Middle Alabama Area Agency on Aging
Regional Plan on Aging Fiscal Years 2018 – 2021

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Verification of Intent

Middle Alabama Area Agency on Aging hereby submits the area plan on aging for the period October 1, 2017 through September 30, 2021 to the Alabama Department of Senior Services. The operating agency named above was given the authority to develop and administer the area plan on aging in accordance with all requirements of the Older Americans Act, as amended, and is primarily responsible for the coordinator of all regional activities related to the purpose of the Act as the designated Area Agency on Aging. This includes, but is not limited to, the development of comprehensive and coordinated systems for the delivery of supportive services, including multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for seniors in the region.

This plan is hereby approved by the Advisory Board and Operating Agency Board of Directors and constitutes authorization to proceed with activities under the plan upon approval of the State Unit on Aging.

The area plan hereby submitted was developed in accordance with all state and federal statutory and regulatory requirements.

This plan is based upon projected receipts of federal, state and other funds and thus is subject to change depending upon actual receipts and/or changes in circumstances. Substantive changes to this plan will be incorporated through amendments to the plan.

04/26/2017
Date

(signed) Chairman, M4A Board of Directors

04/26/2017
Date

(signed) Executive Director

Request for Waivers

Reviewed:	GTM
Approved: Commissioner	[signature]
Denied: Commissioner	
Date:	4/27/17

Alabama Department of Senior Services
FY 2018 WAIVER REQUEST FORM

Area Agency on Aging: Middle Alabama Area Agency on Aging **FY:** 2018

Date Submitted: April 19, 2017

Service/Activity: C1 and C2 meals at the Moody Senior Center (only one service/activity per waiver request)

Part A: Reason for Request:

1. The Area Agency on Aging requests a waiver to deliver services directly for the following reason (please check at least one):

☐ a. The direct provision of such services is necessary to assure an adequate supply of such services.
☐ b. Services of comparable quality can be provided more economically by the area agency.

2. Request for reduction in Senior Center Operating Days. √

3. Request for non-participation in Cost Share. ☐

Part B: Description of reason for waiver request: (Include geographical area to be served and period of time waiver will be in effect.)

The City of Moody in St. Clair County operates Monday-Thursday only; request waiver to operate senior center 4 days per week (Monday-Thursday).

Part C (for Reason 1): Describe Lack of Adequate Supply of Service (Required if number 1 in Part A) 1 is checked. Documentation of the AAA's program development and procurement process is required.)

Part D: Cost-Benefit Analysis (Required if a in Part A) 1 is checked. Documentation that services of comparable quality can be provided more economically by the area agency is required.)

ADSS 8/11/2015

Part E: If request is for reduction in days served (less than 5 days a week), explain how high risk participants and C-2 clients will be served 5 days a week:

Explanation: The Center Manager offers/will offer a meal on Thursdays for high-risk clients (congregate and homebound) so that they will have a noon meal on Fridays.

Part F: If request is for cost share waiver, Part A) 3 answer, check box a or b, and explain.

☐ a. Is a significant portion of the persons receiving the services under the Act and subject to cost sharing under the state threshold of $981.00 per month income? Yes or No (provide documentation)

Explanation: ____________________

____

____

☐ b. Explain how and why cost sharing would be an unreasonable administrative or financial burden on the AAA.

Explanation: ____________________

____

____

Part G: Signature

____________________ ____________________

Signature of Area Agency on Aging Director — Date

04/19/2017

____________________ ____________________

Signature of Executive Director — Date

Section I

Executive Summary

The Middle Alabama Area Agency on Aging or M4A was formed in 1989 by multi-jurisdictional agreement between the counties of Blount, Chilton, Shelby, St. Clair, and Walker. Shortly thereafter, M4A was designated as the Area Agency on Aging for these five counties. M4A is Planning and Service Area (PSA) 3 for the State of Alabama and comprises five of the six counties in the Regional Planning Commission of Greater Birmingham.

M4A's mission is to empower older individuals, people living with disabilities and their caregivers to self-advocate and to live independently and safely in the communities of their choice. M4A fulfills this mission through its various partnerships, programs, and special projects.

M4A's primary partner and funder is the Alabama Department of Senior Services (ADSS), the state unit on aging which receives and distributes federal funding from the Administration for Community Living (ACL). The Alabama Department of Senior Services also provides funding to the Area Agencies on Aging (or AAAs), like M4A, for SenioRx (medication assistance), Emergency Preparedness, Dementia Friendly Communities, Medicaid Waiver Programs, Information and Assistance, Long-term Services and Supports through the Aging and Disability Resource Center, the State Health Insurance Assistance Programs (SHIP or Medicare counseling), the Senior Community Service Employment Program (SCSEP), and Chronic Disease Self-Management.

M4A's other major partners are the five county governments which formed M4A and the numerous municipalities that have agreements with M4A to provide meals and other Older Americans Act (OAA) services. These agreements with municipalities for the senior nutrition sites are critical to the success of M4A's service delivery system as the local senior centers are major focal points not only for the dissemination of information and for the provision of services but also major focal points for consumer feedback and input into strengthening and changing the service delivery system.

Two significant challenges M4A faces over the next 4 years are the increase in the service population in the M4A region and the funding shortfall to keep pace with the growing older adult population. For example, the 65+ population in the M4A region is projected to grow 123% from 2010 to 2040. The state growth rate during the same time period for 65+ is 82.4%. In addition, both St. Clair County and Shelby County will have population increases in the 65+ age group that significantly outpace the state growth: St. Clair, 162.9%; and Shelby, 248.8%. Currently, the M4A region has approximately 462,289 people with approximately 22% or 101,704 people being 60+.

According to the National Association of Area Agencies on Aging (or n4a), in 1980 the US Government budgeted $9.24 for each American 65+. However, in 2010, the federal government spent only $3.85 per American adult 65+. So, although more Americans are 65+ and more Americans are living longer with increased health care and home and community-based needs, the federal dollars to address these needs have decreased 58% in 30 years. The fact that M4A and

other AAAs are heavily dependent on government funding makes us vulnerable and makes the need to innovate, change and diversify funding sources critical if we are to continue to fulfill our respective missions to serve older Americans.

Another challenge for M4A over the next couple of years is the implementation of Medicaid Managed Care under the Integrated Care Networks. M4A and the other Area Agencies on Aging (Regional Councils) in Alabama are currently undergoing transformation in order to contract with Integrated Care Networks. This transformation has created opportunities for improvement and innovation. Because most if not all the Area Agencies on Aging in the State of Alabama are heavily dependent on Medicaid funding, it is critical for M4A and other Area Agencies on Aging to, again, seek viable new funding streams. M4A has done this and will continue to do this over the next four years by examining the benefits of forming a nonprofit organization, expanding evidence-based programs including diabetes education and medical nutrition therapy to the public and private sector, emphasizing cost-share, and developing partnerships for Veterans-Directed Home and Community-Based Services. M4A will also and has also gone after additional grant funding and leveraged partnerships to increase donations of both supplies to help our clients and funding to pay for their needs.

For this Area Plan, the needs of the older individuals in the M4A region were determined by surveys, public hearing, and by recently published reports. In addition, data and statistics from the US Census Bureau and from the Administration for Community Living were used.

During FY 2017, M4A surveyed over 250 people and asked what the top senior needs were. The advantage of this survey was the number of surveys that was completed. The disadvantage of this survey was that most people surveyed were already familiar with M4A and/or consumers of M4A services. Another survey that was used to gauge the needs of older individuals in the M4A region was the EngAge report of the Community Foundation of Greater Birmingham (CFGB). The advantage of this report is that it was done professionally, independently, and is statistically significant.

According to the M4A survey, the top needs of older individuals are transportation, food, money to pay for utilities, and home repairs. The EngAge report indicated that older individuals must have access to nutritious food and live in a safe home and community in order to successfully age in place. The EngAge report also indicated that only 5% of older individuals in the M4A region knew about M4A.

