Idaho Commission on Aging

Brad Little, Governor | Judy B. Taylor, Director

10/24/2022

Southwest Idaho Area Agency on Aging
1505 S. Eagle Road, Ste. 120
Meridian, ID 83642

Dear Director Enriquez,

This is official acknowledgement that your Local plan substantially met all official ICOA planning standards as specified in the ICOA planning manual and mandatory training.

This an accomplishment and I congratulate you and your team. ICOA will use your plan to inform our next state plan, so the outreach and analysis you accomplished will benefit the entire state.

The planning manual has been updated with language around the local plan updates, but as the timeframe approaches, I will provide further guidance. Please don't hesitate to reach out if ICOA can provide guidance during your plan implementation.

In service together,

Judy B Taylor

Judy B Taylor
Director
Idaho Commission on Aging

Area Agency on Aging III

Planning and Service Area III (PSAIII)

Area Plan

Area Plan Dates	In Alignment with Current ICOA State Plan	Informing the Next ICOA Planning Date
October 1, 2022 - September 30, 2026	October 1, 2020 - September 30, 2024	October 1, 2024 - September 30, 2028

Area Agency on Aging *Serving Southwest Idaho*

Southwest Idaho Area Agency on Aging (SWIA3)

1505 South Eagle Road, Suite 120

Meridian ID 83642

(208)-898-7077

AREA PLANS. (IDAHO ADMINISTRATIVE PROCEDURES ACT - IDAPA 15.01.20.052) Each Area Agency on Aging (AAA) shall submit a four (4) year area plan to the Idaho Commission on Aging (ICOA) by close of business June 15, 2022. Annual updates shall be submitted by October 15 of each following year. The area plan and annual updates shall be submitted in a uniform format prescribed by ICOA to meet the requirements of the Older Americans Act and all pertinent state and federal regulations.

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Attachment A: Funding Formula

Executive Summary

On October 1, 2016, the Area 3 Senior Services Agency (A3SSA) was officially designated by the Idaho Commission on Aging (ICOA) to serve as the Southwest Idaho Area Agency on Aging (AAA) III. A3SSA is one of six AAAs located in the state of Idaho. The assumed business name for A3SSA is Southwest Idaho Area Agency on Aging or SWIA3. The SWIA3 is governed by a joint power's agreement between eight of the ten counties in the region. (Ada, Adams, Canyon, Gem, Owyhee, Payette, Valley, and Washington). The counties of Boise and Elmore are also serviced within PSAIII. The programs offered through SWIA3 are primarily offered through state and federal funds awarded through the ICOA.

The ICOA receives an annual allocation of federal funds under Title III and VII of the Older Americans Act (OAA), from the Administration for Community Living (ACL) and state funds under the Idaho Senior Services Act. The federal and state funds are then allocated to the six Idaho AAAs based on a federally approved intrastate funding formula **(Attachment A: Funding Formula).** This formula takes into account statistical data on the geographical distribution of individuals, age 60 or older, with particular attention paid to populations representing the greatest social and/or economic need. The formula projects anticipated need for services by weighing each Planning Service Area's (PSA) population segments most likely to be vulnerable and frail (i.e., individuals 75 or over 85; individuals 60 and over living in rural counties; those 65 and older living alone and/or in poverty; and minorities). Under the formula, regions of Idaho having a higher percentage of residents who are very old, poor, and/or living alone, etc. receive a higher proportion of funding to meet their expected higher service demands.

Vision

"To be the Southwest Idaho long term care resource hub that provides reliable and accessible information."

SWIA3's main responsibilities are:

- To serve as an advocate and focal point for older individuals within the community.
- To enter arrangements and coordinate with organizations that have proven record of providing services to older individuals.
- To make use of trained volunteers in providing direct services delivered to older individuals
- To establish an advisory council consisting of older individuals who are participants or are eligible to participate in programs.
- To coordinate with the State Unit on Aging to increase public awareness of elder abuse, neglect, and exploitation.
- To facilitate an area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings.

The SWIA3 is required to submit a four-year, Area Plan to the ICOA, and provide annual updates thereafter. This Area Pan is in effect from October 1, 2022 through September 30, 2026 and includes planning efforts and data analysis used within the course of its development. The Area Plan identifies goals, objectives, and strategies to improve the delivery of senior services. Furthermore, the area plan identifies performance measures, and sets baselines and benchmarks to evaluate efficacy and quality of the services being delivered. This Area Plan also identifies community partners who will collaboratively help the SWIA3 to reach its goals, identify needed changes, and help overcome service barriers. SWIA3 is required to periodically re-evaluate this Area Plan to identify and address gaps in services hence, this document may seem to be an "evolving," dynamic plan, with the potential to grow and change in response to the needs of the population SWIA3 exists to serve.

The SWIA3 staff, Board of Commissioners, and Advisory Council will utilize the Area Plan as a planning guide and will make every effort to complete the agreed upon strategies. We respectfully submit this four-year Area Plan on behalf of the seniors and vulnerable adults living in our 10-county region and appreciate the efforts of the organizations and individuals that assisted in the development of this Area Plan.

SWIA3 adopts the goals established by the ICOA's State Plan. These goals are divided into to three program categories, Universal, Targeted and Crisis programs. Below are these goals, followed by program objectives.

Universal Programs

- *Goal: Invest in Healthy Aging*
  - *To access reliable and trustworthy information, services and supports*
  - *To stay active in the community*
  - *To plan for our own independent living need*

Targeted Programs

- *Goal: Preventing Institutionalization*
  - *To live as independently as possible*
  - *To choose our own caregiver*
  - *To provide caregiver training and resources*

Crisis Services

- *Goal: Preserving Rights and Safety*
  - *To live without abuse, neglect, and exploitation*
  - *To live with dignity*
  - *To make our own choices*

ICOA Planning Course

The SWIA3 Executive Director successfully completed all planning modules as required in the ICOA Area Planning Manual. SWIA3 incorporated the 6 planning phases into its Area Plan.

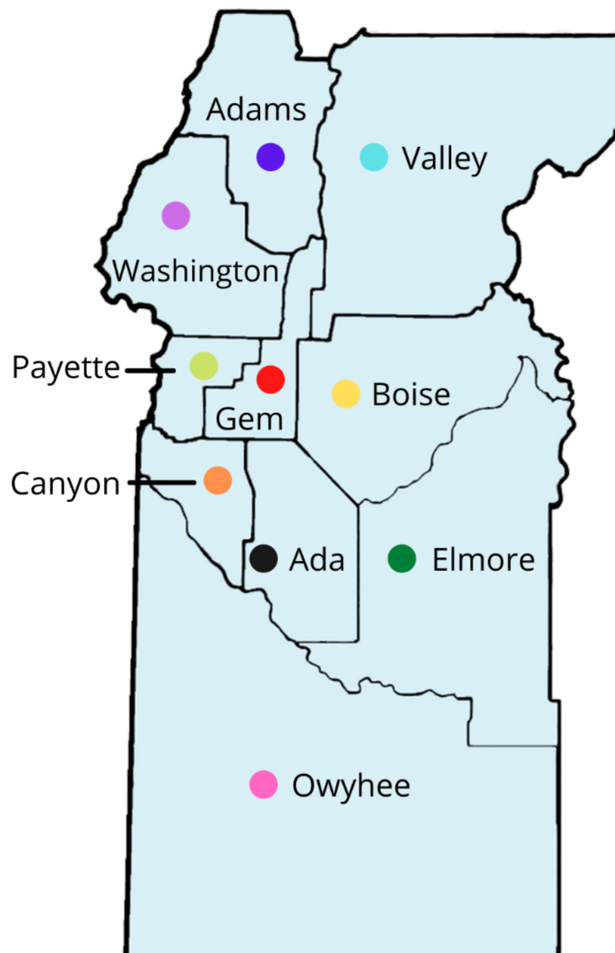
- Phase 1: Planning an Organization
- Phase 2: Environmental Analysis
- Phase 3: Identifying Opportunities
- Phase 4: Strategic Planning
- Phase 5: Strategy Execution
- Phase 6: Continuous Quality

SWIA3 staff utilized various planning tools in the development of the Area Plan. Some of these tools include.

- Article: Building a High-Performance Structure
- Video: Gantt Chart Development
- Work Sheet: SWOT Analysis
- Tip Sheets: Mission, Vision, and Value Statements
- Video: Smart Goals

Map of PSA Boundaries

Southwest Area Agency on Aging



Community Focal Points

- SWIA3
- Council Senior Center
- Boise Basin Senior Center
- Nampa Senior Center
- Metro Community Services
- Mountain Home Senior Center
- Gem County Senior Center
- Homedale Senior Center
- Payette Senior Center
- McCall Senior Center
- Weiser Activity Center for Seniors

1505 S Eagle Rd, Ste 120 | Meridian ID 83642
T 208.898.7060 | Toll Free 1.844.850.2883 | F 208.855.2608

Attestation of Compliance with OAA and Area Plan Assurances

The Area Plan on Aging is hereby submitted for Planning and Service Area III for the period October 22 – September 26. We acknowledge and assume full authority to develop and administer the Area Plan in accordance with Older Americans Act, as amended during the period identified, and related State rules and regulations. In accepting this authority, We assume major responsibility to develop and administer the Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older people in our planning and service area.

By our signatures we further attest:

We have read and understand the AAA obligations and responsibilities required to meet the Sec. 306 of the OAA.
We have developed a plan to serve older individuals who have greatest economic need, individuals who have greatest social need, individuals at risk for institutional placement and respond to the requirements of Sec. 306 of the OAA.
The AAA will comply with OAA rules and regulations through:

- AAA submission and ICOA approval of this plan and all attachments.
- AAA submission and ICOA approved budget.
- AAA submission of records required to verify compliance including contracts, forms, and other documents as requested by ICOA.
- Fidelity to ICOA published manuals, policies, official guidance, and education.

The AAA has systems and processes in place to ensure ongoing compliance throughout the plan timeframe.
The AAA will commit to data integrity and quality to ensure OAA service delivery is accurately tracked and monitored in fulfillment of this plan.

Representative from Parent Organization:	**Area Agency on Aging Representative**
[signature], 8/31/22 Kelly Aberasturi, SWIA3 Board Chair	[signature]; 8/31/22 Raul Enriquez, SWIA3 Executive Director
Representative from the Advisory Council	**Appointed Commissioner**
[signature]; 9-2-22 Karin Hoffer, SWIA3 Advisory Council Chair	[signature] 8-9-22

Section 1: Planning and Organization

Area Plan Submission Timeline

Stakeholders	Meeting Date	Meeting/Activity Topic
Advisory Council Meeting	October 26, 2020	Area Plan Requirements, Timelines
Board Meeting	October 28, 2020	
Universal Steering Committee	February 4, 2021	Universal Programs SWOT
Targeted Steering Committee	February 25, 2021	Targeted Programs SWOT
Crisis Steering Committee	March 4, 2021	Crisis Programs SWOT
Advisory Council	June 18, 2021	Steering Committee SWOT Results
SWIA3 All Staff	July 8, 2021	SWOT Analysis, Mission Statement
Advisory Council	October 15, 2021	Vision and Mission Statement, Outreach Plan
SWIA3 Staff SWOT Analysis	January 10, 2022	Internal SWOT Survey
Advisory Council	December 17, 2022	Focal Point Designation, Environmental Analysis,
Needs Assessment Survey	November 22, 2021- January 31, 2022	Needs Assessment Survey
Needs Assessment Survey Public Ad	January 9, 2022-January 10, 2022	Needs Assessment Survey
Weiser Senior Center	April 26, 2022	Public Meeting
Area Plan Public Comment	May 2, 2022 to May 20, 2022	Area Plan Public Comment
Weiser Senior Center	April 26, 2022	Public Meeting
Mountain Home Senior Center	May 4, 2022	Public Meeting
Dick Eardley Senior Center	May 9, 2022	Public Meeting
McCall Senior Center	May 10, 2022	Public Meeting
Advisory Council Meeting	May 27, 2022	Approval
Board Meeting Approval	June 1, 2022	Board Approval
Area Plan Submission	June 6, 2022	Area Plan Submission

Stakeholder Plan/Table

The following SWIA3 Board Members participated in the development and approval of the Area Plan. Furthermore, the board designates the eleven local community focal points presented in this Area Plan. The members will be responsible to review and approve any subsequent Area Plan updates.

SWIA3 Board Members:

- Kelly Aberasturi, Owyhee County Commissioner – Board Chair
- Nate Marvin, Washington County Commissioner – Board Vice Chair
- Reece Hrizuk, Payette County Commissioner- Member
- Pam White, Canyon County Commissioner – Member
- Kendra Kenyon, Ada County Commissioner – Member
- Viki Purdy, Adams County Commissioner – Member
- Mark Rekow, Gem County Commissioner – Member
- Dave Bingaman, Valley County Commissioner – Member

Advisory Council Members:	
• Karin Hoffer, Chair • Grant Jones, Vice Chair • Kristen Tracy, Secretary • Kelly Aberasturi • Debra Mueller • Liz Mummey • Mary Therese Bruno-Mlot	• Lennie Elfering • Kristin Meyer • Susan Goudie-Adams • Kelli Badesheim • Pam Oliason • Melissa Radloff (Member at Large) • Sonjia Yates (Member at Large)

SWIA3 Area Plan Steering Committees:

Program	Name	Organization
Universal Services Group		
Congregate	Grant Jones, Director	Metro Community Services/Advisory Council
Information and Assistance	Rickie Sautebin, Options Counselor	SWIA3
Information and Assistance	Jeremy Maxand, Director	LINC - Living Independence Network Corporation
Outreach and Education	Dolly Baughman, Consumer	Advisory Council Member
Health Promotions	Natalie Nathan, Special Projects Manager	SWIA 3
Senior Medicare Patrol (SMP)	Esmeralda Zamora, ID SMP and Medicare improvements for Patients and Providers (MIPPA) Program Coordinator	Metro Community Services
Dementia Capable	Amy Leavitt, Lead Navigator	Alzheimer's Association
Planning and Coordination	Kelly Aberasturi, SWIA3 Board Member	Owyhee County Commissioner/Advisory Council
Planning and Coordination	Karin Hoffer, Consumer	Advisory Council Chair
Targeted Services Group		
Home Delivered Meals	Julie Warwick, HDM Coordinator	Caldwell MOW
Nutritional Supplemental Incentive Program	Brandi Waselewski, Contracts/Fiscal Manager	SWIA3
Homemaker	John O'Keefe, Business Owner	Havenwood
Chore	Krista Kramer, Finance Program Coordinator	Idaho Assistive Technology
Senior Transportation	Kelli Badesheim, Executive Director	Valley Regional Transit

Family Caregiver Support Program	Melissa Radloff, Program Director	Jannus
Family Caregiver Support Program	Sarah Toevs, Professor, Department of Community and Environmental Health	Boise State University
Lifespan Respite Project	Julie Torresani, Lifespan Respite Coordinator	SWIA3
Senior Community Service Employment Program	Michelle Miller, SCSEP - Senior Community Service Employment Program	Goodwill Inc.
Medicare Improvement for Patients and Providers Act	Kristen Tracy, Gov't Programs Engagement Manager	Blue Cross/Advisory Council
Commodity Supplement Food Program	Jaime Hanson, Director of Programs & Partnerships	Idaho Food Bank
Minority Group Outreach	Liz Mummey, Consumer	Advisory Council
Veteran's Outreach	Debra Mueller, VHA Section Chief	Veterans Administration
Crisis Services Group		
Ombudsman	Stephanie Persinger, LTC Ombudsman	SWIA3
Ombudsman Volunteer	Judy Drury, LTC Ombudsman	SWIA3
Ombudsman Volunteer	Kurt Lyles, LTC Ombudsman	SWIA3
Legal Assistance	Rachel Piscette, Staff Attorney	Idaho Legal Aid
Adult Protective Services	Chris Parish, APS Supervisor	SWIA3
Adult Protective Services	Lana McCullough, Consumer	Advisory Council/NFJC
Adult Protective Services	Tanner Stellmon, Attorney	Ada County Prosecutor Office
Adult Protective Services	Sgt Strolberg, Police Officer	Meridian Police Department
Advocacy and Rights	Angela Eandi, DRI Staff	Disability Rights Idaho
Advocacy and Rights	Lorraine Elfering, Consumer	Advisory Council
Ombudsman Licensing and Certification	Jaime Simpson, Supervisor	Health and Welfare Licensing and Certification

Community Focal Points (CFR 45, Subpart C; 1321.53 (c)):

The SWIA3 board designates eleven community focal points located in each county. SWIA3 defines communities as counties as required by CFR 45, Subpart C; 1321.53(c). The criteria utilized to select community focal points were the highest number of congregate meal participants in the county and the number of social activities offered. All senior center providers have agreed under contract to participate in the development of community focal points. SWIA3 will identify resources to support the work of community focal points. Resources at minimum will include technical guidance, marketing materials, advertising on website and social media. The criteria for community focal points are as follows:

- Assure access to general information and OAA services
- Designated by Elected Community Officials
- Maximize Collocation and Coordination of Services
- Special Consideration of Senior Centers

Responsibilities of community focal points:

- Provide SWIA3 information at congregate meal sites
- Participate in program sign up day
- Host a Chronic Disease Self-Management Program workshop
- Promote media campaigns (e.g., Senior Nutrition Month, or National Family Caregiver Month)
- Provide at minimum two social activity or health promotion related events monthly.

