure timeframes for termination of services
  - Measure wait time for the start of services and/or submission of authorizations
• Quality: Standards are maintained in the planning, implementation and recording of the provision of services and interventions
  o Evaluate information provided is up-to-date, accurate, and comprehensive
  o Observe and evaluate staff performance to ensure staff competence
  o Ensure ongoing training and professional development is provided to staff
  o Audit program assessment tools for completeness and inter-rater reliability to ensure uniformity and consistency is applied in the assessment process
  o Evaluate policies and procedures for compliance with EOEA and MassHealth guidelines
  o Review documentation for accuracy and compliance with EOEA Documentation Standards and Approved Abbreviations
  o Monitor contracted providers to ensure services are delivered as authorized
  o Monitor providers to ensure staff are properly trained and supervised
  o Monitor providers to ensure compliance with Provider Agreement and Attachment A – Service Descriptions
• Consumer Centered: Consumer feedback is collected to ensure care is meaningful, relevant, and effective in addressing Consumers needs
  o Survey Consumers regarding satisfaction with the promptness of response to calls, assessments, interventions and follow-up
  o Survey Consumers regarding quality related to the accuracy and thoroughness of the information and options provided and relevance to their needs
  o Survey Consumers regarding the courtesy and respect shown by staff
  o Survey Consumers regarding Consumer centered care planning and ability to direct their own care
  o Survey Consumers regarding quality of services provided
  o Survey Consumers regarding outcomes for maintaining independence and dignity

Implementation: LifePath utilizes standardized tools provided by EOEA, MassHealth and/or other applicable governing entity to implement the QA goals and objectives. The following tools and methods are currently utilized by the Quality Assurance & Contracts Manager and the CQAT to measure performance of LifePath staff and contracted providers:

• Reports:
  o Use of SAMS, Harmony, Explorer, and other program specific data bases’ reports to track activities, measure timeframes, collect data, evaluate budget and program capacity.
  o Provider performance reports
  o Feedback logs for complaints and compliments
• Audits
  o Assessments
  o Documentation
  o Files
• Monitoring:
  o Vendor monitoring
  o Joint monitoring
  o Field observation
Outcomes and Findings: The Quality Assurance and Contracts Manager compiles and analyzes the aggregated data to summarize and quantify the performance measure process. Analysis report will be presented to the Continuous Quality Assurance Team and Committee.

Quality Improvement Plan: The Continuous Quality Assurance Committee outlines improvement steps and solutions for implementation by the Continuous Quality Assurance Team responsible for the following functions:

- Develop strategic plan
- Prioritize identified problems
- Set goals and timeframes for resolution
- Create performance measures

Implementation of Quality Improvement Plan: Implementation of the Quality Improvement Plan requires cooperation and participation of all Client Services staff and will be the responsibility of the Continuous Quality Assurance Team:

- Share findings with staff
- Include staff in development of solutions
- Set goals and timeframes with staff
- Provide individual and group education and training
- Address concerns through supervision and evaluation
- Generate corrective action plans
- Develop policies and procedures
- Improve systems
- Increase service options (when indicated)
- Create quantifiable performance measures to evaluate outcomes

Evaluation of Quality Improvement Plan outcomes: The Quality Assurance and Contracts Manager tracks performance measure outcomes. Findings are analyzed and reported to the CQAT and CQAC and determinations are made regarding any further steps.