So, in its objectives for the next four years, M4A will address the need to increase its visibility as a no-wrong-door Aging and Disability Resource Center. In addition, M4A will develop innovative partnerships and initiatives to continue to feed older individuals, provide viable food options, examine ways to coordinate low cost home modifications/home safety checks, and examine innovative transportation models for senior citizens. M4A will also continue to address financial or economic security of older individuals and enhance disease prevention and health promotion to improve health outcomes.

In addition to the priority areas above, the goals of M4A for this Area Plan complement those of the Alabama Department of Senior Services:

GOAL 1.0: Older adults, individuals with disabilities, and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long-term supports and services.

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

GOAL 4.0: Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

M4A will meet these goals and objectives working with its major partners including its County Commissions, senior centers, the Alabama Department of Senior Services and other Area Agencies on Aging, and many more. M4A will also learn from organizations that are successfully meeting the needs of rural, isolated older individuals, such as faith-based organizations and other community-based organizations. M4A will also partner with businesses in the private sector because older individuals and caregivers must be aware of private resources to meet long-term care and other needs.

Section II

Narrative

Introduction

In 2015, state legislation passed which requires competitively managed integrated care networks to assume the financial risk and to oversee the provision of long-term services funded by Alabama Medicaid. This shift in risk from the state Medicaid agency to private companies has taken place across many states in the United States, creating both threats to and opportunities for Area Agencies on Aging, like the ones in Alabama, who provide case management under waiver programs. The change in how the Alabama AAAs will be reimbursed for Medicaid Waiver case management is just one of the challenges M4A faces over the next few years.

Other challenges and opportunities faced by M4A include the need to diversify funding sources; purchase and maintain IT systems which track, monitor and generate outcomes reports; and create new ways to meet the demand for Older Americans Act services. In addition, as M4A analyzed data from its senior needs survey in preparation for this Area Plan, M4A's administrative team saw that there is still great need for basic services, such as food and transportation, in order for senior citizens in the M4A region to live safely and independently at home.

Over the next four years, the M4A Team, with the technical assistance, support, and collaboration of many partners, will address these challenges.

Current and Future Demographics of PSA Aging and Disability Populations

Demographic Information

According to the American Community Survey, the population of the M4A region was approximately 462,289 in 2015 and 465,253 in 2016 with an increase in overall population of 3.29% from 2011 to 2015. The 60+ population in 2011 was approximately 19% of the total population and in 2016 it was about 22% of the total population. There are more women age 60+ in the M4A region than there are men age 60+. Overall, the M4A region is about average with the state for annual income and poverty for those 60+ (8%). Shelby County has a lower percentage (4%) of elders in poverty compared to M4A's other counties: Blount, Chilton, St. Clair and Walker:

	Total 60+	Below Poverty	%
M4A	86,515	6,735	8%
Blount County	12,605	1,195	9%
Chilton County	8,660	910	11%
St. Clair County	16,685	1,450	9%
Shelby County	32,830	1,445	4%
Walker County	15,740	1,735	11%

In the M4A region, 34% of all people aged 60+ have at least a high school degree or equivalent and 24% have some college or associate's degree. The percentage of older individuals in the M4A region who have a bachelor's degree or higher is 19% with a range of 33% in Shelby and 9% in Walker.

According to the 2013 Selected Health Status Indicators published by the Alabama Department of Public Health (ADPH) and the Alabama Rural Health Association, the M4A region has a low percentage of African-American adults, 8%, compared to the state, 26.5%. Blount, Chilton, and Shelby counties, however, have a higher percentage of Hispanics, 7.5%, than the state, 4%. The 65+ population is projected to increase by 123% from 2010 to 2040 with a high of 248.8% in Shelby and a low of 24.7% in Walker. During the same time period, the 65+ population for the State of Alabama will increase 82.4%.

Most of the M4A region is still rural, except Shelby County which is classified as either urban or metropolitan, depending on the source. Shelby County has the largest cities in the M4A region, Alabaster and Pelham. Nonetheless, Shelby County, especially East Shelby County, still has many rural areas and has the highest number of older individuals in the M4A region, according to the USDA, who live in food deserts.

According to the US Census Bureau Special Tabulation, there were approximately 32,460 people 60+ with a disability in the M4A region, based on 2009 to 2013 data from the American Community Survey. Of these, 11% had income in the past 12 months that was below the poverty level. There were more elders living with disabilities in Shelby County but a higher percentage living with disabilities in Walker County. There were more elders with disabilities below the poverty level living in Walker County (1,040) as compared to the other M4A counties.

About 1% of all people 60+ in the M4A region say that they speak English not well or not at all. This is equivalent to approximately 645 people.

Narrative Overview of Characteristics of the Planning and Service Area

According to various resources including the National Institutes of Health (NIH), there are many factors which contribute to the need for long-term care or which put an elder at risk. For example, the older someone is the greater likelihood he or she will need long-term care. In addition, women are more likely to need long-term care than men probably because women statistically outlive men. Other factors which may affect the need for long-term care include family history of chronic medical conditions and also poor diet and exercise. Race and income are indicators of risk in that statistically more minority older individuals live at or below poverty and live in food deserts where there is a strong correlation between diet and chronic medical conditions that affect quality of life and independence. This is supported by statistical data from the EngAge Report which showed that the need for home repairs (a key to safely and successfully age in place) were higher amongst minority seniors and low-income seniors. Older minority individuals, elders who live in rural areas, and elders who are below the poverty level

are also less likely to access services that could improve health outcomes and increase independent living.

Some of the characteristics that M4A examined in preparation for the Area Plan include: race, poverty, rural/urban, disabilities (ambulatory disability, self-care, independent living, and reports of "living with one or more disabilities" which affect independent living) and deaths due to Alzheimer's disease and to Type 2 diabetes.

Below is a table which consolidates data from the Alabama Department of Public Health Selected Health Status Indicators and the US Census Bureau Special Tabulation:

	Alabama	Blount	Chilton	Shelby	St. Clair	Walker
African American	26.50%	1.9%	10.3%	11.4%	9.1%	6.10%
65+	14%	15.0%	14.1%	11.1%	13.1%	16.7%
Change 2010-2040 65+	82.40%	97.7%	81.7%	248.8%	162.9%	24.7%
Below Poverty	19.10%	14.9%	18.3%	8.1%	17.3%	22.1%
200% Below Poverty	38.50%	36.5%	41.2%	20.4%	33.8%	42.8%
Income	$34,880.00	$27,220.00	$28,844.00	$44,734.00	$32,240.00	$33,167.00
Type II Diabetes per 100K	26.8	13.30	15.30	8.20	13.90	35.80
Alzheimer's disease per 100K	31.4	14.50	26.70	13.30	25.10	36.30
Obesity	33%	32%	35%	28%	36%	35%
Life Expectancy at Birth	75.7 years	75.6 years	74.5 years	79.0 years	75.2 years	70.1 years
Ambulatory Difficulty	248,860 OR 26%	3,035 OR 24%	2,600 OR 30%	3,940 OR 24%	6,945 OR 21%	4,795 OR 30%
Self-care or Independent Living Difficulty 60+	96,305 or 10%	1,420 or 11%	950 or 11%	2,495 or 8%	1,735 or 10%	2,130or 14%
Cognitive Decline 60+	101,060 or 11%	1,375 or 11%	1,080 or 12%	2,370 or 7%	1,580 or 9%	2,070 or 13%
With at Least One Disability 60+	158,185 or 17%	2,280 or 18%	1,520 or 18%	4,995 or 15%	3,130 or 19%	2,890 or 18%

In comparison to M4A's other four counties, Walker County had some troublesome health status indicators for Type 2 diabetes and Alzheimer's disease. For example, the deaths in Walker County per 100,000 people attributed to Type 2 diabetes was 35.8 persons. Regionally, this statistic is 17.3 while statewide it is 26.8. In addition, the deaths per 100,000 attributed to Alzheimer's disease for Walker County was 36.3, although regionally this number is 23.2 and statewide this number is 31.4.