Community Focal Points Designated

- Southwest Idaho Area Agency on Aging- (Ada County)
- Council Senior Center- (Adams County)
- Boise Basin Senior Center- (Boise County)
- Nampa Senior Center- (Canyon County)
- Mountain Home Senior Center- (Elmore County)
- Gem County Senior Center- (Gem County)
- Homedale Senior Center- (Owyhee County)
- Payette Senior Center- (Payette County)
- McCall Senior Center- (Valley County)
- Weiser Activity Center for Seniors- (Washington County)
- Metro Community Services- (Canyon County)

Prioritizing individuals at risk for institutionalization:

SWIA3 Staff, Board, Steering Committee, and the Advisory Council recognize the importance to serve individuals that are the most vulnerable. During stakeholder meetings, special consideration was given to individuals residing in rural areas, low-income, minorities, people with severe disabilities, limited English proficiency and people living with dementia. Meetings entailed service and demographic reports of individuals within this population. Topics included the growing senior population of seniors in rural areas and the low participation rate of Hispanics participating SWIA3 services.

Strategies were established to ensure SWIA3 prioritizes the population most in need. Those strategies are as follows. (See Section 4: Goals and Strategies, pg. 38)

Idahoans 65 & older living in poverty

- Share low-income program resource options to consumers during I&A calls and outreach events. (Universal Programs Strategy 1.2)

Idahoans 65 and older living in rural counties

- One outreach presentation and program sign up day at each designated focal point/year. (Universal Programs Strategy 1.1)
- Increase Consumer Direct Respite participation in rural areas (Targeted Programs Strategy 1.1)

Idahoans 65 and older that are low-income minority individuals with limited English proficiency

- Increase home delivered meals/homemaker participation among low-income minority individuals. (Targeted Programs Strategy 3.1)

Older individuals 75

- Provide targeted outreach to counties with the highest rate of individuals over the age of 75. (Universal Programs Strategy 1.5)

Idahoans 65 and older and are Native Americans

- Collaborate with Native American groups located in the PSA region to promote MIPPA materials (Universal Programs Strategy 4.2)

Idahoans 65 and older living with severe disabilities

- Streamline referrals between SWIA3 and LINC (Universal Programs Strategy 1.3)

Section 2: Environmental Analysis

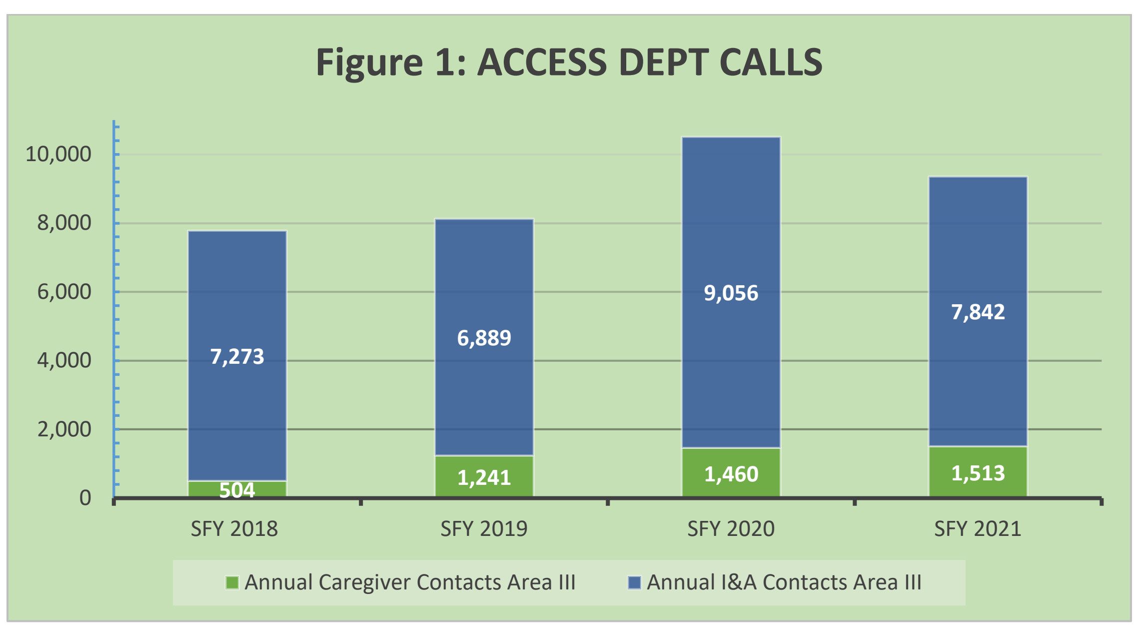
Anticipated Trends:

Process of research and analysis

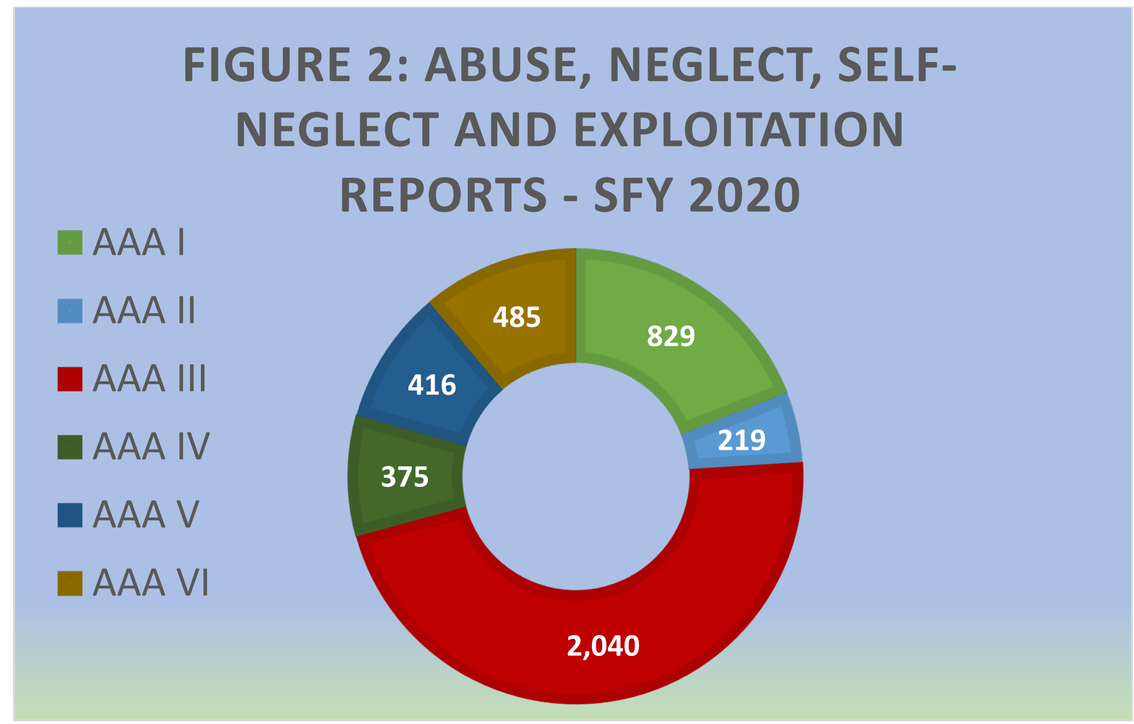
This Area Plan was developed utilizing four evaluation tools. 1. System Reports (GetCare reports); 2. Census Projections; 3. ICOA and SWIA3 Needs Assessment Surveys. 4. Internal and External SWOT analysis.

1. **System Reports:** A review of system reports was conducted to evaluate service utilization over the past several years and to determine if a gap service was not being provided.
   The following is a summary of our system reports evaluation:
   - **Information and Assistance:** 15% overall increase in calls between SFY 19 to SFY20. **(See Figure 1)**
   - **Caregiver programs:** I&A caregiver contacts have increased from 1,241 calls to 1,513 calls from SFY19 to SFY21. Increase to respite services from 6,430 to 11,610 from SFY19 to SFY20. Additional supplemental services (home modifications, assistive technologies, emergency response systems and

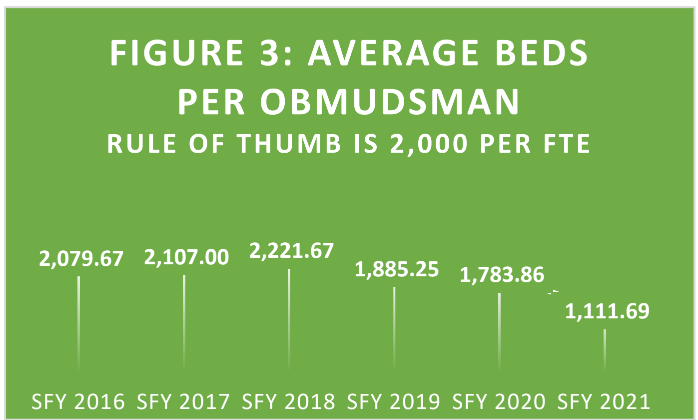
incontinence supplies) for caregiver programs, have not been developed. **(See Figure 1)**

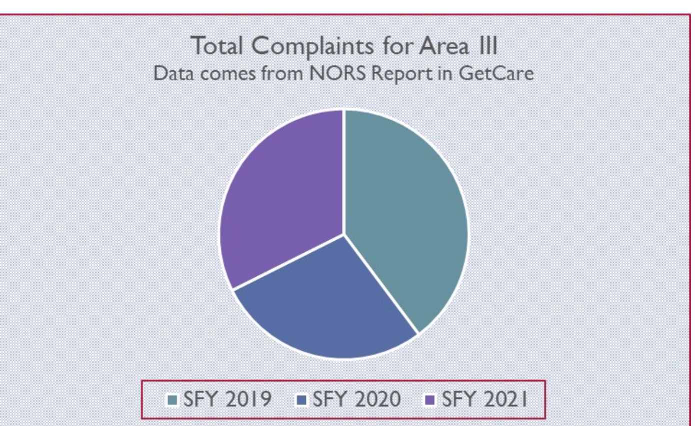


- **Adult Protection:** SWIA3 (one of six Area Agencies on Aging) substantiated 37% of the cases statewide. Increase of reports to Adult Protection increased from 1,911 to 2,266 between SFY19 to SFY21. **(See Figure 2)**



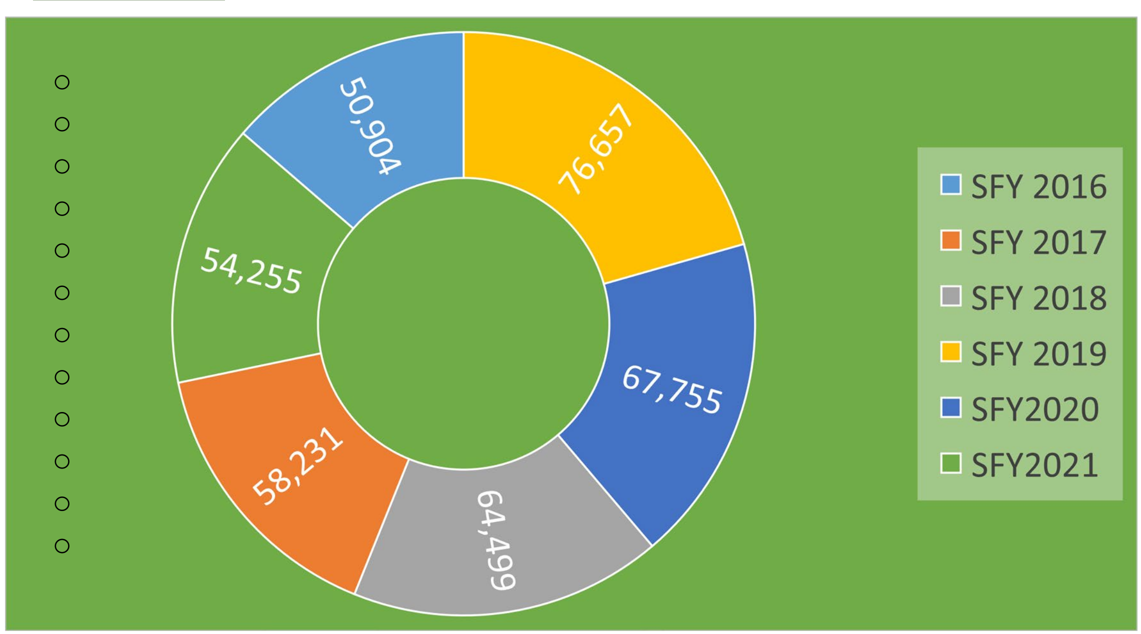
- **Ombudsman:** Two of the highest complaints are non-compliant facility discharges and poor medication management **(See Figure 3)**



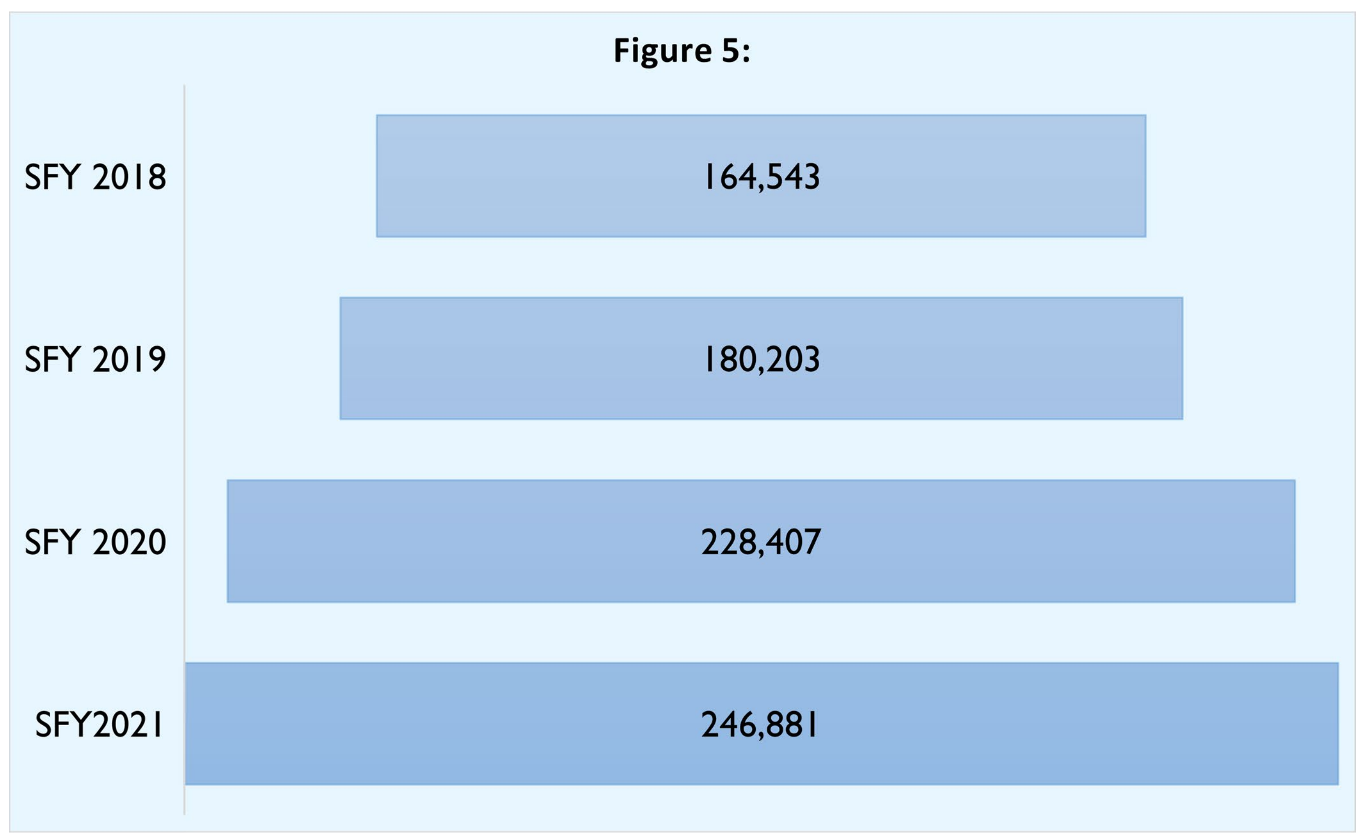


- **Transportation:** The utilization of transportation has slowly decreased over the past year due to COVID-19 restrictions. In SFY20 transportation boardings were at 67,755, these numbers dropped to 54,255 boardings in SFY21. SWIA3 projects these numbers to increase as COVID-19 restrictions are removed. **(See Figure 4)**