St. Clair County, 36%, and then both Chilton and Walker counties, at 35% each, have higher percentages of adult obesity than the state, 33%, while Chilton and Walker counties, both at 30%, have a higher percentage of older individuals 60+ who report some type of ambulatory difficulty. Walker County reports the highest percentage of elders with self-care or independent living difficulty and cognitive decline. A total of 14,815 people 60+ in the M4A region reported at least one disability with about one-third of them living in Shelby County.

In the M4A region, Walker County residents have a lower life expectancy at birth, 71 years, compared to M4A's other counties: Blount 75.6 years, Chilton 74.5 years, Shelby 79.0 years, and St. Clair 75.2 years. The State of Alabama life expectancy at birth is 75.7 years. Finally, Walker County is the only county in the M4A region with a projected decline in the overall population, (-14%), although the 65+ population is anticipated to grow 24.7%, the lowest 65+ growth population projection amongst M4A counties and 57.7% lower than the state projected change in the 65+ age group.

Describe the Methods Used to Assess Needs, Existing Resources to Meet Needs, Needs of the Target Population, and Strategies to Address Unmet Needs

Methods to Assess Needs

The method to determine consumers' needs in the M4A region was primarily survey data and reports based on survey data such as surveys conducted by M4A and the Community Foundation of Greater Birmingham; data gathered by and reports of the Community Foundation of Greater Birmingham, the US Census Bureau, n4a, the Alabama Medicaid Agency, the USDA, the Alabama Department of Public Health, VOICES for Alabama's Children, the Alabama Grocers Association, and the Administration for Community Living. In addition, general information was gathered by researching reports from the NIH website which discuss the prevalence of obesity, its risks and public health impact, including the chronic health conditions that accompany obesity and Type 2 diabetes.

What these statistics and reports indicate is that there is overwhelming need in the M4A region for evidence-based disease prevention and health promotion programs; despite M4A's bests efforts, consumers still do not know who M4A is; older individuals need access to nutritious food and help to stay independently and safely in their own homes; and older individuals need transportation.

Existing Resources to Meet Needs: Local Challenges and Advantages to Meet Current Needs
Each county in the M4A region provides some transportation and some municipalities have their own transportation. What seems to be lacking in transportation is regional coordination of transportation. For example, generally, it is difficult for a consumer in one of the M4A counties to take public transportation to a medical appointment in Birmingham. Also, the cost for such a trip may be prohibitive for consumers. For older individuals living in rural areas, transportation to and from senior centers may be non-existent (Chilton and Walker counties) or unfeasible due to the resources needed to pick-up and drop-off one consumer to a senior center.

Each county in the M4A region has at least one food pantry and each senior center has a food pantry. M4A provides meals, enrolls older individuals for farmers market vouchers each year, and also provides SNAP (Supplemental Nutrition Assistance Program formerly known as Food Stamps) outreach. The county Departments of Human Resources (or DHRs) also enroll in SNAP. The County Commissions and the municipalities in the M4A region, as well as service organizations and faith-based organizations, understand the need for food and each county has at least one nonprofit organization that distributes food.

M4A is the only major public provider of in-home services, which M4A provides through contracts with home health agencies and other respite providers (or direct service providers). Many faith-based organizations in the M4A region have community outreach programs that provide food (through a pantry, for example) and also volunteers for home repair. Volunteers for home repair, however, are seasonal and what is needed for home repair is an organization or organizations willing to coordinate volunteers from faith-based groups, civic groups, professional organizations, and schools. In addition, none of counties or municipalities in the M4A region automatically qualifies for federal funds for home repairs. So, funds for home repair are unpredictable so that an organization would need to solicit home repair materials and donations, too.

In discussions regarding the needs of seniors in the M4A region, potential solutions to meet some needs include: a faith-based adult day care, which has successfully been implemented in other counties in Alabama, and Über for senior citizens. Starting an adult day care is beyond M4A's scope, although M4A would support and partner with organizations who desire to undertake such an initiative. In its Area Plan, however, M4A will look more closely at specific transportation needs and transportation models from other organizations successfully providing transportation options to older adults.

Community Action Agencies and Alabama Power have utility assistance. Emergency organizations like Shelby Emergency Assistance and Chilton Emergency Assistance also provide utility assistance and food assistance. M4A has a senior support fund and partnerships with the faith-based organizations which donates funds for utilities and medical needs plus solicits continence supplies and nutritional supplements. County roundtables and relationships with Disability Rights and Resources and Community Action Agencies have been invaluable to M4A to share resources and also to share community and individual needs so that solutions can be developed.

Needs of the Target Population

The target population for Area Agencies include older individuals with the greatest economic and social needs (for example, those who are impoverished and have a high number of ADLs and/or IADLs), older individuals with disabilities, older individuals living in rural areas, older individuals at-risk for long-term care, low-income minority older individuals, and older individuals with limited English proficiency,

According to survey data, food, safe housing, and in-home supports are the most important or most in need services for older individuals in the M4A service area. In addition, reports and data show that older individuals in M4A's service area need evidence-based disease prevention and health promotion, for example, to address diabetes and its co-morbidities and strengthen physical balance. Finally, people in M4A's service area need to know about M4A and that they can and should call M4A when they need help or have questions:

Senior Needs in the M4A Region:

1. Disease Prevention and Health Promotion
2. Transportation
3. Safe housing/home repair
4. Access to food
5. Financial security
6. Access to information

Strategies to Address Unmet Needs: Disease Prevention and Health Promotion

Over the last 4 fiscal years (FY14-FY17), M4A has committed assets to ensure that evidence-based programs are available throughout the M4A region. For example, in FY FY14, the M4A Board approved a full-time staff position devoted to wellness programs and outreach. In FY15-FY17, M4A partnered with Serve Alabama to implement an AmeriCorps Project whose members, in addition to other responsibilities, promoted evidenced-based disease prevention and health promotion as well as M4A's ADRC and the preventive services available through Medicare.

Although the AmeriCorps Project will end in September 2017, M4A will continue to have a full-time staff person devoted to OAA Part D programs. In addition, M4A has Master Trainers for A Matter of Balance and a Registered Nurse who will begin to implement diabetes education. A goal for M4A in FY17 is to secure the employment of a Registered Dietician with appropriate clinical experience to provide both medical nutrition therapy and also nutrition counseling in the M4A region. The diabetes education and medical nutrition therapy will complement the current Part D programs offered by M4A: Tai Chi for Life, A Matter of Balance, the Arthritis Foundation Exercise Program and Walk with Ease. These programs will benefit senior citizens especially those reporting ambulatory difficulty.

Strategies to Address Unmet Needs: Transportation

Public transportation in some form exists in each of M4A's counties. Nonetheless, those who responded to M4A's senior needs survey cited transportation as a critical need. In addition, those who responded to M4A's survey are primarily those who attend senior centers and, therefore, are familiar with or utilizing public transportation. In order to further understand the transportation needs in the M4A region, M4A will develop a follow-up transportation survey. Once the results of the survey are analyzed, M4A will better understand where to begin to address the transportation need.

Strategies to Address Unmet Needs: Safe Housing/Home Repair

Currently, M4A partners with various community organizations to assist consumers with needed home repairs. In addition, M4A has a waiting list of consumers in need of home repairs. Community Action Agency and the Community Foundation of Greater Birmingham have both provided funding to M4A for home repairs. So, there is great need for home repairs in the M4A region and there is some funding to meet those needs. However, what has been challenging for M4A is to recruit and coordinate the volunteers to provide the home repairs. So, M4A's primary strategy in the Area Plan to meet the need for safe housing is to focus M4A assets on finding individuals and/or organizations who will coordinate community home repair projects.

Strategies to Address Unmet Needs: Access to Food

EngAge: A Report to the Community on Senior Adults in the Greater Birmingham Area published by the Community Foundation of Greater Birmingham in 2015 supports the need for greater access to food, especially to fresh fruit and vegetables. This report also indicated that older individuals are more likely to be impoverished, have chronic health conditions, and live in food deserts if they are minority older individuals.