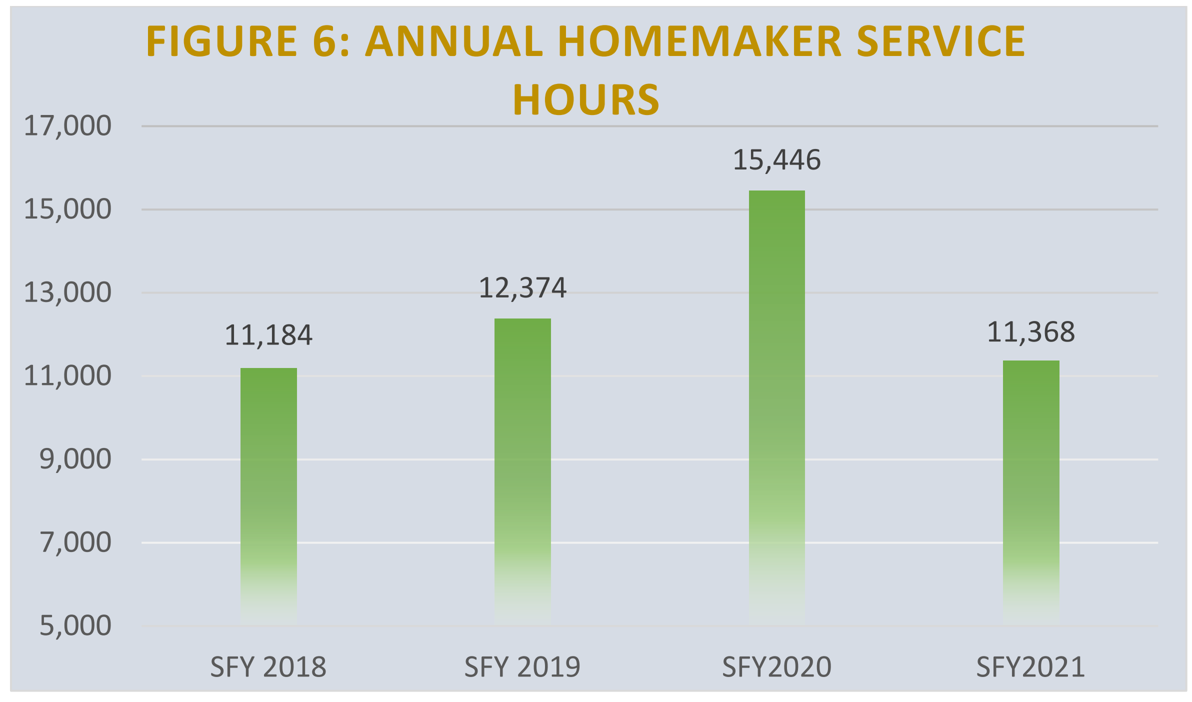
Figure 4:



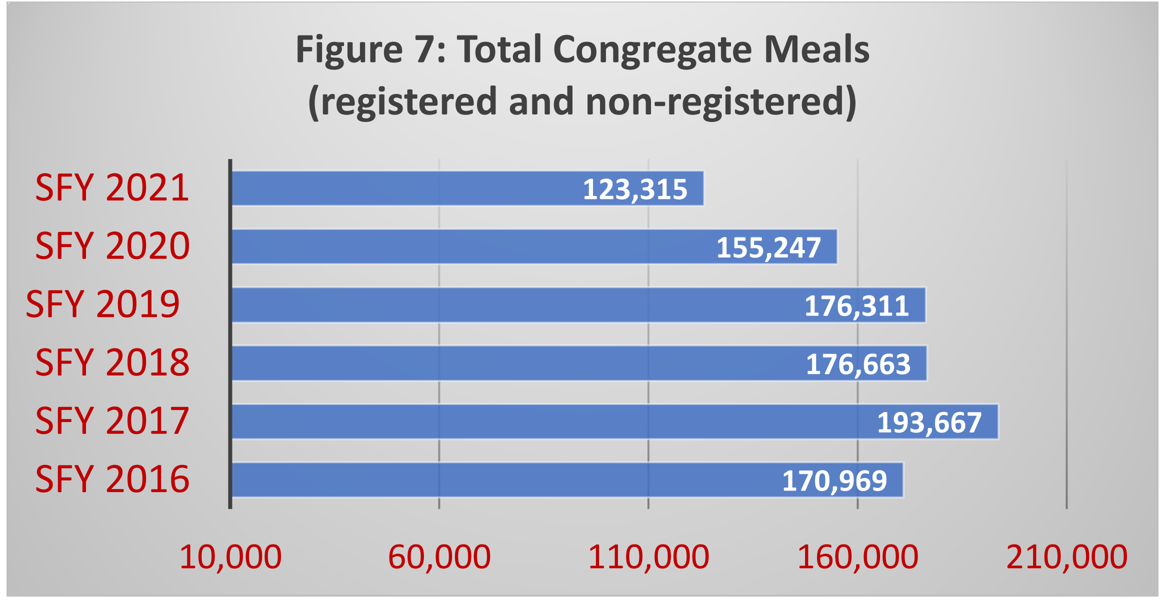
- **Home Delivered Meals:** Home delivered meals has increased from 180,203 meals delivered in SFY19 to 246,881 meals in SFY21. SWIA3 continues to see low participation rates in Hispanics participating in the program. **(See Figure 5)**



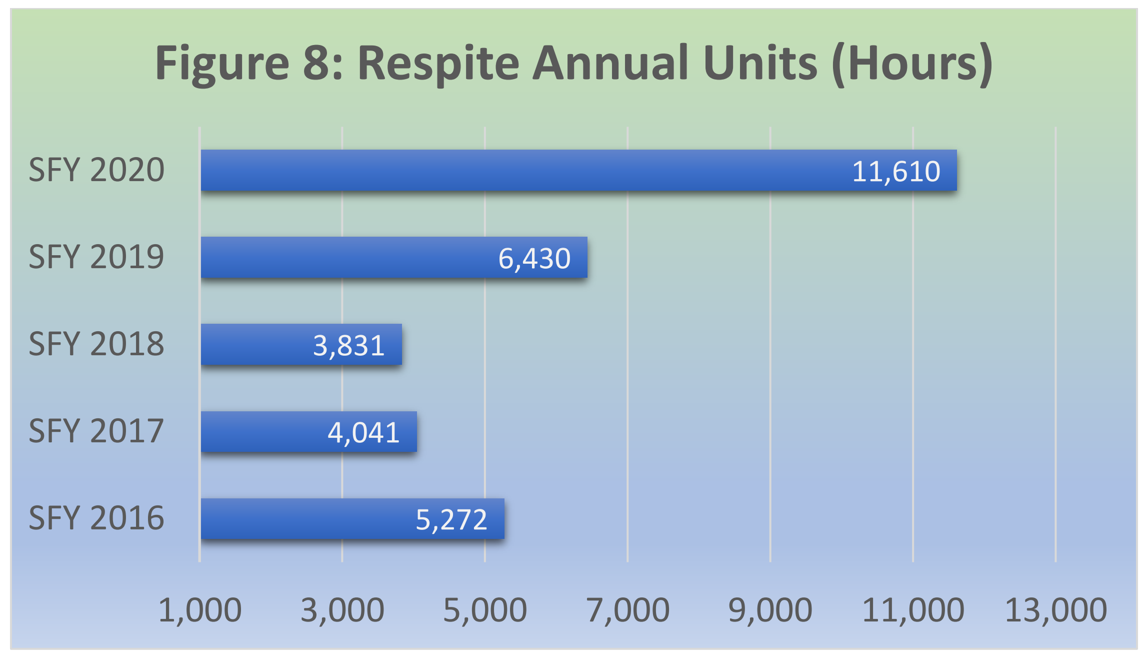
- **Homemaker:** Currently, there are close to 100 consumers waiting for homemaker services. The waitlist is a result of providers unable to find staff interested in working for home health companies. SWIA3 continues to see low participation rates in Hispanics participating in the program. **(See Figure 6)**



- **Congregate Meals:** There has been a decline in service utilization due to COVID-19 concerns. The utilization dropped from 176,311 (SFY19) to 155,247 (SFY20). SWIA3 continues to see low participation rates in Hispanics participating in the program. **(See Figure 7)**



- **Respite:** Significant increase in the utilization of respite between SFY 16 to SFY 20. **(See Figure 8)**



Other:

- **Case Management:** SWIA3 has recorded 0 units of case management since 2016, despite the growing need of seniors looking for service coordination.
- **Chore:** SWIA3 has recorded 0 units of chore since 2017. Despite the growing need for this program.

2. **Review of Census and Projections**: SWIA3 evaluated census projections to determine growing population trends in the region. The following is a summary of these projections.
    - Overall, there has been a 15% increase in seniors living in PSAIII. In, 2019 the total population of PSAIII was at 765,035 with 153,193 over the age of 60 (20% of the population). Three years later, in 2022 total population of the PSAIII region increased to 826,544. The current number of individuals that are 60 and older living in the region are 176,345 (28.55% of the population).
    - The demographic of rural seniors has shown remarkable growth, starting at 28,713 seniors living in rural areas in 2019 to a 60% growth at 46,023.
    - There has been almost a 27% increase of minority seniors living in PSAIII. Starting at 5,567 in 2019 to 6,948 in 2022. **(See Figure 9)**

Figure 9:

State Fiscal Year	TOTAL PSA POPULATION	TOTAL PERSONS AGED 60+ IN PSA	Factors used in Weighted Elderly Population (At Risk)							Total Weighted Factors
			NUMBER OF 65+ LIVING IN POVERT	65+ LIVING ALONE	60+ RACIAL MINORITY (Not Hispanic)	60+ HISPANIC (ETHNIC MINORITY)	60+ LIVING IN RURAL COUNTY	AGED 75+	AGED 85+	
2019	765,035	153,193	9,926	25,260	5,567	7,272	28,713	42,110	11,997	130,845
2020	784,838	159,951	10,340	26,711	5,970	7,924	29,559	43,502	11,926	135,932
2021	806,688	168,188	10,519	27,913	5,833	8,539	30,813	46,493	12,259	142,369
2022	826,544	176,345	10,266	29,275	6,948	9,224	46,023	49,203	12,508	163,447
Growth	**8%**	**15%**	**3%**	**16%**	**25%**	**27%**	**60%**	**17%**	**4%**	**25%**
n	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Notes RE Calculations and Sources

The source documentation is from the ID Dept. of Labor.

Column Source: U.S. Bureau of the Census,, 2010-2014 American Community Survey 5-
Column used as a reference only.

Column Source: U.S. Bureau of the Census,, 2010-2014 American Community Survey 5-
Column used as a reference only.

Column Source: U.S. Bureau of the Census, American Community Survey,2006-2013, 5-
Column 3 is used with columns 4 - 9 to calculate the total "Weighted Elderly

Column Source: U.S. Bureau of the Census, American Community Survey,2006-2013, 5-
Column 4 is used with columns 3 and 5 - 9 to calculate the total "Weighted Elderly

Column Source: U.S. Bureau of the Census, Population Estimates - County Characteristics:
Column 5 is used with columns 3 - 4 and 6 - 9 to calculate the total "Weighted

Column Source: U.S. Bureau of the Census, Population Estimates - County Characteristics:
Column 6 is used with columns 3 - 5 and 7 - 9 to calculate the total "Weighted

Column Source: U.S. Bureau of the Census,, 2010-2014 American Community Survey 5-
Column 7 is used with columns 3 - 6 and 8 - 9 to calculate the total "Weighted

Column Source: U.S. Bureau of the Census,, 2010-2014 American Community Survey 5-
Column 8 is used with columns 3 - 7 and 9 to calculate the total "Weighted Elderly

Column Source: U.S. Bureau of the Census,, 2010-2014 American Community Survey 5-
Column 9 is used with columns 3 - 8 to calculate the total "Weighted Elderly

Column Column 10 sums each row for columns 3 - 9 and identify the total "Weighted Elderly

3. **ICOA and SWIA3 Needs Assessment Surveys:** SWIA3 used the 2020 needs assessment conducted by ICOA as a part of their environmental analysis. Furthermore, SWIA3 conducted its own needs assessment to identify gaps for strategic development. The recommendations from both assessments are as follows:
    - ICOA Needs Assessment
        - Homemaker and Chore: 52% reported a problem with home maintenance and 45% with housework.
        - Nutrition Services: 25% percent of survey respondents identified having issues with access to nutritious meals.
        - Caregiver, Respite Services, and Case Management: A significant portion of patients discharged from hospitals did not get released to home health agencies. This signifies people are discharged from the hospital with no supports in place.
        - Emotional Health/Social Isolation: 38% of respondents reported loneliness, depression, and isolation.
    - SWIA3 Needs Assessment
        - Homemaker and Chore: Homemaker and chore was identified as the top two needed service. 24% of the respondents reported needing assistance with housekeeping and 23% stated needing some type of chore service.
        - Caregiver Service: 32% of the respondents stated they provide 40 hours or more caring for another person(s). 12% of caregivers reported needing help with home modifications and needing caregiver training. 11% stated needing respite care.
        - Transportation: 15% of the respondents stated they utilize Senior Center transportation services. 19% of respondents stated they must rely on others for transportation and cited weather as the top reason for having trouble with transportation.
        - Technology: 75% of respondents stated they send and receive emails. 71% stated they use the internet for information.

Internal and External SWOT Analysis:

SWOT Analysis Process:

- External Process: SWIA3 facilitated three workgroups made up of representatives of each Area Plan service. These workgroups were separated in the three-area plan service categories; Universal, Targeted and Crisis. During these meetings, an overview of the programs were provided along with performance reports. Members were then provided an opportunity to share feedback and identify strengths, weaknesses, opportunities, and threats. SWIA3 compiled the results and provided each member with a summary of the SWOT results.
- Internal Process: SWOT surveys were distributed to the thirty-five employees to provide front line staff the opportunity to provide input on programs and provide recommendations to improve services. Comments were grouped and then summarized and sent out to the staff for final comment.

Figure 10

	Internal Influences		External Influences	
	Strength	Weaknesses	Opportunities	Threats
Staff	• Knowledgeable Staff • Ingenuity of Staff • Team Collaboration	• Staff Pay/Benefits • Staff turnover • Limited Rules and Regs	• New Engaged Partnerships • Program Development • Consumer Direct Services	• Limited Provider Staffing • Growing Population • Pandemic Impacts
Universal Stakeholders	• Senior Centers Partnership • Resource for Information • SWIA3 Community Partnerships • Devoted Staff	• Senior Center Stigma • Senior Center Capacity • Rural Area Broadband • Loss of fundraising during the pandemic	• Collaborate on updating resources. (211 & Linc) • Innovative ways to provide outreach. • Enhance partnerships • Increase in population	• Complacency • Poor communication with partners • Not planning with other organizations
Targeted Stakeholders	• Innovative approaches to transportation and other programs • Implementing Consumer Direct Services	• Low transportation provider reimbursement • Lack caregiver program development • Low minority participation	• Coordinate transportation programs • Leverage technology • Collaborate with other org to serve Hispanics • Consumer Direct services	• Limited funding • Uncertainty of the pandemic impacts • Volunteering is on the decline • Limited translated materials
Crisis Stakeholders	• Collaboration with other organizations • Devoted staff • Focused Care Coordination • Reporting Systems	• Staff Retention • Lack of information on powers of attorney • Rules and Regs Interpretation	• Additional funding • Partnerships • Marketing potential • New evaluation tools	• Growing population • Siloed systems • Lack of guardianships

External and Internal SWOT results:

- Universal Services Steering Committee Recommendations
    - Work with Senior Centers to combat social isolation
    - Collaborate with providers to identify solutions for low staffing
    - Enhance outreach and marketing efforts to reach seniors and caregivers
    - Pursuit additional resources to respond to the demographic growth
- Targeted Services Stakeholder Recommendations
    - Explore Innovative projects to providing transportation
    - Development of caregiver support programs
    - Expand the utilization of homemaker and chore services
    - Develop targeted marketing campaigns to reach Hispanics
- Crisis Services Stakeholder Recommendations
    - Strengthen collaboration between staff and organizations
    - Address SWIA3 Staffing turnover and shortages
    - Provide training on least restrictive decision making
    - Provide trainings to organization on APS rules and regulations

Program development and the response to SWOT challenges

The SWOT activities conducted by staff and stakeholders, did identify upcoming challenges in the implementation of the Area Plan objectives. SWIA3 will provide quarterly Area Plan updates to the advisory council, SWIA3 Board, leadership quarterly meetings and ICOA commissioner meeting reports.

These challenges and the SWIA3's ability to respond are outlined below.

Challenge #1: Limited provider and agency staffing: SWIA3 has limited influence on Idaho's workforce to mitigate this challenge. Due to limited funding, SWIA3 is unable to compete with the average private pay reimbursement rate ($30+) for in home homemaker services. Currently, SWIA3's reimbursement rate for in-home care is at $22.00 per hour. Other staffing issues are recruitment and retention of highly trained staff and providing staff with competing salaries and benefits. SWIA3 will be able to emphasize and expand consumer direct services, which allows consumers to hire their own care. We have found that this model allows consumers to negotiate more hours, and in some cases, half the cost. SWIA3 will look at other benefit options to help with employee staffing. Such as, flex scheduling and remote work.

Challenge #2: Growing demographic and increase in demand for services: The growing population of seniors does put an increasing demand on services. The Intrastate Funding Formula does apply specific indicators to provide more funding with AAA regions experiencing growth within certain demographic senior population. However, the overall funding growth rate is not proportional to population growth. SWIA3 recognizes, it will need to prioritize senior services to individuals that meet high risk for institutional placement.