Although M4A has a relatively low percentage of minority older individuals, these minority older individuals tend to live in the areas identified as food deserts. The US Department of Agriculture defines a food desert as "an area with limited access to supermarkets that is home to a relatively high number of low-income residents." According to a 2015 report by the Food Trust, the Alabama Grocers Association, and VOICES for Alabama's Children, more than 1.8 million Alabama residents live in areas that are considered food deserts. (Grocery Store Chains Avoid Opening in Alabama Food Deserts, www.al.com, December 7, 2015.)

Even in the areas that are not predominantly defined as food deserts, older individuals with impaired activities of daily living such as ambulatory difficulties, still cite transportation as one of their greatest needs. So, even if an older individual lives in an area where grocery stores with fresh fruits and vegetables are nearby, the older individual may have access challenges due to a lack of transportation.

So, what is M4A doing to address seniors' access to food? M4A has successfully partnered with community-based organizations that are delivering food to people. One initiative in Walker County is faith-based with the goal of having a mobile food unit that takes food into rural communities. Similar models for taking the services to the people in need exist already in Shelby

County where the Shelby Baptist Association has a mobile unit which travels to primarily rural and isolated areas in Shelby County to bring canned goods and also fresh fruits and vegetables to individuals in need. M4A partners with these organizations to sign senior citizens up for SNAP benefits and Farmers Market vouchers, which promote economic stability and good health.

Blount County has a well-established and highly successful faith-based ministry which distributes canned goods and fresh fruits and vegetables in at least two locations in Blount County. M4A has established food banks in each of its 25 senior centers many of which are located in rural areas.

In 2017, M4A also had its first fundraiser, called "feeding frenzies" and promoted "to end senior hunger." St Clair County was selected as the first location for the fundraiser because of the high number of older individuals on M4A's nutrition waiting list, well over 300. The purpose of the fundraiser was, first, to increase awareness of senior needs, especially the need for basics such as food; second, to raise funds to help feed senior citizens in St. Clair County; third, to strengthen existing and to develop new community-based partnerships in St. Clair County; and, fourth, to increase the public's awareness of M4A and its services.

M4A is currently planning a second "Soup-er Feeding Frenzy" fundraiser in Chilton County where there is another significant nutrition waiting list. As in St. Clair County, the purpose of the fundraiser in Chilton County will have specific goals which include raising money to feed senior citizens but also, and perhaps more importantly, to raise community awareness of the needs of senior citizens. M4A hopes that by raising community awareness of the needs of senior citizens that the local community will mobilize to work with M4A and with each other to develop community-based solutions to senior needs, including access to food.

Strategies to Address Unmet Needs: Financial Security

M4A's primary strategy to meet unmet financial needs has been to refer consumers to resources that provide financial assistance, such as Community Action Agencies, County Emergency Relief Centers, Project Share, and various faith-based organizations. To help with financial or economic security, M4A has the Senior Community Service Employment Program (SCSEP) and M4A's ADRC (Aging and Disability Resource Center) screens and helps consumers to apply for programs that help with economic security such as the Supplemental Nutrition Assistance Program, the Medicare Savings Program, Veteran's benefits, the Limited Income Subsidy Program, Medicaid Waiver Programs, and Older Americans Act Services.

Strategies to Address Unmet Needs: Outreach and Access to Information

According to the EngAge report very few older individuals in the M4A region know about M4A:

> Area Agencies on Aging are normally a source of information about area resources for seniors, but this was not the case in most areas survey. Two-this (67%) of older adults in the six-county area are not familiar with the Middle Alabama Area Agency on Aging (M4A) or the Jefferson County Office of Senior Citizen Services. Percentages of older adults unfamiliar with these agencies are even higher in Blount, 74%; Shelby, 77%;

> Walker, 77%; and St. Clair, 84% Counties. Overall, 82% of older residents have never attended one of the programs these agencies provide, and 72% have never contacted them for information. When reporting the best source of information about services in their communities, only 6% of the older adults mention the M4A or the Jefferson County Office of Senior Citizen Services. (page 20)

Therefore, M4A will continue to develop marketing and outreach plans that increase the public's awareness of M4A as the no-wrong-door for long-term services and supports. M4A has already made strides in this area by the creation of a marketing and development position at the agency, developing and executing a marketing plan which included rebranding of the agency, and also creating new marketing materials. In addition, M4A has formed a special group of Advisory Council members called "M4A Messengers" who are committed to sharing M4A resources and outreach in their local communities. M4A has also developed a weekly e-newsletter which oftentimes contains links to the M4A website plus M4A has an active Facebook page. The e-newsletter currently has almost 1,000 subscribers.

In addition to the new marketing materials and social media outreach, M4A will continue to provide community outreach through health fairs, open enrollment events, Older Americans Month picnics/Blooming Benefits Days, and highly successful outreaches at community focal points such as pharmacies and "mom and pop" grocery stores (for SenioRx, SHIP, and SNAP outreach). M4A will also continue to place flyers and brochures in municipal locations where people pay utilities and at public housing and senior housing/apartment complexes.

M4A's Comprehensive and Coordinated Service Delivery System

M4A is part of the statewide coordinated service delivery system of the Alabama Department of Senior Services which provides funding to the 13 Area Agencies on Aging in Alabama. As an integral part of the statewide service delivery system, M4A participates and receives referrals from the 1-800-AGELINE number as well as directly from the Alabama Department of Senior Services. On the local level, M4A is responsible for developing, maintaining and continually improving a comprehensive, coordinated service delivery system which not only includes program and services administered by M4A and its Older Americans Act partners and contractors but also includes agreements/partnerships and collaboration with other private and public social service and community-based organizations for outreach and other projects.

All consumers who need assistance in the M4A region are encouraged to first speak with one of M4A's ADRC Specialists who completes a "Universal Assessment." This completed assessment helps the ADRC Specialists to connect consumers to benefits and services that meet the consumers' needs and goals. Programs, including the ADRC, which M4A administers as part of its service delivery system include:

Aging and Disability Resource Center: The ADRC provides information, referrals, resources, and options/benefits counseling to individuals in need of help. The ADRC serves as a single-point-of-entry and the "no-wrong-door" for people calling M4A. Trained ADRC Specialists complete a written assessment and provide appropriate information, referrals, and resources to

meet the caller's needs. Individuals can also schedule appointments for one-on-one, face-to-face assistance.

Alabama Cares: Alabama Cares is a caregiver support program for unpaid caregivers providing at least 20 hours of service a week to a loved one who is at least 60 years of age. It can also provide assistance to a grandparent 55+ caring for a grandchild, or a relative 55+ who is caring for a severely disabled family member. The Alabama Cares Program provides homemaker services, personal care assistance, respite care, and supplies. There is no income requirement.

Alabama Elderly Simplified Application Project: AESAP is a food assistance program for those households where all members are elderly (age 60+) and have no earned income.

Health and Wellness Programs: This program promotes healthy living through evidence-based programs in group settings. Programs include Arthritis Exercise, Tai Chi classes, A Matter of Balance, and Chronic Disease Self-Management workshops.

Legal Services: Our legal program provides non-fee generating, non-criminal, legal services for people 60 years of age or older. There is no income requirement. Legal services include powers of attorney, wills, health care directives, Medicaid and nursing home problems, and public benefits.

Medicaid Waiver Services: Medicaid (Elderly and Disabled plus Alabama Community Transition or ACT) Waivers provide in-home assistance for people who are nursing home eligible and are at risk of going into a facility (or in the case of ACT, provide in-home services to help consumers transition from the nursing home back into the community) if they do not receive in-home assistance. Potential clients must be on Medicaid or Medicaid eligible plus in need of in-home assistance to stay at home.

Alabama Elderly Nutrition Program: Homebound meal recipients must be at least 60 years old. Meals are delivered hot once a day, Monday through Friday. Congregants (those eating at the senior center) must be at least 60 years old, the spouse of a participant, or individual with a disability living with an eligible participant can also receive services, regardless of age. There is no income requirement.

Ombudsman: This program provides advocacy for people in long-term care facilities and for their loved ones. Ombudsmen investigate complaints from residents and others of long-term care communities and provide information about nursing facility care, assisted living facilities and specialty care assisted living facilities.

SenioRx: SenioRx provides medication assistance to people 55 years of age or older, or people on Social Security Disability of any age, who are paying high out of pocket costs for their medicines. For example, the SenioRx Program helps consumers in the Medicare prescription "gap" and people in the Social Security Disability 24-month waiting period to get Medicare. When a consumer does not qualify for cost-free or discounted medications available the

pharmaceutical companies, the SenioRx Program assists consumers to access other types of medication help, such as drug rebates and drug discount cards, through short-term case management.

Senior Community Service Employment Program: SCSEP provides on-the-job training for people 55 years of age or older. Participants of SCSEP are placed at a host agency (non-profit or public organization agency) where they work for 20 hours a week earning minimum wage. During this time the participant is learning, improving, and building skills to assist them in finding permanent employment. Participants must be within 125% of the poverty level.

Senior Medicare Patrol (SMP): The SMP Medicare Patrol Program's primary goal is to teach Medicare beneficiaries how to protect their personal identity; detect potential errors, fraud and abuse; and report healthcare fraud. M4A works with regional organizations to disperse information to Medicare beneficiaries.

Senior Support Fund: The Senior Support Fund provides financial assistance to qualified individuals who need help paying for utilities, medicines, critical home modifications, and other unmet needs when the need cannot be met by other organizations.

State Health Insurance Assistance Program (SHIP): Through SHIP, our certified counselors and volunteers are committed to helping Medicare beneficiaries make informed choices regarding health benefits. SHIP provides unbiased counseling to Medicare beneficiaries and their caregivers who have questions, concerns or problems with their health coverage plan. Counselors and volunteers are not affiliated with any insurance company and will not attempt to sell Medicare beneficiaries an insurance plan.

M4A prides itself on having all staff cross-trained as aging specialists and requires program staff to become AIRS (Alliance of Information and Referral Systems) certified. The specific AIRS certification that program staff are required to achieve is the CIRS-A/D or Certified Information and Referral Specialist-Aging and Disability.

Another critical component to M4A's service delivery system are the senior centers in the M4A region which are the primary hub for food, socialization, recreation, and education. From these important senior center participants, M4A receives valuable input on how services can be strengthened and better coordinated. In addition, the senior centers and public transportation provide one important remedy to social isolation and help to maintain cognitive and physical health. Although not all senior centers in the M4A region are part of M4A's Title III senior nutrition program, each senior center is invaluable as a focal point for senior physical, spiritual and mental health.

In addition to agreements with municipalities to support Older Americans Act services at senior centers, M4A also has agreements with other public and private vendors to provide transportation, legal services, homemaker services, chore, respite, and personal care. These

services are essential for some consumers if they are to live safely and independently in their own homes.

Public and private vendors, municipalities, senior center managers, other Area Agencies on Aging, other social service organizations and M4A work together on various projects designed to increase the number of consumes who are aware of and access public and private services. For example, each year, M4A collaborates with many partners for the combined Older Americans Month picnics and Blooming Benefits Days in Blount, Chilton, St. Clair and Walker counties. At these events, public agencies sign qualified consumers up for benefits and services; private sector vendors provide information about products and services; M4A gives away donated door prizes which usually consist of gift cards to help attendees pay for essentials; food banks and food ministries handout sacks of groceries; and special speakers talk about scams, healthy aging, assistive technology, legal assistance, health insurance, and much more.

M4A’s Alabama Cares and Ombudsman programs continue to have a caregiver conference each year plus M4A has partnered with the district attorney’s office and the Alabama Securities Commission for additional outreaches. M4A representatives participate in local community roundtables, advisory councils, and boards where challenges are shared as well as resources and where M4A can learn about and become active in community initiatives.

Finally, M4A has applied for grant funds to enhance the delivery system and to meet unmet needs. For example, M4A has applied for grants to enhance home safety through home repair, safety checks, fire extinguishers and carbon monoxide detectors. M4A has applied for grants that cover medical alert devices and M4A has partnered with first responders, local faith-based groups, and other social service organizations to implement these projects and provide services to older individuals and those living with disabilities.

Area Agencies on Aging and the Integrated Care Networks

A challenge for M4A and the Area Agencies on Aging are the Integrated Care Networks (ICNs) which will be risk-bearing organizations contracted with Alabama Medicaid to ensure coordinated, quality and cost-effective long-term care services to Medicaid beneficiaries. To meet the challenges and opportunities presented by the Integrated Care Networks, M4A and the other Area Agencies on Aging are working with the Alabama Department of Senior Services and its contracted consultants to become NCQA (National Committee for Quality Assurance) accredited for long-term services and supports case management. According to its website, NCQA is a nonprofit organization dedicated to ensuring quality healthcare through the development of measurements and standards. All of the Area Agencies on Aging in Alabama have been making changes to ensure compliance with relevant NCQA standards in order to be accredited. This accreditation is a huge step forward to working with the ICNs and successfully contracting with them in the future. Some of the work taking place at M4A to prepare for integrated care includes changes to IT, update of HIPAA and confidentiality, training, compliance review and documentation, increasing the number of staff members with clinical experience and licensing, and capturing and tracking outcomes.

Summary of Needs Assessment (SWOT Analysis, Community Needs Assessment, Advisory Council Meeting, and Public Hearing)

SWOT Analysis
In preparation for the Area Plan, M4A conducted an internal SWOT analysis which focused on M4A employees' perceptions of M4A strengths, weaknesses, opportunities, and threats. Of the 54 recipients who were emailed a SWOT survey, 50% responded. M4A's greatest strength, according to respondents, is the people who are employed: their compassion and focus on quality services to clients plus the flexibility of leadership to new ideas and change. Other strengths reported by respondents are teamwork and cross-training which enhance employees' resources to assist clients and solve problems. M4A's weaknesses are funding, lack of upward mobility in the organization, the need to strengthen communication, and employees feeling unappreciated. The greatest threat to M4A was also the greatest opportunity and that is the changes brought about by Medicaid Managed Care. To address the changes brought about the Integrated Care Networks, respondents relied on partnerships, marketing and outreach

Community Needs Assessment
A total of 243 individuals were surveyed for M4A Community Needs Assessment between January 2017 and March 2017. The top 5 needs according to those surveyed in the M4A region include: transportation, meals, help paying for utility bills, and home repair assistance.

Advisory Council Meeting
The following attended M4A's Advisory Council meeting which was held on July 19, 2017 at American Village in Montevallo, Alabama: Sandra Smith, Mary Piazza, Daisy Washington, Vanessa McKinney, Daniel Lord, Carolyn Thomas, Susan Tedford, Frances Phelps, Tim Thompson, LeAnne Knight, Martha Pszyk, Eric McLemore, Von Hales, Tiffany Chess, Virginia Rediker, Robin DeMonia, Gail Pollock, Allie Green, Dayla Hamilton, Tim Bryant, Paige Landry, Nancy Tempel, Saderia Mormon, Kendal Head, Jon Head, Terry Collier, Andrea Carter, Tammy Noah, Matthew Haynes, Steve Griffin, Jane Griffin, Lauren Jones, and Kaitlyn Puzzitiello. After the presentation, the Executive Director asked if there were any comments. No comments were made. The Executive Director asked for a motion approve. Sue Tedford made a motion to accept the plan and it was seconded by Fran Phelps. All were in favor. No one apposed. Minutes for the Advisory Council meeting can be found in Exhibit 8.

Public Hearing
The following community members were present for M4A's Area Plan Public Hearing which was held on August 9, 2017 at Shelby County Services Building in Pelham, Alabama: Senta Goldman; Reggie Holloway; Gwendolyn Brown; Matt Haynes; Marvin Shackelford; Shannon Williams; Jennifer Atkins; Marvin Copes. The following M4A Staff were also present: Carolyn Fortner, Crystal Crim, Sharon Echols, Cody Lewis, and Robyn James. After the presentation, the Executive Director asked if there were any comments. Comments and responses can be found in Appendix L.