Challenge #3: Uncertainty of the COVID-19 impacts and the increase (or decrease) of infection rates: Currently, SWIA3 region is seeing low transmission rate of COVID-19. We have seen an

increase in need for socialization and the residual impacts of social isolation. Discussions with stakeholders and with survey respondents, does indicate a need for social activities for improved mental health. SWIA3 is prepared to respond to increases and decreases in infection rates. Examples of strategies to respond to increased infection rates are, remote work for staff, curbside services at senior centers, friendly calling to combat social isolation, food box deliveries and vaccine promotion.

Challenge #4: Long Term Care Services are siloed, lack of communication between providers: SWIA3 believes in the No Wrong Door approach to improve access to services. Our agency mission is "to be the Southwest Idaho long term care resource hub that provides reliable and accessible information." The SWIA3 Area Plan incorporates specific strategies that we believe will improve access for the people we serve. Examples of these strategies include, improve referral process, program sign up days at senior centers, coordination of in-services and formulizing partnerships through Memorandum's of Understanding (MOU's).

SWOT Education Plan to Mitigate threats and Weaknesses:

We understand that during the implementation of this plan we will experience threats and barriers of many kinds. We will continue to capitalize on the ingenuity of the staff by providing opportunities to share ideas on ways to improve and leadership training to staff and stakeholders. Below are strategies we will use to address threats and barriers in a solution based and positive manner.

1. **Establish a solution-based work culture through inspiration and training:** We will inspire the staff to think outside the box when confronted with threats and barriers. This will be accomplished by praising staff that come up with new ideas to improve processes. Continually review the mission, vision, and value statements to ensure all staff know the direction of the organization. The recognition of staff will be incorporated into our new performance review system. Monthly leadership meetings are established to provide training, allow opportunities to brainstorm and discuss solutions to threats and barriers.
2. **Provide transparent communication and reporting to leadership, providers, and stakeholders**: We will provide both good and bad reports on area plan goals. We will not only highlight the good things that are going on with area plan strategies but also point out threats and barriers as they arise. We will provide a safe place during stakeholder and staff meetings to ensure all ideas are considered. Ideas will be written down and prioritized based on the consensus of the group. We are willing to hire an external mediator or seek out guidance from ICOA program staff to mediate internal and external barriers.
3. **Encourage humility among the leadership team to ensure we are open to new ideas and opportunities:** Among the SWIA3 leadership we believe that the effectiveness of the strategy depends on team departments and not solely on the supervisor/manager. Leaders are expected to get team input periodically and assess periodically the needs of their staff. This fosters an environment of open sharing and ensure we capture good ideas from front line staff. This will also help us to assess and respond to area plan

strategy threats. We will continue to use the SWOT process and surveys to obtain input from both staff, providers, and stakeholders.

4. **Provide leadership with ongoing professional development:** We will pursuit ongoing trainings for leadership staff and advisory council that is solution oriented. Leadership will be evaluated based on problem solving abilities, initiative, and their positivity. We will also expose solution-based training for advisory council members. We intend on taking the business acumen course provided by UsAging.
5. **Stay connected to national initiatives:** We will stay connected to national initiatives and seek out input from other states to learn of best practices and improve programs. We will attend the UsAging conference every year to learn from other states and to network with other AAAs.

Section 3: Identified Opportunities

Planning and Outreach Activities

SWIA3 Community Needs Assessment: SWIA3 released a community needs assessment survey from December 2, 2021 to January 31, 2022. The survey was shared with multiple organizations to distribute the survey to their members. Additionally, the printed copies were provided to each senior center and post cards were provided to encourage to people to fill the survey out online. A public notice was posted in the Idaho Statesmen to inform the public about the survey. Translation options were provided to limited English speakers.

Q1. I am completing this survey for: If you are completing this survey for someone else, please select the responses that apply to that person.		
Answer Choices	Responses	
Self	87.65%	149
Someone else	12.35%	21
	Answered	**170**
	Skipped	**22**
Q2. What county do you live in?		
Answer Choices	Responses	
Ada	25.26%	48
Adams	9.47%	18
Boise	4.21%	8
Canyon	20.00%	38
Elmore	11.58%	22
Gem	8.95%	17
Owyhee	1.58%	3
Payette	3.68%	7
Valley	7.89%	15
Washington	7.37%	14
	Answered	**190**
	Skipped	**2**

Q3. What city do you live in?		
Answered	**165**	
Skipped	**27**	
Q4. What is your gender?		
Answer Choices	Responses	
Male	32.11%	61
Female	67.89%	129
Other (please specify)	0.00%	0
	Answered	**190**
	Skipped	**2**
Q5. What is your age?		
Answer Choices	Responses	
49 or younger	6.32%	12
50-59	12.63%	24
60-69	20.00%	38
70-79	35.79%	68
80-89	18.95%	36
90-99	6.32%	12
100+	0.00%	0
	Answered	**190**
	Skipped	**2**
Q6. Are you a Veteran?		
Answer Choices	Responses	
Yes	17.11%	32
No	82.89%	155
	Answered	**187**
	Skipped	**5**
Q7. Are you the spouse of a Veteran?		
Answer Choices	Responses	
Yes	27.27%	51
No	72.73%	136
	Answered	**187**
	Skipped	**5**
Q8. Which of the following best describes you?		
Answer Choices	Responses	
Asian or Pacific Islander	1.08%	2
Black or African American	0.00%	0
Hispanic or Latino	2.70%	5
Native Indian or Alaska Native	1.08%	2
White or Caucasian	94.59%	175
Multiracial or Biracial	0.00%	0

A race/ethnicity not listed here	0.54%	1
	Answered	**185**
	Skipped	**7**
Q9. What is your marital status?		
Answer Choices	Responses	
Widowed	32.28%	61
Divorced	17.46%	33
Married	44.97%	85
Single	5.29%	10
	Answered	**189**
	Skipped	**3**
Q10. Is your monthly income: (Please select one)		
Answer Choices	Responses	
Below $1,073 per month	9.89%	18
Between $1,074 and $1,288	14.29%	26
Between $1,289 and $1,503	11.54%	21
Between $1,504 and $1,717	4.95%	9
Between $1,718 and $1,932	7.14%	13
Above $1,933 and over	52.20%	95
	Answered	**182**
	Skipped	**10**
Q11. How many people, including yourself, live in your household?		
Answer Choices	Responses	
1 - One	39.89%	75
2 - Two	36.70%	69
3 - Three	10.64%	20
4 - Four	4.79%	9
5+ - Five+	7.98%	15
	Answered	**188**
	Skipped	**4**
Q12. Who lives with you? (check all that apply)		
Answer Choices	Responses	
Spouse	45.60%	83
Significant Other/Partner	1.10%	2
At least one child	15.93%	29
Child(ren) and his/her/their family	7.14%	13
Other relative(s)	2.75%	5
Unrelated adults/friends	4.40%	8
Grandchildren/Great-Grandchildren	7.69%	14
Father	1.65%	3
Mother	3.85%	7
Live by myself	34.07%	62

Other (please specify)	2.20%	4
	Answered	**182**
	Skipped	**10**
Q13. What is your employment status?		
Answer Choices	Responses	
Retired	63.35%	121
Working part-time (semi-retired)	12.57%	24
Working full-time	17.80%	34
Not employed at this time	6.28%	12
	Answered	**191**
	Skipped	**1**
Q14. Do you have any family, friends or neighbors that contact you at least twice a week?		
Answer Choices	Responses	
Yes	89.42%	169
No	10.58%	20
	Answered	**189**
	Skipped	**3**
Q15. COVID-19 has affected each of our lives differently. Over the last year we have learned about the individual and collective impact of social isolation and loneliness. Social isolation is commonly described as a lack of relationships or infrequent social contact, while loneliness is defined as the subjective perception of being alone. Research suggests that remaining socially engaged improves the quality of life for older adults and is associated with better health. What are some of the ways that you remain socially engaged or active in the community in which you live? (check all that apply)		
Answer Choices	Responses	
Belong to a book club	1.58%	3
Participate in New Knowledge Adventures (Lifelong Learning)	4.21%	8
Attend a local senior center/community center	63.16%	120
Attend religious activities	33.16%	63
Play sports	7.89%	15
Play a musical instrument	6.84%	13
Travel	20.53%	39
Volunteer	35.79%	68
Gardening	28.42%	54
Going to the library	13.16%	25
Member of a professional organization or club	17.37%	33
Go to the theater, symphony or concerts	9.47%	18
Social Media group/Online group/Message board	20.53%	39
I have a hobby/hobbies I engage in	44.21%	84
Intergenerational activity	8.42%	16
Visits and contact with family	57.89%	110
Practice and prepare for the Idaho Senior Games	4.21%	8

Other (please specify)	18.95%	36
	Answered	**190**
	Skipped	**2**
Q16. According to the Dietary Guidelines for Americans, a nutritious meal incorporates a variety of colorful vegetables and fruits, whole grains, fat-free or low-fat dairy, and lean protein options, and limits processed oils, fats, and sugar. Would you say that you have ongoing, adequate access to nutritious food?		
Answer Choices	Responses	
Yes	93.16%	177
No	6.84%	13
	Answered	**190**
	Skipped	**2**
Q17. Is there anything keeping you from eating nutritious meals? (check all that apply)		
Answer Choices	Responses	
No, I eat nutritious meals	77.13%	145
I live alone and don't feel like preparing meals	12.77%	24
I am physically unable to cook or prepare meals	3.72%	7
I don't have enough money to buy nutritious foods	5.85%	11
I am physically unable to shop for or carry groceries	6.38%	12
Other (please specify)	7.98%	15
	Answered	**188**
	Skipped	**4**
Q18. On a typical day, what do you do for lunch?		
Answer Choices	Responses	
I prepare my own lunch	50.00%	96
I eat lunch that is served by a senior center or Home Delivered Meal (Meals on Wheels) provider (home delivered meal, congregate meal or curbside meal)	34.90%	67
Someone else prepares lunch for me in my own home	2.60%	5
I do not eat lunch	7.81%	15
I eat lunch at a restaurant	2.08%	4
Other (please specify)	2.60%	5
	Answered	**192**
	Skipped	**0**
Q19. Do you need help with any of the following activities? (check all that apply)		
Answer Choices	Responses	
Personal care such as bathing, dressing or toileting	3.61%	6
Transportation	18.67%	31
Housekeeping	24.10%	40
Meal Preparation	7.83%	13
Shopping	10.24%	17
Emotional Support	7.83%	13

Financial Assistance (do not have enough money to pay for necessities)	6.02%	10
Money Management (unable to decide what to pay or need help writing checks)	5.42%	9
Companionship	7.23%	12
Chore or yard care	22.89%	38
Medicare, Medicaid, or other insurance issues	9.64%	16
Assistance with medications	4.22%	7
Legal Assistance	3.01%	5
Dental, Vision or Hearing	11.45%	19
Housing	4.82%	8
Caregiving	7.23%	12
Access to mental health services	2.41%	4
Access to health care	1.81%	3
I do not need assistance - go to question 22	48.80%	81
Other (please specify)	3.01%	5
	Answered	**166**
	Skipped	**26**
Q20. Are you currently receiving the assistance to meet your needs?		
Answer Choices	Responses	
Yes - Go to question 22	54.76%	69
No - Go to question 21	45.24%	57
	Answered	**126**
	Skipped	**66**
Q21. If you need help with any of the above activities and currently DO NOT receive that help, is it because: (check all that apply)		
Answer Choices	Responses	
I do not know what is available in our community	23.53%	16
I do not have family, friends, neighbors, or church support available	13.24%	9
I do not want to ask for help	35.29%	24
I am afraid to ask for help because someone may say I need to be in a facility	13.24%	9
I do not have enough money to pay for help	27.94%	19
I do not want to pay for help	7.35%	5
The help I need is not available in our area	5.88%	4
Other (please specify)	23.53%	16
	Answered	**68**
	Skipped	**124**
Q22. If you ever needed assistance or you needed more assistance, is there someone you know that you could call to get the assistance you need? (check all that apply)		
Answer Choices	Responses	
Yes, a family member	69.02%	127

Yes, a friend or neighbor	45.11%	83
Yes, other	11.96%	22
Yes, a medical provider	14.67%	27
Yes, the Area Agency on Aging	15.22%	28
Yes, a Clergy or church member	11.41%	21
No	9.78%	18
	Answered	**184**
	Skipped	**8**
Q23. Do you provide unpaid care for one or more family members or friends on a regular basis?(If you are completing this survey for someone else, please select the response that applies to that person)		
Answer Choices	Responses	
Yes - Go to question 24	22.22%	38
No - Go to question 27	77.78%	133
	Answered	**171**
	Skipped	**21**
Q24. Whom do you provide care for?(If you are completing this survey for someone else, please select the response that applies to that person)		
Answer Choices	Responses	
Spouse (wife/husband)	25.49%	13
Significant Other	3.92%	2
Parent (mother/father)	13.73%	7
At least one child	9.80%	5
Child(ren) and his/her/their family	7.84%	4
Other Relatives	3.92%	2
Unrelated adults/friends	13.73%	7
Grandchildren/Great-grandchildren	11.76%	6
Other (please specify)	9.80%	5
	Answered	**51**
	Skipped	**141**
Q25. How many hours per week do you spend providing care for this person or persons?(If you are completing this survey for someone else, please select the response that applies to that person)		
Answer Choices	Responses	
1-5 hours	28.26%	13
6-10 hours	13.04%	6
11-15 hours	6.52%	3
16-20 hours	8.70%	4
21-25 hours	0.00%	0
26-30 hours	6.52%	3
31-35 hours	0.00%	0
36-40 hours	2.17%	1

More than 40 hours	34.78%	16
	Answered	**46**
	Skipped	**146**
Q26. What kinds of assistance could you use more help in within your caregiving role? (check all that apply)(If you are completing this survey for someone else, please select the response that applies to that person)		
Answer Choices	Responses	
None of the above	51.52%	34
Organized support group	12.12%	8
Formal advice or emotional support (from a therapist, counselor, psychologist, psychiatrist or family care physician) on issues such as caring for grandchildren and other caregiving issues	10.61%	7
Services such as respite care (a temporary break from caregiving)	13.64%	9
Communication tips for people with reduced mental function (i.e. Dementia or Alzheimer's)	12.12%	8
Physical care assistance (lifting, diapering, transporting, cleaning)	10.61%	7
Obtaining equipment (such as walker, wheelchair, cane, shower chair, other assistive devices, etc.)	4.55%	3
Home modifications for safety (wheelchair ramp, grab bars, railings, etc.)	12.12%	8
How to take better care of your own health and well-being (Powerful Tools for Caregivers class)	15.15%	10
Medication Management	4.55%	3
	Answered	**66**
	Skipped	**126**
Q27. How do you find out about community activities, events and resources? (check all that apply)		
Answer Choices	Responses	
TV News	30.65%	57
TV Advertisements	9.14%	17
Newspaper	31.72%	59
Radio	12.37%	23
Internet	33.87%	63
Senior Publications (including senior center newsletters and organizations/club newsletters)	38.71%	72
Family, Friends, Neighbors, Church	65.05%	121
Facebook pages	30.65%	57
Other (please specify)	6.99%	13
	Answered	**186**
	Skipped	**6**
Q28. For most of your trips, how do you travel? (please select one)		
Answer Choices	Responses	
Drive myself	70.37%	133

Ride with a family member or friend	23.28%	44
Walk	1.06%	2
Bike	0.53%	1
Use a volunteer service	1.06%	2
Public Transportation (Valley Regional Transit, ValleyRide, City Bus)	1.06%	2
Taxi, Lyft or Uber	1.06%	2
Non-Emergency Medical Transportation	1.06%	2
Not applicable - I never leave the house	0.53%	1
	Answered	**189**
	Skipped	**3**
Q29. Within the last twelve months, have you used a public transportation service? (check all that apply)		
Answer Choices	Responses	
None of the above	82.02%	146
Harvest Transit	0.00%	0
Metro Community Services	0.00%	0
Senior Center Transportation Services	14.61%	26
SHIP - Supportive Housing and Innovative Partnerships	0.00%	0
Valley Regional Transit Bus System	2.25%	4
Other (please specify)	1.12%	2
	Answered	**178**
	Skipped	**14**
Q30. How often has it been difficult for you to arrange transportation for each of the following activities?		
	Frequently	
Medical trips	7.78%	13
Shopping	4.49%	7
Personal errands	7.05%	11
Recreational or social trips	6.33%	10
	Sometimes	
Medical trips	14.97%	25
Shopping	7.69%	12
Personal errands	8.33%	13
Recreational or social trips	12.03%	19
	Never	
Medical trips	77.25%	129
Shopping	87.82%	137
Personal errands	84.62%	132
Recreational or social trips	81.65%	129
	Total	
Medical trips		167
Shopping		156

Personal errands		156
Recreational or social trips		158
	Answered	**168**
	Skipped	**24**
Q31. When you have trouble getting the transportation you need, what would you say are the reasons? (check all that apply)		
Answer Choices	Responses	
I have to rely on others	19.02%	31
Weather	21.47%	35
Not available when I need to go	7.98%	13
Car doesn't work/Problems with vehicle	7.98%	13
Transportation does not go where I need to go	0.61%	1
Can't afford it	6.13%	10
Don't know who to call	5.52%	9
Disability or health reasons	7.98%	13
Not available in my community	6.13%	10
Too far/Distance related	8.59%	14
Have trouble getting around without someone to help	6.13%	10
Sidewalks are in poor condition or missing	3.07%	5
Not Applicable	50.92%	83
Other (please specify)	3.07%	5
	Answered	**163**
	Skipped	**29**
Q32. Do you have a computer/tablet at home?		
Answer Choices	Responses	
Yes	73.60%	131
No	26.40%	47
	Answered	**178**
	Skipped	**14**
Q33. Do you send and receive email?		
Answer Choices	Responses	
Yes	74.60%	141
No	20.63%	39
Receive but not send	4.76%	9
	Answered	**189**
	Skipped	**3**
Q34. Do you search the internet for information?		
Answer Choices	Responses	
Yes	72.58%	135
No	27.42%	51
	Answered	**186**

	Skipped	6
Q35. Within the last 12 months have you utilized assistance or support from one or more of the following services the Area Agency on Aging is able to offer? (check all that apply)		
Answer Choices	Responses	
None of the above	65.09%	110
Information and Assistance	10.06%	17
Long-Term Care Ombudsman	0.59%	1
Veteran Support	3.55%	6
Senior Medicare Patrol - Help with Medicare questions	1.18%	2
Homemaker	2.96%	5
Respite Care	4.14%	7
Caregiver Support Program (Powerful Tools for Caregivers)	3.55%	6
Home Delivered Meals	5.33%	9
Congregate Meals/Curbside Meals	13.61%	23
Assistive Technology (Lending Closet)	0.59%	1
Legal Assistance	0.59%	1
Adult Protective Services	0.00%	0
Chronic Disease Health Management	4.14%	7
Kinship Program	5.92%	10
	Answered	**169**
	Skipped	**23**
Q36. Have you EVER utilized assistance or support from one or more of the following services the Area Agency on Aging is able to offer? (check all that apply)		
Answer Choices	Responses	
None of the above	61.05%	105
Information and Assistance	13.95%	24
Long-Term Care Ombudsman	2.33%	4
Veteran Support	6.98%	12
Senior Medicare Patrol - Help with Medicare questions	2.91%	5
Homemaker	2.91%	5
Respite Care	6.40%	11
Caregiver Support Program (Powerful Tools for Caregivers)	5.23%	9
Home Delivered Meals	8.14%	14
Congregate Meals/Curbside Meals	13.95%	24
Assistive Technology (Lending Closet)	1.74%	3
Legal Assistance	2.91%	5
Adult Protective Services	2.91%	5
Chronic Disease Health Management	2.91%	5
Kinship Program	4.65%	8
	Answered	**172**
	Skipped	**20**
Q37. Do you go to a local senior center for meals or activities?		