Service Delivery Plan and Goals, Objectives, Strategies and Outcomes
M4A's Goals and Objectives for the Area Plan correspond directly to those identified and outlined by the Alabama Department of Senior Services:

GOAL 1.0: Older adults, individuals with disabilities, and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long-term supports and services.

OBJECTIVE 1.1: Increase the number of people who contact the Aging and Disability Resource Center (ADRC) and who know who/what M4A is.

Strategies:
- Promote the ADRC and M4A in print and other media.
- Increase the number of subscribers to M4A's e-newsletter.
- Continue to host events (workshops and conferences), participate in community outreaches and roundtables, disseminate M4A outreach materials, and utilize M4A Messengers.

Outcome:
- M4A will increase the visibility of its ADRC as a trusted resource for information and assistance in the M4A region.

OBJECTIVE 1.2: Sign Memorandums of Agreements with Mental Health, 310 Boards and Independent Living to strengthen outreach of the ADRC.

Strategies:
- Enlist the help of members of the Advisory Council and community groups who work for or with mental health to obtain meetings with mental health representatives.
- Meet with mental health representatives, members of 310 boards and independent living to discuss mutually beneficial partnerships.
- Formalize partnerships.
- Invite mental health representatives and independent living representatives to participate in M4A's Advisory Council.

Outcomes:
- More consumers in the M4A region will recognize M4A as the organization to "assist all ages at all stages."
- M4A will increase its knowledge base of the needs of the populations served by mental health, 310 boards and independent living thereby strengthening M4A and M4A's ADRC.
- M4A's ADRC will have increased opportunities to provide assistance and support to those living with disabilities.

OBJECTIVE 1.3: Increase minority participation in M4A's planning and outreach.

Strategies:

- M4A will partner with other social service and public organizations to target areas of the M4A region where minority older individuals live and/or work.
- M4A will seek out partnerships and meetings with organizations who already successfully reach minority older individuals in the M4A region.
- M4A will develop outreach strategies for this target population based upon input from various partners.

Outcomes:

- More minority older individuals will receive assistance from M4A.
- M4A will have effective strategies to reach minority older individuals, including minority older individuals living in rural areas.

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.1: Promote Medicaid Waivers Programs which are designed to provide in-home services and case management to enable consumers, who are nursing home eligible, to live at home.

Strategies:

- M4A will continue its current outreach efforts but, because of estate recovery, M4A will target outreach to housing authorities and senior housing.
- Strengthen relationships with local doctors' offices and Medicaid District Offices.

Outcome:

- More consumers will be aware of Medicaid Waivers.

OBJECTIVE 2.2: Evaluate the current effectiveness of M4A's home repair and home safety program which has helped older individuals and individuals living with disabilities live safely and independently in their own homes.

Strategies:

- Contact organizations (civic, faith-based, nonprofit, government, public) to determine who is doing what by way of home repair and safety.
- Through meetings, surveys, etc., determine whether there is an organization charged with or who wants to spearhead the coordination of volunteers and/or the evaluation of referrals (i.e., for home repairs).
- Determine funding that is available for home repairs.

- If there is no organization charged with or who wants to coordinate volunteers and evaluate referrals, then determine next steps to develop an action plan or report of findings with recommendations.

Outcome:
- Home repair and home safety are essential to older individuals who want to remain in their own homes; yet, there is no reliable funding stream to support the coordination of these services and to pay for materials for home repair and safety. So, the outcome of this objective is to determine the status of home repair/safety in the region and to develop a realistic work plan or recommendations to address this critical need.

OBJECTIVE 2.3: Provide food options to older individuals so that they can remain in their own homes.

Strategies:
- Continue to provide SNAP outreach and farmers market voucher sign-up opportunities to older individuals which will provide them with resources to obtain healthy foods such as meats, fresh fruit, and fresh vegetables.
- Continue to work with food pantries, food ministries, and senior centers in the M4A region.
- Continue to strengthen M4A's "fight to end senior hunger" and "feeding frenzy" fundraisers.
- Target outreach in "food deserts" identified by the USDA.
- Increase the public's awareness of senior hunger and food deserts.

Outcomes:
- There will be fewer hungry older individuals in the M4A region.
- Local communities will have greater awareness of senior hunger and food deserts.

OBJECTIVE 2.4: Continue to provide information, access services and supplemental services to caregivers; increase respite options available to caregivers and offer educational opportunities to caregivers.

Strategies:
- Through the ADRC and Alabama Cares Program, caregivers will continue to receive access services and information. Information will continue to be provided through outreaches.
- Continue to provide supplemental services to support caregivers, including grandparents who need school supplies, clothing, and summer or after school programs.
- Increase the number of partners who provide after school programs or summer programs for grandparents raising grandchildren. Currently, M4A has agreements with the YMCA and Boys and Girls Clubs to offer after school programs which assist grandparents with respite and helps children with study skills, social skills, and self-confidence.

- Increase respite options to caregivers through agreements with the Alabama Lifespan Resource Network.
- Promote and encourage cost-sharing for caregivers when appropriate/allowed.
- Provide educational opportunities to caregivers so that they can learn better how to care for themselves and their loved ones and offer respite services to caregivers so that attending these events is convenient.

Outcomes:

- Caregivers will have greater awareness of resources available to them and have tools to help manage the responsibilities of caregiving.
- Caregivers will have more choices for respite and supplemental services.

OBJECTIVE 2.5: Work with other Area Agencies on Aging to implement Veterans-Directed Home and Community Based Services (VDHCBS): M4A has already completed the certification process for VDHCBS; however, the Veterans Administration is not currently making referrals for this service. Once the Veterans Administration approves veterans for VDHCBS, M4A will implement the following strategies:

Strategies:

- Hire a qualified licensed social worker to oversee the VDHCBS, receive referrals, meet with veterans, implement services, and monitor care plan.
- Educate ADRC staff members and other M4A program staff on the VDHCBS program so that they can begin to educate veterans and other consumers about this program.

Outcomes:

- Veterans will have a service to help them remain independently and safely in their own homes.
- Veterans will have choices for home and community based services and self-directed care.
- M4A will diversify its funding sources.

OBJECTIVE 2.6: Continue to enhance the economic security of older individuals through Older Americans Act programs and through local partnerships which enable older individuals to have resources to live safely and independently in their own homes and communities.

Strategies:

- Continue to promote and achieve the goals and objectives of the Senior Community Service Employment Program, including recruiting new host agencies and making contacts with potential employers.
- Continue to make referrals to community-based organizations (such as Community Action Agency, County Emergencies Relief Agencies, and Project Share) and faith-based organizations that provide financial assistance for utilities, copays, and medical bills.

- Continue to promote the Aging and Disability Resource Center which screens consumers and assists them in applying for public benefits such as the Medicare Savings Program, the Limited Income Subsidy, the Supplemental Nutrition Assistance Program, Farmer Market Vouchers, and M4A core OAA services.

Outcomes:
- Older individuals and other consumers who contact M4A will have access to public benefits that will improve their economic security.
- Older individuals and other consumers who contact M4A will have resources to help them live independently and safely in their own homes.

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

OBJECTIVE 3.1: Continue to offer existing Part D programs (such as A Matter of Balance, Arthritis Foundation Exercise Program, Arthritis Foundation Walk with Ease, and Tai Chi) and pilot diabetes education and medical nutrition therapy.

Strategies:
- M4A will continue to employ a Part D or Wellness Coordinator who will be responsible for administering (coordinating and training) Part-D programs such as A Matter of Balance, Arthritis Foundation Exercise Program, Arthritis Foundation Walk with Ease, and Tai Chi.
- M4A's Wellness Coordinator will increase the number of community volunteers who are trained to provide Part D evidence-based disease prevention and health promotion to address the anticipated lower Part D units of service brought about by the end of M4A's AmeriCorps Project.
- M4A will employ a Registered Nurse and a Registered Dietician for diabetes education and medical nutrition therapy. Until there is written clarification as to whether these two Medicare-reimbursed services are Part D supported programs, M4A will support these programs with local funds.
- M4A will pilot at least one diabetes education class and medical nutrition therapy class in FY 2018.