Answer Choices	Responses	
Yes - Go to question 38	66.84%	125
No - Go to question 41	33.16%	62
	Answered	**187**
	Skipped	**5**
Q38. Which nutrition provider/senior center do you attend or receive meals from?		
	Answered	**127**
	Skipped	**65**
Q39. What do you like most about the senior center you attend?		
	Answered	**126**
	Skipped	**66**
Q40. Would you recommend the meal program to a friend?		
Answer Choices	Responses	
Yes	90.23%	120
No	1.50%	2
Not sure	8.27%	11
	Answered	**133**
	Skipped	**59**
Q41. If you do not go to the local senior center for meals or activities, why not?		
(Available upon Request)	**Answered**	**66**
	Skipped	**126**
Q42. Please tell us how you would respond to an emergency, such as a fire, earthquake, severe weather or flood:		
In case of an emergency or disaster, you have talked with a doctor about an emergency back-up plan for any needed medical treatments, such as oxygen, dialysis, or chemotherapy	Yes 25.15% (41) No 74.85% (122) Total (163)	
You have a Grab and Go Bag ready that includes water, medications, food that won't spoil, can opener, utensils, plate and cup, underwear and socks, wipes, flashlight and a radio with batteries	Yes 29.09% (48) No 70.91% (117) Total (165)	
If you have a pet, Grab and Go Bag includes food and water for your pet	Yes 23.84% (36) No 76.16% (115) Total (151)	
Supplies in Grab and Go Bag would last for at least three (3) days	Yes 34.87% (53) No 65.13% (99) Total (153)	
If ordered to evacuate, you could leave home and travel to a safe place without help	Yes 73.33% (121) No 26.67% (44) Total (165)	

Signed up to receive Reverse 911 calls or emergency text message alerts from county Sheriff's Office or local public safety office	Yes 32.28% (51) No 67.72% (107) Total (158)	
Have spoken with friends, family and/or neighbors about the help you might need, including the evacuation plans, if a disaster occurs	Yes 32.1% (52) No 67.90% (110) Total (162)	
Keep a list of medications, emergency contacts and physicians in Grab and Go Bag.	Yes 34.81% (55) No 65.19% (103) Total (158)	
	Answered	**176**
	Skipped	**16**
Q43. Which services do you use now, and which services do you think you'll need to start using in the next 12 months?		
Meals delivered to my home-		
Use Now:	5.68%	5
May use in the next 12 months:	18.18%	16
May start using in the next 5 years:	76.14%	67
Total:		88
A break from caregiving to take care of my own needs		
Use Now:	16.92%	11
May use in the next 12 months:	23.08%	15
May start using in the next 5 years:	60.00%	39
Total:		65
In-home care with personal care		
Use Now:	0.00%	0
May use in the next 12 months:	22.86%	16
May start using in the next 5 years:	77.14%	54
Total:		70
Help with Medicare options and issues		
Use Now:	13.64%	9
May use in the next 12 months:	22.73%	15
May start using in the next 5 years:	63.64%	42
Total:		66
Meals at a senior center		
Use Now:	69.30%	79
May use in the next 12 months:	7.89%	9
May start using in the next 5 years:	22.81%	26
Total:		114
In-home help with housekeeping		
Use Now:	18.48%	17
May use in the next 12 months:	29.35%	27
May start using in the next 5 years:	52.17%	48

Total:		92
Shuttle/bus to pick me up at home and take me to place I need to go		
Use Now:	11.69%	9
May use in the next 12 months:	15.58%	12
May start using in the next 5 years:	72.73%	56
Total:		77
Help with my caregiving role, i.e. counseling, caregiver training, support group		
Use Now:	6.25%	4
May use in the next 12 months:	28.13%	18
May start using in the next 5 years:	65.63%	42
Total:		64
	Answered	**136**
	Skipped	**56**
Q44. Other comments you would like to make?		
(Available upon request)	**Answered**	**40**
	Skipped	**152**

Public Meetings

Four public meetings were held throughout the PSA region to solicit feedback from the public. These meetings were held at the following designated focal points.

- Weiser Senior Center; April 26, 2022
- Mountain Home Senior Center; May 4, 2022
- Dick Eardley Senior Center; May 9, 2022
- McCall Senior Center; May 10, 2022

Two Public Notices, were posted in the Idaho Statesman, announcing the public comment period May 2- May 20, 2022. Invitation to public comment were also posted on the front page of the website, Facebook and email blasts to stakeholders.

A Frequently Asked Questions (FAQ) document was developed and handed out to public meeting attendees. The FAQ provided an overview of the Area Plan and information on how to access the plan. Public meeting topics were as follows:

- Area Plan Requirements
- Focal Point Designation
- Gaps Identified
- Proposed Strategies

Finding Compilations from Public Comment

A summary of the statistical information is as follows:

Prioritize the top 5 services that you need or may need in the next year					
Service	**Weiser**	**Mtn Home**	**McCall**	**Boise**	**TOTAL**
Information on Senior Services	3	11	3	1	**18**
Senior Center Lunch	3	13	6	0	**22**
Diabetes or Chronic Pain Management Classes	0	7	2	0	**9**
Advice on Medicare Programs	1	10	1	2	**14**
Services to combat loneliness	3	7	3	0	**13**
Grandparents Raising Grandchildren Support Groups	0	2	2	0	**4**
Transportation	1	9	4	3	**17**
Home Delivered Meals	4	2	2	1	**9**
Food Boxes	2	3	2	0	**7**
Homemaker	0	6	3	3	**12**
Alzheimer and Dementia Information and Support	0	3	1	2	**6**
Legal Assistance	0	5	6	0	**11**
Long-Term Care and Assisted Living Advocacy	0	4	2	0	**6**
Adult Protective Services	2	5	0	2	**9**

Section 4: Goals and Strategies

Vision~
To be the Southwest Idaho long term care resource hub that provides reliable and accessible information.

Mission statement~
To promote independence, choice, well-being, and dignity for older individuals, vulnerable adults, and their loved ones through education, advocacy and a coordinated system of home and community-based services.

Value Statements~

1. **Advocacy for vulnerable adults**: We provide a voice for adults that have lost the capacity to self-determine or are lost in the system looking for resources.

2. **Compassionate staff:** We understand that the work that we do impacts the population we serve.

3. **Supportive services:** We provide essential services to seniors to support them to live independently in their homes as long as possible.

4. **Dedicated staff:** Our staff are committed to the work and understand the mission of the organization.

5. **Resourceful:** We are innovative and think outside the box when it comes to supporting individuals at risk for institutional placement.

6. **Meaningful Partnerships:** We strive to collaborate with organizations that will help meet the needs of the seniors we serve and avoid siloes through coordination.

Gap Priorities: SWIA3 utilized the following indicators to prioritize gaps uncovered in the environmental scan of the region.

- Does the identified gap coincide with the vision, mission, and scope of the organization?
- Does it belong to another organization?
- Does the SWIA3 staff/partners agree that we have the capacity to address the gap?
- Does the strategy prioritize seniors at risk for institutionalization?

List of Gaps uncovered in the environmental scan:

- Increase demand for Home Delivered Meals, Information and Assistance, Transportation and Respite
  - Solution: Utilize high risk for institutional placement indicators to prioritize seniors most in need.
- Combat social isolation
  - Solution: Promote focal point social activities and the friendly calling program to combat loneliness
- No Chore and Case management services being provided despite the requested need
  - Solution: Implement a home modification program and case management program.
- Increase in Adult Protection Reports
  - Solution: Increase staffing and employ retention measures.
- Increase in rural area senior population
  - Solution: Marketing and outreach strategies to rural areas.
- Low participation rates of Hispanics on SWIA3 Services
  - Solution: Translation of materials to Spanish, targeted marketing campaigns.

I. Universal Programs

"Goal: Investing in Health Aging" (ICOA Senior Services State Plan)
Objectives: • *To access reliable and trustworthy information, services and supports* • *To stay active in the community* • *To plan for our own independent living need*

1. **Focus Area - Information and Assistance Services and Aging & Disability Resource Connection (ADRC)**		
Strategy 1.1: One outreach presentation and program sign up day at each designated focal point/year		
Prioritized Gap: Combat Social Isolation; Increase participation in rural area participation.	**Measurement Tool:** Outreach Plan; GetCare rural registered **Target:** 10 Outreach sign-up days conducted; 10% Increase in rural seniors participating in OAA programs.	Year 1: Pilot, establish Process and schedule Year 2: 10 focal Point Visits Year 3: 10 focal point visits Year 4: 10 focal point visits
Strategy 1.2: Share low-income program resource options to consumers during I&A calls and outreach events		
Prioritized Gap: High risk for institutional placement; low-income seniors.	**Measurement Tool:** GetCare Referral Report, **Target:** # of low-income referrals to Medicaid, Housing, Utility Assistance, Food Pantries.	Year 1: Establish process and enter resources Year 2: 4% Increase in resource referrals. Year 3: 3% Increase in resource referrals. Year 4: 3% Increase in resource referrals.
Strategy 1.3: Streamline and increase referrals between SWIA3 and LINC		
Prioritized Gap: ADRC Initiative, individuals with severe disabilities	**Measurement Tool:** GetCare Referral Reports **Target:** # of LINC Referrals in GetCare	Year 1: Pilot, establish process and schedule Year 2: 2% Increase in resource referrals. Year 3: 2% Increase in resource referrals. Year 4: 1% Increase in resource referrals.
Strategy 1.4: Obtain Alliance of Information and Referral Systems (AIRS) certification for 50% of the Access Department staff that are eligible		
Prioritized Gap: ADRC Initiative;	**Measurement Tool:** Training Log **Target:** # of staff AIRS certified	Year 1: Certify Staff Year 2: Maintain 50% level Year 3: Maintain 50% level Year 4: Maintain 50% level
Strategy 1.5: Provide targeted outreach to counties with the highest rate of individuals over the age of 75		
Prioritized Gap: High risk for institutional placement; individuals over the age of 75.	**Measurement Tool:** GetCare registered age report; outreach plan	Year 1: Develop marketing plan and materials Year 2: 8 rural focal point visits

	Target: # of targeted outreach campaigns	Year 3: 8 rural focal point visits Year 4: 8 rural focal point visits

2. Focus Area - Congregate Meals		
Strategy 2.1: Improve the overall quality of Congregate meals		
Prioritized Gap: Combat social isolation; community focal point	**Measurement Tool:** Survey Monkey on meal quality. **Target:** 80% positive quality assurance consumer survey responses	Year 1: Establish quality assurance baselines Year 2: Implement and evaluate 2nd survey Year 3: Provide training Year 4: Implement and evaluate 3rd survey
Strategy 2.2: Coordinate program sign up days during the congregate meal, market national months and hold Chronic Disease Self-Management Program (CDSMP) classes at community focal points		
Prioritized Gap: Combat social isolation; diabetes and pain management	**Measurement Tool:** Outreach plan; workshop wizard **Target:** # of designated focal points, # of public events, # of CDSMP classes, # of program sign up days	Year 1: Establish Community Focal Point stakeholder meetings, Measure strategy performance annually Year 2: 2 focal point workshops; 4 national campaigns Year 3: 2 focal point workshops; 4 national campaigns Year 4: 2 focal point workshops; 4 national campaigns
Strategy 2.3: Promote senior centers to the public as an option for volunteering and promote SCSEP to the providers		
Prioritized Gap: OAA Requirement; combat social isolation; limited staffing at senior centers	**Measurement Tool:** Senior center survey; request # of senior center SCSEP slots from subgrantee **Target:** # of volunteers or SCSEP connected to senior centers. # of marketing events to promote senior center marketing	Year 1: Establish volunteer referral protocols with senior centers. Establish marketing materials to promote volunteering at senior centers Year 2: 1 senior center slot filed Year 3: 1 senior center slot filed Year 4: 1 senior center slot filed

3. Focus Area – Health Promotion		
Strategy 3.1: Provide 8 CDSMP workshops annually		
Prioritized Gap: Increase in senior population; individuals living with diabetes and chronic pain	**Measurement Tool:** Workshop wizard **Target:** # of workshops conducted annually	Year 1: 8 CDSMP workshops Year 2: 8 CDSMP workshops Year 3: 8 CDSMP workshops Year 4: 8 CDSMP workshops
Strategy 3.2: Promote and recruit additional CDSMP lay leaders		
Prioritized Gap: Increase in senior population; individuals living with diabetes and chronic pain	**Measurement Tool:** Workshop wizard **Target:** # of lay leader trainings annually	Year 1: 1st Lay Leader training Year 2: N/A Year 3: 2nd Lay Leader training Year 4: N/A
Strategy 3.3: Establish a funding source to support CDSMP classes		
Prioritized Gap: Lack of funding and staff capacity;	**Measurement Tool:** Outreach Plan **Target:** # of funding sources	Year 1: 1 funding source proposal Year 2: 1 funding source proposal Year 3: 1 funding source proposal Year 4: 1 funding source proposal

4. Focus Area – MIPPA/SMP		
Strategy 4.1: Increase website and social media activity for MIPPA resources		
Prioritized Gap: High risk for institutional placement; low-income seniors.	**Measurement Tool:** WordPress; Facebook posts, MIPPA reporting gorm **Target:** Program links added to website as available. # of MIPPA posts to agency social media account annually	Year 1: Add media language to MIPPA RFP as a goal with each grant opportunity Year 2: 1 MIPPA post per month, 4% increase in website traffic. Year 3: 1 MIPPA post per month, 4% increase in website traffic. Year 4: 1 MIPPA post per month, 4% increase in website traffic.
Strategy 4.2: Collaborate with Native American groups located in the PSA region to promote MIPPA materials		

Prioritized Gap: High risk for institutional placement; Native Americans	**Measurement Tool:** MIPPA Reporting Form **Target:** # of outreach efforts reported annually to grant	Year 1: 2 Native American MIPPA outreach events Year 2: 2 Native American MIPPA outreach events Year 3: 2 Native American MIPPA outreach events Year 4: 2 Native American MIPPA outreach events
Strategy 4.3: Increase referrals to Statewide Health Insurance Benefits Advisors (SHIBA) through I&A Calls		
Prioritized Gap: High risk for institutional placement; low-income seniors.	**Measurement Tool:** GetCare Referral Reports **Target:** # of SHIBA referrals in the GetCare	Year 1: Establish process and enter resources Year 2: 2% Increase in resource referrals. Year 3: 2% Increase in resource referrals. Year 4: 2% Increase in resource referrals.