Outcome:
- Older individuals in the M4A region will have opportunities to improve their health through wellness programs offered by M4A.

OBJECTIVE 3.2: Educate consumers about the preventive services available through Medicare and medication assistance available through the state-funded SenioRx Program.

Strategies:

- The SHIP and SenioRx Coordinators will continue to be cross-trained and promote each other's programs.
- SenioRx, SHIP and Medicare preventive services information will be available on M4A's website and shared periodically in M4A's e-newsletter.
- SHIP and SenioRx will target counties that have high populations of dual-eligibles for outreach.
- SHIP and SenioRx will promote volunteer opportunities available with SHIP as well as promote M4A and its ADRC.

Outcomes:

- More consumers, especially dual eligibles, will know about SHIP, SenioRx and Medicare preventive services.
- SHIP will increase its number of volunteers.

OBJECTIVE 3.3: Achieve the performance measures, as outlined by ADSS and SSAI, for the Senior Community Service Employment Program (SCSEP).

Strategies:

- The marketing team will work with the SCSEP Project Director on outreach.
- The administrative team will support SCSEP Project Director to meet goals for unsubsidized employment and develop strategies to increase employment opportunities for SCSEP participants.

Outcome:

- The SCSEP Program has a waiting list of participants and also host agencies who have requested a SCSEP participant; therefore, the Area Plan focuses on increasing the success of current SCEP participants to meet the goals outlined in their individual employment plan and to obtain unsubsidized employment.

OBJECTIVE 3.4: Examine models to address transportation needs of older individuals in the M4A region.

Strategies:

- Develop a follow-up transportation survey to better understand the transportation needs in the M4A region.
- Research successful models to address senior transportation needs in rural areas.
- Present at least two models to a senior transportation steering committee (or similar group convened by M4A).
- Gauge community interest and support of a pilot senior transportation program.

- If there is interest and defined support then develop work plan to implement a pilot senior transportation program looking at factors such as funding, coordination, referral, implementation, measurement, outcomes, and sustainability.

Outcome:

- The community and community-based organizations will better understand senior transportation needs, options for addressing senior transportation needs, and have at least one option to pilot a project to address one or more senior transportation needs.

GOAL 4.0: Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.

OBJECTIVE 4.1: M4A will work closely with its Legal Services Provider to provide outreach and education on elder abuse and fraud.

Strategies:

- M4A and the Legal Services Provider will provide educational materials for publication on M4A’s website, for use in M4A’s e-newsletter, and for distribution to the public on topics that will educate older individuals on elder abuse (neglect and exploitation, their rights and remedies) and on frauds/scams which target older individuals.
- M4A and the Legal Services Provider will increase the number of older individuals who receive legal services.

Outcome:

- More older individuals in the M4A region will be empowered to report abuse and to know where to report abuse and to get help.

OBJECTIVE 4.2: The Ombudsman Program will provide outreach and education on elder abuse, elder rights, and residents’ rights.

Strategies:

- The Community Ombudsman Representative will utilize the Ombudsman Advisory Council to disseminate information in local communities on elder abuse and elder rights.
- The Community Ombudsman Representative will increase the number of ombudsman program volunteers by recruiting from the community and by outreach in coordination with other M4A coordinators and departments.
- The Community Ombudsman Representative will increase the number of ombudsman volunteers who visit long-term care facilities and educate residents, family members, and long-term care employee on residents’ rights.
- The Community Ombudsman Representative will continue to work with the Alabama Cares Coordinator on an annual caregiver workshop which focuses on a systemic long-term care but also educates attendees on residents’ rights and elder rights.

Outcomes:

- The Ombudsman Program will have at least 3 additional volunteers by FY 2020 who are fully trained and assigned to facilities.
- Those who live and work in long-term care will have a greater awareness of elder abuse, what it is and how to report it, plus residents' rights and how to contact the Community Ombudsman Representative.
- More residents and their loved ones will be aware of the Ombudsman Program which will be measured by the number of outreach activities completed by the Community Ombudsman Representative, volunteers, and Advisory Council members; and by the number of closed or resolved cases.

OBJECTIVE 4.3: M4A will continue to expand dementia friendly communities and aging sensitivity.

Strategies:

- M4A will continue to participate in World Elder Abuse Awareness Day and Memory Screening events.
- M4A will continue to partner with local law enforcement, first responders, and Adult Protect Services in Shelby County to develop training programs and materials for a dementia friendly community. These materials will be made available throughout the M4A region and training will be offered to Sheriff's Offices in each of M4A's counties.
- M4A will sustain and expand Dementia Friendly Communities by disseminating law enforcement and first responder training materials and tools developed with funding from the Dementia Friendly mini-grant. In addition, in the summer of 2017, M4A had the opportunity to address law enforcement officers at the Alabama Sheriffs Association Summer Conference at Orange Beach. The response to M4A's training materials was positive and may open doors for full workshops at the Alabama Sheriffs Association Winter Conference in 2018. To help to sustain and expand this project, M4A is working with local law enforcement on strategies to train training officers. In addition, M4A plans to apply for another Dementia Friendly Communities mini-grant and M4A has applied for an Alzheimer's and dementia-related disorders grant from ACL.
- M4A will offer Virtual Dementia Tours in its region.
- M4A will disseminate materials developed from its dementia friendly mini-grant to other communities and provide technical assistance to implement dementia friendly communities throughout the region.

Outcome:

- Communities in the M4A region will have a greater understanding of the aging process, dementia, and the needs of the elderly making M4A a more dementia friendly region.

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

Outcome: Because M4A (and the other Area Agencies on Aging in Alabama) is undergoing preparation for NCQA (National Council for Quality Assurance) accreditation, M4A must address the need for tracking client outcomes, ensuring HIPAA compliance, and ensuring appropriate staff training which complement Goal 5. So, the Outcome M4A plans to achieve for Goal 5 and its Objectives is successful NCQA accreditation and compliance.

OBJECTIVE 5.1: M4A will increase the quality and accuracy of the data it collects.

Strategies:

- Full implementation of PeerPlace for ADRC and for SHIP. (M4A already ensures the quality of data in PeerPlace by monthly review of PeerPlace and AIMS reports).
- Implementation of FAMCare for Medicaid Waivers and for other programs which provide case management.
- Monthly review of FAMCare data.

Outcome:

- M4A will have reporting systems in place that capture and monitor outcomes.

OBJECTIVE 5.2: M4A will improve the security and efficiency of the technology that supports the organization and safeguards electronic protected health information.

Strategies:

- M4A will require relevant IT training and certification of its IT Support/Security Officer and its Privacy Officer.
- M4A will provide annual HIPAA and confidentiality training to all employees.
- M4A will alert staff to security breaches and provide ongoing security training and reminders to guard against potential breaches.

Outcomes:

- All M4A staff members will have greater understanding of HIPAA compliance.
- M4A staff members will know how to accurately input data into the reporting, case management and data gathering systems used by M4A.
- M4A will have employees with relevant expertise to ensure M4A's compliance and the integrity of client and employee information.

OBJECTIVE 5.3: M4A will improve its intra-organization communication.

Strategies:

- M4A will continue to provide its coordinators with annual program budgets, including fiscal and programmatic benchmarks, and copies of contracts or agreements. M4A will continue to have monthly staff meetings where information from ADSS is shared with staff members and where program information and staff training can take place. M4A will also continue to have monthly program meetings in which administrative and

program staff meet to determine, in addition to other things, whether and how programmatic and fiscal goals are being met. During these meetings, Program Coordinators can also share concerns/opportunities/new ideas with the administrative team so that strategies can be developed to address concerns/share opportunities with other coordinators or leverage opportunities and partnerships/deny or approve new projects/develop plans for new projects

- M4A will eliminate any unnecessary administrative layers so that staff members will have a clear chain of command.
- Supervisors will be encouraged to meet with staff members regularly and administrative staff members will meet with all staff at least monthly but more often if necessary.
- Information will be shared with all staff members either through email, memo, and/or at mandatory monthly staff meetings.
- M4A's administrative team will respond proactively and promptly to concerns of program staff with clear actions.