5. Focus Area – Loneliness Reduction / Multigenerational Socialization		
Strategy 5.1: Promote socialization activities offered at community focal points		
Prioritized Gap: Combat social isolation	**Measurement Tool:** WordPress, Facebook **Target:** # of promotional activities;	Year 1: 2 activities a month Year 2: 2 activities a month Year 3: 2 activities a month Year 4: 2 activities a month
Strategy 5.2: Develop and establish one multigeneration program		
Prioritized Gap: Combat social isolation	**Measurement Tool:** Area Plan quarterly reports **Target:** # of multigenerational programs	Year 1: Survey and assess existing multigenerational programs Year 2: Identify program and draft strategies Year 3: One multigeneration program established Year 4: Sustain and report successes
Strategy 5.3: Expand friendly calling program to the adult protection and ombudsman consumers		
Prioritized Gap: Combat social isolation	**Measurement Tool:** Friendly calls tracking; GetCare follow up and stats	**Year 1:** Establish process, train staff and schedule **Year 2:** 10 Referrals from APS and Ombudsman

	Target: # of APS and OMB referrals to Friendly Calling Program	**Year 3**: 10 Referrals from APS and Ombudsman **Year 4:** 10 Referrals from APS and Ombudsman

II. Targeted Services

Goal: Preventing Institutionalization
Objectives: • *To live as independently as possible* • *To choose our own caregiver* • *To provide caregiver training and resources*

1. Focus Area - Family Caregivers/Respite/Grandparents raising grandchildren		
Strategy 1.1: **Increase Consumer Direct Respite participation in rural areas**		
Prioritized Gap: High risk for institutional placement; seniors living in rural areas	**Measurement Tool:** GetCare Custom Export Report **Target:** # of respite caregivers living in rural areas	Year 1: 2% Increase in service Year 2: 2% Increase in service Year 3: 2% Increase in service Year 4: 2% Increase in service
Strategy 1.2: Establish two additional Idaho Relatives as Parents (IRAP) groups; Maintain four total IRAP groups		
Prioritized Gap: Caregivers; Kinship families; 2 support groups only in a 10-county region.	**Measurement Tool:** Outreach Plan **Target:** # of IRAP groups that are active	Year 1: 1st group established Year 2: Maintain and sustain 3 groups Year 3: 2nd group established Year 4: Maintain and sustain 4 groups
Strategy 1.3: Develop one supplemental service program for caregivers to assist with home modifications		
Prioritized Gap: Caregivers; No chore program developed	**Measurement Tool:** GetCare; area plan quality plan **Target:** # of caregivers served in supplemental service	Year 1: Develop supplemental service for caregivers Year 2: Implement service Year 3: Monitor performance Year 4: Annually review performance measurements
Strategy 1.4: Pilot and establish the Community Care Program to provide case management to family caregivers		
Prioritized Gap: Caregiver support program	**Measurement Tool:** Annual and Semi-Annual grant reports; GetCare	Year 1: Pilot demonstration Year 2: Implement Statewide Year 3: Fully integrate and

	Target: # of caregivers provided with case management service	annually review performance measurements Year 4: Monitor & document best practices and lessons learned
2. Focus Area - Transportation		
Strategy 2.1: Promote transportation participation to seniors at risk for nursing home placement		
Prioritized Gap: High risk for institutional placement; seniors living in rural areas, Hispanic population	**Measurement Tool:** GetCare; units delivered in rural areas. **Target:** # of marketing materials translated into Spanish; # of trips in rural areas	Year 1: Develop marketing plan & materials Year 2: Implement and monitor Year 3: Increase in rural areas Year 4: Increase in rural areas
Strategy 2.2: Develop and launch one new innovative transportation project		
Prioritized Gap: Increase in demand for transportation options	**Measurement Tool:** Area plan quality plan **Target:** # of innovative transportation projects implemented	Year 1: Develop project Year 2: Implement and monitor Year 3: Increase utilization innovative transportation project. Year 4: Increase utilization innovative transportation project.
Strategy 2.3: Streamline transportation resources to improve consumer access by providing on demand scheduling and travel ambassadors		
Prioritized Gap: Increase in demand for transportation options	**Measurement Tool:** GetCare; VRT On demand reports; Area Plan quality plan **Target:** # of boardings; # of individuals accessing on demand scheduling, # of travel ambassadors	Year 1: Develop project Year 2: Implement and monitor Year 3: Increase utilization of on demand scheduling Year 4: Increase utilization of on demand scheduling

3. Focus Area - Home Delivered Meals/Nutrition Services Incentive Program (NSIP)
Strategy 3.1: Increase home delivered meal participation among seniors at risk for nursing home placement, including low-income minority individuals

Prioritized Gap: High risk for institutional placement; seniors living in rural areas, Hispanic population	**Measurement Tool:** GetCare demographic reports **Target:** # of at-risk seniors participating in the program; # of targeted materials developed	Year 1: Develop marketing plan and materials Year 2: Distribution of materials Year 3: Exceed the demographic percentage Year 4: Exceed the demographic percentage
Strategy 3.2: Improve meal quality through contract monitoring		
Prioritized Gap: Combat social isolation; senior center participation	**Measurement Tool:** Survey Monkey **Target:** % of positive survey responses; Aggregate survey responses	Year 1: Establish quality assurance baselines Year 2: Implement and evaluate 2nd survey Year 3: Implement and evaluate 3rd survey Year 4: Implement and evaluate 4th survey

4. Focus Area – Commodity Supplemental Food Program		
Strategy 4.1: Coordinate two all staff in-services with Idaho Food Bank on the CSFP		
Prioritized Gap: High risk for institutional placement; low income	**Measurement Tool:** Area plan quality plan **Target:** # of in-services	Year 1: 1st in-service Year 2: N/A Year 3: 2nd in-service Year 4: N/A
Strategy 4.2: Share CSFP program information on website and social media		
Prioritized Gap: High risk for institutional placement; low income	**Measurement Tool:** WordPress clicks and views **Target:** # of page views, clicked links; # of social media posts	Year 1: Develop website content Year 2: Monitor page views, clicks and social media posts Year 3: Increase in page views and clicks Year 4: Increase in page views and clicks

5. Focus Area - Homemaker		
Strategy 5.1: Increase homemaker participation among seniors at risk for nursing home placement, including low-income minority individuals		
Prioritized Gap: High risk for institutional placement; low-income minorities	**Measurement Tool:** GetCare demographic reports **Target:** # of at-risk seniors	Year 1: Develop marketing plan and materials Year 2: Year 3: Exceed the demographic percentage

	participating in the program; # of targeted materials developed	Year 4: Exceed the demographic percentage Year 3: Exceed the demographic percentage Year 4: Exceed the demographic percentage
Strategy 5.2: Incorporate consumer direct as a service model for homemaker service		
Prioritized Gap: Limited provider staffing	**Measurement Tool:** GetCare demographic reports **Target:** # of consumers receiving consumer direct	Year 1: Incorporate ICOA standards into SWIA3 process Year 2: 2% Increase in service Year 3: 2% Increase in service Year 4: 2% Increase in service

6. Focus Area - Dementia Capability		
Strategy 6.1: Incorporate dementia training as a requirement for all AAA staff		
Prioritized Gap: OAA priority group; individuals living with dementia	**Measurement Tool:** AAA staff training report **Target:** # of staff trained	Year 1: Establish internal process, leadership training Year 2: All staff trained Year 3: All staff trained Year 4: All staff trained
Strategy 6.2: Incorporate dementia program resources in the resource database system		
Prioritized Gap: OAA priority group; individuals living with dementia	**Measurement Tool:** GetCare referral report **Target:** # of resources in database	Year 1: Identify dementia resources in the system and those that need to be added Year 2: Increase in dementia resources referred Year 3: Increase in dementia resources referred Year 4: Increase in dementia resources referred
Strategy 6.3: Collaborate with ICOA & Division of Public Health to meet State Plan Strategies		
Prioritized Gap: OAA priority group; individuals living with dementia	**Measurement Tool:** Area plan quality plan **Target:** # of strategies SWIA3 is assigned and meeting participation	Year 1: Collaborate with ICOA and DPH. Establish strategies. Year 2: TBD after year 1 Year 3: TBD after year 1 Year 4: TBD after year 1

III. Crisis Services

Goal: Preserving Rights and Safety
Objectives: • To live without abuse, neglect, and exploitation • To live with dignity • To make our own choices

1. Focus Area - Elder Rights and Legal Assistance		
Strategy 1.1: Promote legal risk detector tool on website and social media		
Prioritized Gap: Increase in adult protection reports; adult protection recidivism	**Measurement Tool:** Area plan quality plan; GetCare referral report **Target:** # of legal risk detector tool referrals in PSA III	Year 1: Annually review performance measurements Year 2: Increase in GetCare referrals Year 3: Increase in GetCare referrals Year 4: Increase in GetCare referrals
Strategy 1.2: Expand the use of preventative programs. (i.e., goods and services, FCC, and C-FCC)		
Prioritized Gap: Increase in adult protection reports; adult protection recidivism	**Measurement Tool:** APS Intervention Semi Annual Reports **Target:** # of individuals served on the APS goods and services and consumer direct project	Year 1: Establish program baselines Year 2: Increase in goods and services participation Year 3: Increase in goods and services participation Year 4: Increase in goods and services participation
Strategy 1.3: Hire, retain and train quality APS staff to ensure adequate staffing needs		
Prioritized Gap: Staffing shortages & turnover	**Measurement Tool:** AAA staff training report, staff attrition report **Target:** # Staff retention rate	Year 1: 15% staffing attrition rate Year 2: 15% staffing attrition rate Year 3: 15% staffing attrition rate Year 4: 15% staffing attrition rate
Strategy 1.4: Promote least restrictive training on decision making to staff and provide access to information on website		

Prioritized Gap: Increase in adult protection reports; adult protection recidivism	**Measurement Tool:** AAA staff training report, WordPress clicks and views **Target:** # of trainings provided, # of views on website, # of social media posts	Year 1: Incorporate information on website Year 2: Track and monitor clicks and views Year 3: Increase in website traffic Year 4: Increase in website traffic

2. Focus Area - Ombudsmen		
Strategy 2.1: Improve data tracking and documentation of complaints		
Prioritized Gap: Increase in senior population; Increase in facility beds	**Measurement Tool:** Quarterly ombudsman report **Target:** Established quarterly tracking tool that will assist in determining staffing	Year 1: Establish process and schedule; determine staffing baselines Year 2: Implement and track activity Year 3: Track activity for staffing Year 4: Track activity for staffing
Strategy 2.2: Establish sustainability for the Communication Access Program		
Prioritized Gap: Combat Social Isolation	**Measurement Tool:** IATP reports; GetCare referral reports **Target:** # of referrals to IATP (Idaho Assistive Technology Project) by the Ombudsman. This will be measured by IATP in grant reports	Year 1: Increase in utilization; Establish sustainable resources. Year 2: Sustain program Year 3: Sustain program Year 4: Sustain program
Strategy 2.3: Increase the number of referrals between the Ombudsman and the Friend Calling staff to combat against the effects of social isolation		
Prioritized Gap: Combat Social Isolation	**Measurement Tool:** GetCare Referral Reports **Target:** # Residents in LTC setting receiving Friendly Caller Services	Year 1: Establish process and schedule Year 2: Increase in referrals Year 3: Increase in referrals Year 4: Increase in referrals

Section 5: Plan Execution

Organization Chart

The development of the area plan and its strategies have been reviewed and accepted by the SWIA3 Board of Directors and the agency staff. Plan strategies and assignments can be found in. The existing staff that will be utilized in the implementation of the plan are below.

<table>
<tr><td colspan="6">Board of Directors</td></tr>
<tr><td colspan="6">Executive Director: Raul Enriquez</td></tr>
<tr><td colspan="3">Office Manager: Jan Adams</td><td colspan="3">Veterans Directed: Michelle Randall</td></tr>
<tr><th>Option Counselor Staff</th><th>Ombudsman Staff</th><th>Caregiver Support Staff</th><th>Admin Staff</th><th>Special Projects Staff</th><th>Adult Protection Staff</th></tr>
<tr><td colspan="3">Roberta Bischel</td><td rowspan="2">Brandi Waselewski</td><td rowspan="2">Natalie Nathan</td><td>Chris Parish</td></tr>
<tr><td>Rachel Fiedler</td><td>Stephanie Persinger</td><td>Julie Torresani</td><td>Kyle Srack</td></tr>
<tr><td>Rickie Sautebin
Chantelle Kates
Donna Queen
Ken Honda
Valerie Palmer
Brenda Hubbard
Ismael Hernandez</td><td>Sherry Young
Mary Bringman
Susan Brandel
Melanie Holman
Seonaid Uebelhardt</td><td>Charlye Hahn
Elva Villarreal
Frances Villegas</td><td>Michelle Sutton
Diana Hedberg</td><td>Gaby Tapia</td><td>Marissa O’Berry
Shannon Franklin
Brooke Frye
Amorette Rosenthal
Tami Parks
Brad Fernandes</td></tr>
<tr><td colspan="6">Area Plan Leadership Staff (Blue)</td></tr>
<tr><td colspan="6">SWIA3 Staff</td></tr>
</table>

Area Plan Assignments

Core Area	Reference	Strategy	Assigned Staff
Universal Programs	1.1	One outreach presentation and program sign up day at each designated focal point/year.	Access Department Supervisor
Universal Programs	1.2	Share low-income program resource options to consumers during I&A calls and outreach events.	Access Department Supervisor
Universal Programs	1.3	Streamline referrals between SWIA3 and LINC	Access Department Supervisor
Universal Programs	1.4	Obtain AIRS certification for 50% of the Access Department staff	Access Department Supervisor
Universal Programs	1.5	Provide targeted outreach to counties with the highest rate of individuals over the age of 75.	Special Projects Manager
Universal Programs	2.1	Improve the overall quality of Congregate meals.	Contracts Manager; Director
Universal Programs	2.2	Coordinate program sign up days during the congregate meal, market national months and hold Chronic Disease Self-Management Program (CDSMP) classes at community focal points	Contracts Manager; Director
Universal Programs	2.3	Promote senior centers to the public as an option for volunteering and promote SCSEP to the providers	Contracts Manager; Director
Universal Programs	3.1	Provide 8 CDSMP workshops annually.	Special Projects Manager
Universal Programs	3.2	Promote and recruit additional CDSMP lay leaders.	Special Projects Manager

Universal Programs	3.3	Establish a funding source to support CDSMP classes	Special Projects Manager
Universal Programs	4.1	Increase website and social media activity for MIPPA resources	Program Manager
Universal Programs	4.2	Collaborate with Native American groups located in the PSA region to promote MIPPA materials	Program Manager
Universal Programs	4.3	Increase referrals to SHIBA through I&A Calls	Program Manager
Universal Programs	5.1	Promote socialization activities offered at community focal points.	Special Projects Manager
Universal Programs	5.2	Develop and establish one multigeneration programs	Director
Universal Programs	5.3	Expand friendly calling program to the adult protection and ombudsman consumers	Program Manager
Targeted Programs	1.1	Increase Consumer Direct Respite participation in rural areas	FCSP Supervisor
Targeted Programs	1.2	Establish two additional IRAP groups; Maintain four total IRAP groups	FCSP Supervisor
Targeted Programs	1.3	Develop one supplemental service program for caregivers to assist with home modifications	FCSP Supervisor
Targeted Programs	1.4	Pilot and establish the Community Care Program to provide case management to family caregivers	FCSP Supervisor
Targeted Programs	2.1	Promote transportation participation to seniors at risk for nursing home placement.	Contracts Manager; Director

Targeted Programs	2.2	Develop and launch one new innovative transportation project.	Contracts Manager; Director
Targeted Programs	2.3	Streamline transportation resources to improve consumer access by providing on demand scheduling and travel ambassadors	Contracts Manager; Director
Targeted Programs	3.1	Increase home delivered meal participation among seniors at-risk for nursing home placement, including low-income minority individuals	Contracts Manager; Director
Targeted Programs	3.2	Improve meal quality through contract monitoring	Contracts Manager; Director
Targeted Programs	4.1	Coordinate two all staff in-services with Idaho Food Bank on the CSFP.	Executive Director
Targeted Programs	4.2	Share CSFP program information on website and social media	Special Projects Manager
Targeted Programs	5.1	Increase homemaker participation among seniors at risk for nursing home placement, including low-income minority individuals	Contracts Manager; Director
Targeted Programs	5.2	Incorporate consumer direct as a service model for homemaker service.	Contracts Manager; Director
Targeted Programs	6.1	Incorporate dementia training as a requirement for all AAA staff	Director
Targeted Programs	6.2	Incorporate dementia program resources in the resource database system	Access Department Supervisor
Targeted Programs	6.3	Collaborate with ICOA & Division of Public Health to meet State Plan Strategies	Executive Director

Crisis	1.1	Promote legal risk detector tool on website and social media	Adult Protective Services Supervisor
Crisis	1.2	Expand the use of preventative programs. (i.e., goods and services, FCC and C-FCC)	Adult Protective Services Supervisor
Crisis	1.3	Hire, retain and train quality APS staff to ensure adequate staffing needs	Adult Protective Services Supervisor
Crisis	1.4	Promote least restrictive training on decision making to staff and provide access to information on website	Adult Protective Services Supervisor
Crisis	2.1	Improve data tracking and documentation of complaints	Adult Protective Services Supervisor
Crisis	2.2	Establish sustainability for the Communication Access Program	Ombudsman Supervisor
Crisis	2.3	Increase the number of referrals between the Ombudsman and the Friend Calling staff to combat against the effects of social isolation	Ombudsman Supervisor

Section 6: Continuous Quality

Data Integrity Plan: SWIA3 has established a process to ensure data is reviewed periodically to ensure data is being entered properly. SWIA3 has trained staff on how to run report features and will review progress at a minimum quarterly to ensure consistency of data entry.

Program	System	Report Types	Responsible Staff
Information and Assistance	GetCare	GetCare; # of Calls; Referral Types	Access Supervisor
Nutrition	GetCare; Survey Monkey	Quality Assurance Surveys; # of meals; high risk demographic	Contracts & Fiscal Manager
Health Promotions	GetCare; Workshop Wizard	# of classes; # of participants	Special Projects Manager
MIPPA/SMP	GetCare; MIPPA Report; website, Facebook	# of contacts; website clicks; social media events; views	Program Manager
Loneliness Reduction	GetCare; website	# of views; Referral Types	Program Manager; Special Projects Manager
Transportation	GetCare	# of trips	Executive Director
CSFP	Website; Social Media	Website and social media, clicks and views;	Special Projects Manager
Homemaker	GetCare	# of homemaker hours; # of consumer direct participants; high risk demographic	Executive Director
Adult Protection	GetCare; Legal Risk Detector	# of reports; Legal Risk Detector referrals	Adult Protection Supervisor
Ombudsman	GetCare	# of cases; compliant types, information and assistance visits	Ombudsman supervisor

Quality Plan

SWIA3 will utilize the following indicators to monitor strategy performance. Progress will be determined by the measurement identified in the Area Plan Implementation Plan. Reports will include the following indicators on each strategy to track and monitor performance.

- Pending: Strategy not yet started, timeline to implement
- In Progress: Strategy started, report milestones and key dates
- Completed: Date strategy was completed, identify measurements.
- Barriers to implement: Report barriers, recommendations for improvements.

The following is the list of venues and the schedule that will be utilized to present strategy performance.

- **Leadership Meetings:** SWIA3 will use its existing leadership monthly meetings to have leadership report on Area Plan strategy performance measurements. Leadership will be required to submit progress made, barriers, and propose any improvements to Area Plan strategies. Leadership members will be evaluated semiannually on Area Plan assignments and will be subject to employee performance reviews. **Report frequency: Monthly**

- **SWIA3 Board and Advisory Council Reports:** SWIA3 Executive Director will provide the board with an Area Plan semiannual quality assurance report. The board and advisory council will get the opportunity to provide feedback and any recommendations. Board and council members will be utilized to approve annual updates and changes. **Report frequency: Semiannually**

- **ICOA Commissioners Report:** Area Plan strategy progress and updates will be provided during ICOA Commissioners meetings. An initial report will be provided to the assigned region commissioner for PSAIII and an opportunity to provide feedback an any recommendations for improvements. **Report frequency: Quarterly**

- **Area Plan Updates:** A quality assurance report will be attached to Area Plan updates and submitted to ICOA for review. The report will include any proposed strategy changes, barriers identified and justification for unmet strategies. Area Plan updates will also include changes to staffing and strategy assignments. **Report frequency: Annually**

Section 7: Continuation of Operations:

National, State and Local Roles:

National Role: The Administration for Community living provides national guidance and funding to the State Units on Aging to be distributed to the Area Agencies on Aging. The Southwest Idaho Area Agency on Aging (SWIA3) supports disaster planning efforts by participating in funding awards during emergencies and collaborates with ICOA to implement a local disaster plan strategy.

In addition, SWIA3 promotes emergency preparation resources to the public through email distribution and social media. Currently, SWIA distributes COVID 19 CDC information, follows the guidelines and educates its providers on COVID 19 protocols.

State: SWIA3 is responsible to respond to any coordination efforts initiated by Idaho Commission on Aging (ICOA) during regional emergencies. The ICOA is a supporting agency in the Idaho Office of Emergency Plan and is responsible to coordinate senior services during statewide emergencies through the Area Agencies on Aging.

https://ioem.idaho.gov/wp-content/uploads/sites/57/2020/07/2019-Idaho-Emergency-Operations-Plan.pdf

The responsibility to ensure services continue without interruption is listed in the SWIA3 and ICOA Contract.

> *Continuity of Services. The Contractor recognizes that the services provided under this Contract are vital to the ICOA and must be continued without interruption. The Contractor further recognizes that upon Contract expiration or termination, a successor, either the ICOA or another entity, may continue services within the PSA. Upon notification of termination the Contractor must provide a transition plan subject to the approval of the ICOA that minimizes any negative effects to the consumers and provide for an orderly and controlled transition to the ICOA. (ICOA Performance Based Agreement; Item 20)*

Local: SWIA3 is currently established under a joint power's agreement between 8 out of the ten counties in our area. Members of the SWIA3 board consist of elected county commissioners which have authority and oversite over the organization. The county commissioners have the authority to determine a local disaster emergency. (Idaho Code 46-1011) The Board of Commissioners are provided with the necessary authority over the business operations of SWIA3 and can delegate responsibilities as needed to respond to regional emergencies.

Senior center providers are required to describe emergency procedures to apply to be a nutrition provider, to ensure no loss of services occur during emergencies. In addition, Service providers are required to provide at minimum 30-day notices before contract termination and 24 hours before or after changes in service delivery schedules.

SWIA3 is also a volunteer member of the Idaho Voluntary Organizations of Active in Disaster (IDVOAD) association. VOAD is an association of governmental and nonprofit organizations that work together to mitigate and alleviate the impact of disasters. https://www.idvoad.org/

Basic Components of an Area-Wide Disaster Plan:

1. Name and title AAA person responsible for implementation of area's Disaster Plan:
`

AUTHORITY TO IMPLEMENT COOP PLAN				
Key Executive	Title/Position	Office Phone #	Alternate Phone	email
Raul Enriquez	Executive Director	208-898-7070	208-284-4072	raul.enriquez@a3ssa.com
Roberta Bischel	Program Manager	208-898-7069		Roberta.bischel@a3ssa.com

2. COOP Team:

Department	Team Members	Team Responsibilities
Alternate emergency contact information is stored at the front desk in a locked file cabinet. (Office Manager, Program Manager, Executive Director will have access)		
Administration	Raul Enriquez, Executive Director Work Phone: 208-898-7070 Work Email: raul.enriquez@a3ssa.com Brandi Waselewski, Fiscal and Contracts Manager Work Phone: 208-898-7077 Work Email: brandi.waselewski@a3ssa.com Jan Adams, Office Manager Work Phone: 208-898-9642 Work Email: jan.adams@a3ssa.com	• Communication with providers • Communication with IT • Communication with Telephone • Ensure no discontinuation of services with contracted providers • Website Notifications • Public Service Announcements • Social Media Notifications • Communication with the administration team • Communication with Newspapers • Communication with ICOA Staff
Access	Roberta Bischel, Program Manager Work Phone: 208-898-7069 Work Email: roberta.bischel@a3ssa.com Rachel Fiedler, Access Supervisor Work Phone: 208-888-3777 Work Email: rachel.fiedler@a3ssa.com	• Communication with homebound seniors. • Serve as a referral source to direct people to emergency services • Provide information • Reporting on homebound seniors • Communication with Access Department Team
Adult Protection	Christopher Parish, Adult Protection Supervisor Work Phone: 208-898-9829 Work Email: christopher.parish@a3ssa.com Kyle Srack, Adult Protection Lead	• Communication with Adult Protection team • Communication with law enforcement and bureau of facility licensing • Communication with vulnerable adults

	Work Phone: 208-898-7072 Work Email: kyle.srack@a3ssa.com	
Ombudsman	Roberta Bischel, Program Manager Work Phone: 208-898-7069 Work Email: roberta.bischel@a3ssa.com Stephanie Persinger, Ombudsman Lead Work Phone: 208-898-7067 Work Email: stephanie.persinger@a3ssa.com	• Communication with Ombudsman staff • Communication with facilities • Communication with ICOA Ombudsman program specialist • Communication with Volunteer Ombudsman
Family Caregiver Support	Julie Torresani, Family Caregiver Support Supervisor Work Phone: 208-871-2344 Work Email: julie.torresani@a3ssa.com	• Communication with caregivers • Communication with Kinship families
Special Projects	Natalie Nathan, Special Projects Manager Work Phone: 208-860-9053 Work Email: natalie.nathan@a3ssa.com	• Communication with Living Well workshop attendees • Assist in Marketing and Networking • Social Media Posts • Communication Living Well Volunteers

Succession Planning:

Below is a list of orders of succession to essential positions critical to the SWIA3 COOP plan.

Essential Position	1st Successor Name/Position	2d Successor Name/Position	3d Successor Name/Position
Executive Director	Board Chair	Program Manager	Fiscal/Contracts Manager
Program Manager	Executive Director	Department Supervisors	Department Lead
Fiscal/Contracts Manager	Executive Director	Board Chair	Contracts Specialist

3. Alternate AAA business location if primary office is inaccessible or uninhabitable:

Alternate Location Address	Type of Arrangement	Unmet Space Needs
Living Independently Network Corporation; 1878 W Overland Rd, Boise, ID 83705	Warm Site; Operations; 5 Workstations- Administration and Management staff	Access to Network Drive
Remote Work for Front Line Staff	Warm Site; Telework, 30 Workstations	Printing, Telephones

4. Does the AAA have personal and community disaster preparedness information available for clients, services providers and the general public?

Yes, this information is shared on our social media page and information is located in our office. AAA staff also provide personal and community disaster preparedness information over the phone, by email and my mail. The information provided to clients, service providers and the public may come from a variety of sources including:

- Centers for Disease Control and Prevention
- Red Cross
- ready.gov website
- Idaho Office of Emergency Management
- https://acl.gov/emergencypreparedness

5. Local Emergency coordinators and Red Cross coordinators in EACH county or city with whom the AAA coordinates emergency planning for the needs of older citizens, and will collaborate during an emergency or disaster situation:

AGENCY/AREA	COUNTY/ OTHER JURISDICTION	LEAD CONTACT NAME/INFORMATION	GENERAL CONTACT
American Red Cross of Greater Idaho	Ada, Adams, Boise Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties	Pending	5380 W. Franklin Road Boise, ID 83705 Local: 208-947-4357 Local: 1-800-853-2570 Gen.: 1-800-733-2767
Idaho Voluntary Organizations Active in Disaster (IVOAD)	Ada, Adams, Boise Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties	Rick Sego, Board Chair Phone: (208) 321-2217 idavoadchair@gmail.com Jeremy Maxand, Board Secretary 1-208-336-3335 Ext. 223 jmaxand@lincidaho.org	707 N. Armstrong Place | Boise, ID 83704 Phone: (208) 321-2217 Email: idavoadchair@gmail.com
Idaho Office of Emergency Management	Ada, Adams, Boise Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties	Rob Feeley SW & South Central Area Field Officer 208-258-6519 rfeeley@imd.idaho.gov Heidi Novich SW & South-Central Area Field Officer 208-258-6523 hnovich@imd.idaho.gov	4040 Guard St., Bldg. 600 Boise, ID 83705-5004 208-422-3040 or 208-258-6500
Central District Health	Ada, Boise, Elmore, and Valley Counties	Natalie Bodine Program Manager Public Health Preparedness Phone: 208-321-2217	Ada: 707 Armstrong, Boise, ID 83704 208-375-5211 McCall:

		Email: nbodine@cdh.idaho.gov	703 1st St., McCall, ID 83638 208-634-7194 Mountain Home: 520 E. 8th Street N, Mountain Home, ID 83647 208-587-4407
Southwest District Health	Adams, Canyon, Gem, Owyhee, Payette, and Washington Counties	Wilson Terry Public Health Planner 208-455-5326 Ricky Bowman Public Health Preparedness Phone: 208-716-6198 Idaho State Communications Center 1-800-632-8000	Caldwell: 13307 Miami Lane Caldwell, Idaho 83607 208-455-5300 Payette: 1155 Third Ave. North Payette, ID 83661 208-642-9321 Weiser Office: 46 West Court Weiser, ID 83672 208-549-2370 Emmett: 1008 East Locust Emmett, ID 83617 208-365-6371
St. Alphonsus Medical Center	Ada, Adams, Boise Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties	Kathryn Quinn Safety Officer Phone: 208-367-4142 kathryn.quinn@saintalphonsus.org	1055 North Curtis Road Boise, ID 83706 208-367-2121
Idaho Foodbank	Ada, Adams, Boise Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties	Jennifer Erickson Safety and Compliance Manager Email: jerickson@idahofoodbank.org Phone: 208-577-2725	Phone: 208-336-9643 Email: info@idahofoodbank.org
Ada County	Ada County	Joe Lombardo Director Ada County Emergency Management Phone: 208-577-4750	7200 Barrister Dr. Boise, ID 83704-9292 208-577-4750
Ada County Sheriff	Ada County	Sheriff Matt Clifford	7200 Barrister Dr. Boise, ID 83704 208-577-3000 208-377-6790 (Non-emergency Dispatch)
Adams County Sheriff	Adams County	Sheriff Ryan Zollman Phone: 208- 253-4228 ext. 4160 Email: rzollman@co.adams.id.us	201 Industrial Ave. Council, ID 83612 208- 253-4227 (Dispatch – Press 2)
Boise County	Boise County	Trina Richardson Fire Mitigation and Emergency Manager	Phone: 208-807-0073 Email: trichardson@co.boise.id.us

Boise County Sheriff	Boise County	Sheriff Scott Turner Email: shturner@co.boise.id.us	3851 ID-21 Idaho City, ID 83631 208-392-4411 (Non-Emergency Dispatch)
Canyon County	Canyon County	Christine Wendelsdorf Emergency Management Coordinator Phone: 208-989-2132 Email: christine.wendelsdorf@ canyoncounty.id.gov	Phone:208-454-7271 office
Canyon County Sheriff	Canyon County	Sheriff Kieran Donahue Email: sheriffsoffice@canyonco.org	1115 Albany St Rm.137 Caldwell, ID 83605 208-454-7510 208-454-7531 (Non-Emergency Dispatch)
Elmore County	Elmore County	Carol Killian Emergency Manager	Phone: 208-590-0967 Email: ckillian2005@msn.com
Elmore County Sheriff	Elmore County	Sheriff Mike Hollinshead Phone: 208-587-3370 ext. 1028	2255 East 8th North Mountain Home, ID 83647 208-587-3370
Gem County	Gem County	Laurie Boston Emergency Manager	Phone: 208-284-0772
Gem County Sheriff	Gem County	Sheriff Donnie Wunder Phone: 208-477-2026 Email: sheriff@co.gem.id.us	415 E Main St. Emmett, ID 83617 208-365-3521
Owyhee County	Owyhee County	Jim Desmond Emergency Coordinator	Phone: 208-249-0571 Email: ocnrcdir@aol.com
Owyhee County Sheriff	Owyhee County	Sheriff Perry Grant Email: pgrant@co.owyhee.id.us	20381 State Highway 78 Murphy, ID 83650 208-495-1154 or 911
Payette County	Payette County	Adam Gonzalez Emergency Coordinator	Phone: 208-642-6006 Email: agonzalez@payettecounty.org
Payette County Sheriff	Payette County	Sheriff Andrew Creech Phone: 208-642-6006 Email: acreech@payettecounty.org	1130 3rd Ave. N. Rm.101 Payette, ID 83661 208-642-6006
Valley County	Valley County	Chief Juan Bonilla Emergency Manager Donnelly Rural Fire Protection Association	244 W Roseberry Rd, Donnelly, ID 83615 dfc@frontiernet.net 208-325-8619
Valley County Sheriff	Valley County	Sheriff Patti Bolen Phone: 208-382-7150 Email: sheriff@co.valley.id.us	107 W Spring St Cascade, Idaho 83611 208-382-5160 (Dispatch)
Washington County	Washington County	Tony Buthman Emergency Manager	Office: 208-414-4744 or 208-907-2275

Washington County Sheriff	Washington County	Sheriff Matt Thomas Email: wcsheriff@co.washington.id.us	262 East Court Street Weiser, ID 83672 208-414-2121 (Dispatch)

6. Included clauses in contracts, grants and agreements with service providers describing and assuring their response during a disaster or emergency.

During request for proposals applications providers are asked, *"Describe in detail the Emergency Procedures in the event nutrition services are not operational".* Responses are reviewed and taking into consideration before contract execution.

Senior center providers are required to describe emergency procedures to apply to be a nutrition provider, to ensure no loss of services occur during emergencies. In addition, Service providers are required to provide at minimum 30-day notices before contract termination and 24 hours before or after changes in service delivery schedules.

7. List service providers of major programs (transportation, nutrition, homemaker, etc.) with whom the AAA will coordinate emergency services.

8. SERVICE PROVIDER NAME AND ADDRESS	COUNTY/ OTHER JURISDICTION	CONTACT NAME	PHONE / E-MAIL
Metro Community Services	Ada, Canyon, Gem, and Owyhee	Gale Kennedy	208-459-0063 gale@metrocommunityservices.net
Metro Meals on Wheels	Ada	Cheryl Johnson	208-321-0031 cjohnson@metromealsonwheels.net
Nampa St. Alphonsus Home Delivered Meals	Canyon	Tonia Bradshaw	208-205-0292 tonia.bradshaw@saintalphonsus.org
Elderly Opportunity Agency	Adams, Boise, Canyon, Gem, Owyhee, Payette, Valley, and Washington	Bree King	208-365-4461 director@eoaidaho.org
A Helping Hand	Ada, Boise, Canyon, Gem, Elmore, Owyhee, Payette, Washington	Kristi Olson	208-908-6111 care@idahohelpinghand.com
Addus Home Care	All Areas	Darby Anderson	208-342-1222 natlcontracts@addus.com
Bluebird Health	Ada and Canyon	Lynne Ward	208-336-9898 lward@bluebirdhealth.com
Caldwell Senior Center	Canyon	Patty Brackett	208-454-7211 caldwellseniors@yahoo.com
Cascade Senior Center	Valley	Janey Chappell	208-382-4256 cascadeseniorcenter@frontier.com
Comfort Keepers (DBA)	Ada, Canyon, Mountain Home, Emmett, Homedale, and Marsing	Sonjia Yates	208-357-4595 sonjiayates@comfortkeepers.com
Council Senior Center	Adams	Nancy Schwartz	208-253-4282 csc@ctcweb.net

Havenwood	Ada, Canyon, Gem, Elmore	John O'Keefe	208-327-1011 jokeeffe@havenwoodhomecare.com
Homewatch Caregivers	Boise, Caldwell, Eagle, Emmett, Garden City	Eric Wallentine	208-273-9308 ewallentine@homewatchcaregivers.com
Horseshoe Bend Senior Center	Boise	Kimarie Graham	208-793-2344 hsbseniors@gmail.com
LINC	Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley and Washington	Sharon Barber	208-336-3335 sbarber@lincidaho.org
Melba Valley Senior Center	Canyon	Michelle Martinez	208-495-2168 Melbavalleyseniors2@gmail.com
Mountain Home Senior Center	Elmore	Lisa Simpson	208-587-4562 mountainhomeseniorcenter1000@gmail.com
Parma Senior Center	Canyon	Pam Garza	208-722-5421 parmaseniorcenter@yahoo.com
Payette Senior Center	Payette	Kathy Patrick	208-642-4223 goldenrule836@yahoo.com
Three Island Senior Center	Elmore	Kay Knab	208-366-2051 knab.3islandsrs@gmail.com
WICAP	Adams, Horseshoe Bend, Gem, Payette, Valley, Washington	Jonathan Gonzalez	208-642-9086 Ext. 1011 gonzalezj@wicap.org

9. Does the AAA have a process to identify homebound, frail, disabled, isolated and/or vulnerable clients who may need assistance in the event of a man-made or natural disaster:

Yes, this information is maintained on the statewide Management information system (MIS). All recipients of Home Delivered Meals, Homemaker, Chore, Respite and Case Management Services have addresses and/or directions to their home accessed through the statewide MIS database (GetCare). The database has client demographics and emergency contact information to determine the status of the individual that there may be a concern about.

Another resource our AAA has available to identify frail, disabled and/or vulnerable clients is the HHS emPOWER Map 2.0. This internet-based tool helps to further identify specifics about Medicare beneficiaries in our area. The HHS emPOWER Map 2.0 features the monthly total of Medicare beneficiaries with electricity-dependent equipment claims at the U.S. state, territory, county, and zip code level to identify the areas and populations that may be impacted and at risk for prolonged power outages. The AAA will likely receive information from this internet-based tool from personnel of the local incident command system. AAA staff will then be able to provide further assistance to homebound, frail, disabled, isolated and/or vulnerable adults as directed by these local emergency officials.

10. Describe the AAA's process for intake and recording of information about the disaster related needs of older people, providing access to needed services, and follow-up during and beyond the recovery period.

The capability and extent of assistance the AAA`s can provide, in case of a disaster or emergency are limited. Primary to the mission is disaster relief and assistance. The first 24 hours of a disaster or emergency are key to accessing relief and assistance. In case of a disaster or emergency the following information should be recorded on any known victims:

- Name
- Home address
- Telephone number, if working
- Known health conditions
- Next of kin and telephone number
- Nature of need
- Location of individual if not at home

This information should be relayed to Idaho Office of Emergency Management (IOEM) if rescue is required. The AAA Director and ICOA should be made aware of all efforts accomplished by IOEM.

The AAA will be prepared to pass on information to the Idaho Commission on Aging about the approximate number of older persons that might be residing in each area.

It is vitally important that any contracted nutrition providers who provide commodities or meals during a disaster or emergency, keep extensive and accurate records of what was provided to whom, when, and under what circumstances and at whose direction. These services are reimbursable by the federal government if properly authorized but require good records in order to make a claim. The (AAA) must be able to indicate how many older persons might be residing in a given area. This information is to be provided to ICOA by the AAA involved immediately after a disaster. Region X is required to contact the ICOA to obtain and forward this information to the federal government.

11. Describe the AAA's process for staff and service providers to record employee's time and expenses associated with disaster related activities (see example below: necessary to apply for reimbursement in the event of a presidential disaster declaration):

AAA staff and service providers must maintain accurate records during an emergency event, including time worked, emergency purchases made, and personal miles driven for work purposes, as well as instructions and information that the individual engaged in. These documents will be required for monetary reimbursement and payroll. These records will be invaluable after the event to improve the AAA emergency preparedness plan. AAA utilizes the example below for the documentation that is necessary to apply for reimbursement in the event of a presidential disaster declaration. Copies of this form will be available at the front desk at the agency and an electronic copy will be available on the AAA shared drive.

AAA Employee Emergency/Disaster Record								
Authorized Person's Name:								
Date	**Time Worked**	**Emergency Purchases Made**	**Purpose of Purchase**	**Costs of Emergency Purchase**	**Personnel Miles Driven**	**Store Purchase made and Location**	**Instructions & information**	**Instructions Came From**

12. Describe activities the AAA will undertake during the contract period to expand emergency preparedness of the Aging Network within the PSA (i.e. attend LEPC meetings, work with local emergency management officials to advocate for inclusion of older citizens' needs in emergency planning, establish CERT Training in senior centers, make 72-hour kits available for homebound clients, establish "call-down' lists and procedures to be used during emergencies, include emergency preparedness activities in contracts with providers, etc.)

AAA staff will work with local emergency management officials, particularly the regional Idaho Healthcare Coalition and the Local Emergency Planning Committee's (LEPC) in our area, to advocate for inclusion of older citizens' needs in emergency planning. The AAA will cultivate strategic partnerships with entities that have expertise in service to aging and/or adult populations with disabilities. These partnerships might include local chapters of the Voluntary Organizations Active in Disasters (VOAD), the regional Idaho Healthcare Coalition and Local Emergency Planning Committee's (LEPC). The AAA service providers contracts or agreements will continue to include clauses that describe and assure their response during a disaster or emergency.

AREA AGENCY ON AGING RESPONSIBILITIES IN THE EVENT OF AN EMERGENCY OR DISASTER

- Develop and maintain Continuity of Operations Plan (COOP) to (a) address how the agency will provide essential services to citizens during response and recovery, and (b) return the agency to normal operations
- Agencies will notify the IOEM of any significant event, incident, emergency or disaster, impacting the ability of government to provide public services within the State of Idaho
- Provide resource and logistical support (i.e. personnel, equipment, materials, supplies, etc.) to the IDEOC as requested, within the scope, laws, and policies that govern their organizations
- The primary goal of our agency during an emergency is to maintain a continuity of service at a minimum level for older adult and family caregivers in our area. Highest consideration will

be placed on senior nutrition and information and assistance which are an essential part of response and recovery. Efforts will be made to identify and map vulnerable populations.

- AAAIII recognizes that the responsibility for coordinating emergency preparedness rests with the Idaho Office of Emergency Management (IOEM) through public health officials and local elected officials. As an Area Agency on Aging however, we are responsible to ensure the needs of older adults are considered and addressed in time of natural and man-made disasters. AAAIII first priority after a disaster is to ensure that services to our consumers and contract agencies continue or are restored as soon as possible. AAAIII staff will assess the status of provider staff and clients, facilities and needs as soon as possible after a disaster in an effort to provide them with needed assistance to continue operations. After addressing the needs of AAAIII consumers and programs, AAAIII staff may assist local emergency operations with specific emphasis on older adults and family caregivers.

Evacuation/Non-Evacuation

Evacuation

There are many types of natural and human-caused emergencies that could occur while we are at work. When an emergency arises, we will be notified through official channels.

Evacuation of facility in the event of:

- Covid 19 infection rates
- Flood
- Fire
- Chemical Spills (inside the building)
- Earthquake (non-high rise building)
- Bomb (threat or explosion)
- Violence
- Bio-Terrorism

Evacuation Procedure:

- When time allows, shut your door, before you leave the building
- Exit the building in a calm manner through one of the main doors of the building (doors at the north or south side of the building)
- Staff must reassemble at the predetermined location (northwest end of parking lot) to verify everyone is safely out of the building

No Evacuation of facility in the event of:

- Weather

- Chemical Spills (outside)
- Civil Disorder

The Idaho Emergency Operations Plan indicates Area Agencies on Aging will assist during an emergency in the following ways:

Mass Care (Idaho Emergency Support Function)

- Inform local emergency officials and Idaho Commission on Aging of the needs of the elderly and homebound elderly
- Coordinate senior services with contracted providers
- Provide disaster related information /assistance to consumers
- Assist with coordination for the utilization of senior citizen centers for shelter, mass feeding, and rest centers

Pandemic Influenza

- Disseminate informational and action-required messages received by the, local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management
- Provide assistance in coordinating with senior centers for mass vaccination operations (i.e., facilities, staffing) as listed under Mass Care.

Flooding

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Earthquake

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Severe Weather

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Nuclear/Radiological Incident

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Cybersecurity Incident

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Terrorism

- Provide support as requested and coordinated by local public health officials, Idaho Commission on Aging and/or Idaho Office of Emergency Management. The level of involvement will vary based on the disaster

Should a disaster or state of emergency exist in our area, the following individuals will be responsible for actions indicated. The Executive Director has been assigned as the Emergency Coordinator. In their absence, Program Manager, has been assigned alternate.

AREA AGENCY ON AGING FISCAL OPERATIONS:

Payments during emergencies will continue to providers for on-going distribution of services. We will ensure funds are made available to contracted providers to support their ability to serve vulnerable seniors during emergencies. SWIA3 must be able to receive funding and make payments to the providers.

Process for paying bills to providers in the event we lose access to network, internet is disabled or office closures:

- Back up internet MIFI's can be utilized to connect to the internet. (if the internet is disabled.)
- Fiscal Manager will have the ability to remote into the fiscal management system from home. (QuickBooks)
- QuickBooks data is backed up daily and offsite. IT will assist, staff to have access to data if staff lose the ability to have access locally.
- Payroll system will continue as normal. Payroll is processed offsite utilizing the ADP system.
- Fiscal team can access outlook emails offsite to accept and approve invoices.
- There are currently three signers assigned to sign checks if needed.
- ICOA payments are electronically deposited into the bank account.

RECORD KEEPING

AAA staff must maintain accurate records during an emergency event, including time worked, emergency purchases made, personal miles driven for work purposes, as well as noteworthy benchmark activities, instructions, and information. These documents will be required for monetary reimbursement and payroll and be invaluable after the event in order to improve emergency preparedness plans.

Vital Records:

Vital Record	Storage Location	Maintenance Frequency	Current Protection Method(s)	Recommendations for Additional Protection
Contracts	Adjacent to Fiscal Office; Previous years back hallway.	3 years	Locked File Cabinet	Electronically stored on shared drive
Fiscal Records	Adjacent to Fiscal Office; Previous years back hallway.	3 years	Locked File Cabinet	Electronically stored on shared drive
Human Resources	Executive Directors Office	5 Years	Locked File Cabinet	Electronically stored on shared drive
LTC Ombudsman	Center Hallway adjacent to Ombudsman Offices	3 Years	Locked File Cabinet	None
Emergency Call List	Emergency Preparedness Folder; Executive Directors Office and Front Desk	6 Months	Locked File Cabinet	Electronically stored on shared drive

Attachment A: Idaho Intrastate Funding Formula

Attachment E

Idaho Intrastate Funding Formula **SFY 2022** **Adopted April 30, 2013** Updated: 5/28/2021

OAA Title III Funds (not including Title VII) and State of Idaho General Funds **Effective July 1, 2022**

Total OAA Federal Funds	$ 6,141,517
Total State Funds	$ 3,697,600
Total Funds	$ 9,839,117
Less 10% Base Amount of Federal and State Funds	$ 983,912
Balance to be Distributed by Formula:	**$ 8,855,205**

Factors used in Weighted Elderly Population (At Risk): columns 3–9

PSA	2019 TOTAL PSA POPULATION	TOTAL PERSONS AGED 60+ IN PSA	NUMBER OF 65+ LIVING IN POVERTY	65+ LIVING ALONE	60+ RACIAL MINORITY (Not Hispanic)	60+ HISPANIC (ETHNIC MINORITY)	60+ LIVING IN RURAL COUNTY	AGED 75+	AGED 85+	WEIGHTED ELDERLY POPULATION (AT RISK)	**WEIGHTED "At Risk" PERCENTAGE**	**Federal Fund Base**	**State Fund Base**	**Federal Funds Distributed by Formula**	**State Funds Distributed by Formula**	**TOTAL FUND ALLOCATION**
												$ 614,152	**$ 369,760**	**$ 5,527,365**	**$ 3,327,840**	**$ 9,839,117**
I	245,861	70,175	3,357	10,983	2,246	1,363	30,349	19,911	4,906	73,115	17.47%	$ 102,359	$ 61,627	$ 965,493	$ 581,291	**$ 1,710,770**
II	109,777	29,578	1,805	5,178	1,375	386	11,758	9,371	2,683	32,556	7.78%	$ 102,359	$ 61,627	$ 429,906	$ 258,832	**$ 852,724**
III	826,544	176,345	10,266	29,275	6,948	9,224	46,023	49,203	12,508	163,447	39.05%	$ 102,359	$ 61,627	$ 2,158,339	$ 1,299,463	**$ 3,621,788**
IV	201,031	44,026	2,860	7,042	1,445	3,846	26,499	13,533	3,584	58,809	14.05%	$ 102,359	$ 61,627	$ 776,581	$ 467,553	**$ 1,408,119**
V	173,987	36,641	2,102	6,234	1,931	1,860	19,819	10,508	2,836	45,290	10.82%	$ 102,359	$ 61,627	$ 598,060	$ 360,072	**$ 1,122,118**
VI	229,865	42,724	1,911	6,833	1,192	1,752	18,137	12,278	3,257	45,360	10.84%	$ 102,359	$ 61,627	$ 598,985	$ 360,629	**$ 1,123,599**
TOTAL	**1,787,065**	**399,489**	**22,301**	**65,545**	**15,137**	**18,431**	**152,585**	**114,804**	**29,774**	**418,577**		**$ 614,152**	**$ 369,760**	**$ 5,527,365**	**$ 3,327,840**	**$ 9,839,117**
Column Ref.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Notes RE Calculations

The source documentation is from the ID Dept. of Labor.

Column 1 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column used as a reference only.

Column 2 Source: U.S. Bureau of the Census,, 2014-2019 American Community Survey 5-Year Estimates - Table B17001 (Column 2).
Column used as a reference only.

Column 3 Source: U.S. Bureau of the Census,, 2014-2019 American Community Survey 5-Year Estimates - Table B11010 (Column 3).
Column 3 is used with columns 4 - 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 4 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 4 is used with columns 3 and 5 - 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 5 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 5 is used with columns 3 - 4 and 6 - 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 6 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 6 is used with columns 3 - 5 and 7 - 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 7 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 7 is used with columns 3 - 6 and 8 - 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 8 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 8 is used with columns 3 - 7 and 9 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 9 Source: U.S. Bureau of the Census, Population Estimates - County Characteristics: Vintage 2019
Column 9 is used with columns 3 - 8 to calculate the total "Weighted Elderly Population (At Risk)" in Column 10.

Column 10 Column 10 sums each row for columns 3 - 9 and identify the total "Weighted Elderly Population (At Risk)" per PSA.

Column 11 Weighted At Risk percentage from the Intrastate Funding Formula: Column 11 turns Column 10's totals into percentages.
These percentages are used to calculate federal funds in column 14 and state funds in column 15 for each of the PSAs.

Column 12 Federal "Base" funds are evenly divided amongst the 6 PSAs.
Column 12 is used to record the total federal base funding located at the top of Column 12 into six even amounts for each PSA.

Column 13 State "Base" funds are evenly divided amongst the 6 PSAs.
Column 13 is used to record the total state base funding located at the top of Column 13 into six even amounts for each PSA.

Column 14 Federal Funds multiplied by the Weighted Percentage.
Column 14 shows the distribution of the remaining federal funds after the "base" was distributed.
The remaining federal funding is located at the top of Column 14 and is multiplied by each "Weighted At Risk Percentage" in Column 11 to determine the appropriate distribution.

Column 15 State Funds multiplied by the Weighted Percentage:
Column 15 shows the distribution of the remaining state funds after the "base" was distributed.
The remaining state funding is located at the top of Column 15 and is multiplied by each "Weighted At Risk Percentage" in Column 11 to determine the appropriate distribution.

Column 16 Column 16 shows the total federal and state distribution and is a total of Columns 12, 13, 14 and 15.