Outcome:

- M4A will effectively address internal concerns about communication and any staff members feeling marginalized.

OBJECTIVE 5.4: M4A will improve the expertise and professional growth opportunities of its employees.

Strategies:

- Program staff will be encouraged to explore state, regional or national workshops and conferences that will enhance their skillset, professional knowledge, or that will address a professional or client need for training and expertise.
- Program staff members will be required to achieve CIRS-A/D certification and attend continuing education classes to maintain and enhance this certification.

Outcome:

- Improved employee morale by providing each employee the opportunity for professional growth.

Targeted Populations: Older Individuals with Greatest Economic and Social Need

Low-income Minority Elders and Elders with Limited English Proficiency
There is a total of 6,740 older individuals in the M4A region who are low-income. Approximately 10.8% are Black or African American and less than 1% is Hispanic or Latino. About 84.5% of elders 60+ who are low-income are White. Approximately 18% of all African American 60+ in the M4A region live below poverty compared to 7% of White elders 60+. A Hispanic or Latino elder 60+ is more likely to live in poverty in St. Clair County where 40% of all Hispanic or Latino elders 60+ live in poverty. Twenty-two percent of all African American or Black elders in Walker County live in poverty. Less than 1% or about 645 elders in the M4A region responded that they spoke English not well or not at all.

Older Individuals with Disabilities and Older Individuals at Risk for Long-term Care
About 25% of older individuals 60+ in the M4A region report ambulatory difficulty and about 10% to 11% report some sort of self-care/independent difficulty or cognitive decline. About 17% report living with at least one disability. The M4A region is about average compared to the state for obesity and death due to Type 2 diabetes but this doesn't say much considering Alabama has one of the highest obesity and Type 2 diabetes statistics in the United States.

So, there is a significant number of older individuals in the M4A region who have risk factors that make them likely to need long-term care, including living in poverty.

Older Individuals Living in Rural Areas
According to the 2010 Census, 58% of all elders in the M4A region lived in rural areas or about 49,000 people 60+. Only 28% of elders in Shelby County lived in rural settings, although 87% of the elders in Blount and Chilton lived in rural areas and 72% of elders in St. Clair and Walker lived in rural areas. The rural population is fairly spread out with Blount, St. Clair and Walker counties each having approximately 11,000 rural elders 60+ and Chilton and Shelby counties each having approximately 8,000 rural elders 60+.

Narrative
In order to target minority elders and elders with limited English-speaking ability, M4A will partner with organizations who share M4A's mission to reach these special groups. In addition, M4A will determine which local organizations are successfully serving these groups and learn strategies for outreach from these organizations. M4A will also invite representatives from minority populations to participate in M4A's Advisory Council.

To target elders at risk for long-term care, M4A will continue to provide Part D and other programs through the 27 senior centers (25 with nutrition programs and 2 without nutrition programs through M4A), many of which are located in rural areas. In addition, M4A will continue to partner with faith-based organizations who recognize the need to provide food, information, and assistance to elders in rural areas where elders are less likely to have access to food, resources, and help.

M4A's model for reaching all target populations is to take the information and services to them since transportation is a challenge and because this model (with volunteers and, in many cases, with food vans or mobile units) has been successfully utilized by faith-based and community-based organizations in Blount (Hope House; West Blount Food Pantry), Chilton (Through the Grace of God Ministries), Shelby (the Shelby Baptist Association), St. Clair (the Christian Love Pantry), and Walker (Christian's Place Mission) counties.

M4A will also reach these target populations through outreach to low-income and senior housing units and by using print and other media. When M4A hosts a public benefits outreach (i.e., the Blooming Benefits Days which are usually in May to correspond with Older Americans Months picnics), M4A provides transportation to ensure that elders can attend.

M4A has a strong service delivery system that has been built over the years through the dedicated efforts of individuals coming together in our local communities to serve the public.

These local initiatives, which are an integral part of M4A's service delivery system, have made commendable strides towards meeting the essential needs of older individuals, including food, clothing, emergency funds to pay for utility bills, and ensuring safe homes through volunteer home repairs. The number one challenge to this service delivery system is the sheer number of people who are and who will be 60+ in the M4A region. For example, although food deserts are located throughout the M4A region, the number of seniors living in food deserts in Shelby County, the most urban and wealthy of M4A's counties, accounts for more than 50% of the total number of seniors in the M4A region living in food deserts. In addition, M4A still has a high number of older individuals who live in rural areas.

In addition, in spite of all outreach and marketing efforts, most M4A consumers do not know that M4A exists. So, M4A does not even have the opportunity to serve a vast majority of the older individuals, people living with disabilities, and their caregivers in the M4A region because these important consumers do not know M4A.

The lack of M4A brand recognition is already being addressed through new marketing efforts, including a rebranding of M4A (new logo, tagline). In the rebranding of M4A, M4A's website was reimagined and the new marketing team developed an e-newsletter which is emailed each Thursday to elected officials, service partners, consumers, and anyone else who will agree to be on the M4A mailing list. While M4A always wants to circulate substantive information in its e-newsletter, M4A also wants to become a familiar organization to the public.

In addition to lack of brand recognition, M4A oftentimes puts consumers on waiting lists for services. So, to conduct outreach and encourage consumers to call us when we know we have waiting lists for services such as meals, respite, homemaker, and home repair help seems insincere if M4A does not actively seek new opportunities for funding and partnerships. M4A will continue to promote cost-sharing, implement Medicare-reimbursed programs such as diabetes education, and apply for other types of grant funding. In addition, M4A will continue to strengthen its Advisory Council and the involvement of the M4A Board in M4A outreach and initiatives. We will continue to seek out private and other partners to help subsidize the cost of outreach, educational events, and conferences which benefit the public who need to know not only about public benefits but private resources that are also available to meet long-term care needs.

M4A contractors and direct service providers will continue to address the needs of our shared service population based on relevant contracts and agreements, service definitions and scopes of services. Municipal and County partners help M4A to plan for events which increase the public's awareness of and sensitivity to aging and dementia. These local government partners, too, provide essential local funds and feedback to M4A.

In its service provision, M4A has noted a significant decrease in services provided to caregivers. This is attributable to funding (M4A had excess Title IIIE carry forward one year which was spent, thus leaving M4A with current year funding the next fiscal year). In addition, M4A anticipates a decrease in meal service if meal prices continue to increase, even nominally. For example, in spite of additional funding from ADSS and fundraising efforts which have allowed M4A to provide meals to seniors on M4A's nutrition waiting list, M4A's nutrition waiting list

has not significantly decreased. This waiting list which looms at just under 1,000 older individuals is a significant and disturbing indicator of the needs facing older individuals in the M4A region as well as the overall and unprecedented growth in the 60+ population in the M4A region. When federal and state funds for senior service look bleak, partnerships with local governments become even more critical. Fortunately, the County Commissions and municipal representatives (Mayors and City Council Members) in the M4A region are committed to serving older individuals.

Because funding is so tight, M4A does not anticipate being able to shift funds. M4A's Board has agreed to commit local funds to diabetes education start-up and to ensure that seniors currently receiving meals continue to receive meals.

The diabetes education offered by M4A will be Medicare reimbursed and M4A hopes to generate some funds from this to sustain the salaries of the diabetes educators plus to enhance evidence-based programs designed to improve health outcomes and keep individuals safely and independently in their own homes. M4A also hopes to not only market Part D programs to private companies but also to case manage veterans under the Veterans-Directed Home and Community Based Services (VDHCBS) Program. All of these efforts (Medicare reimbursed diabetes education, expansion of evidence-based programs to the private sector) are ways in which M4A is attempting to diversify its funding sources to sustain and expand services.

Recently, M4A has signed agreements with the Alabama Lifespan Resource Network and other nonprofit organizations in order to provide more choice and greater flexibility to all types of caregivers. For example, grandparents have choices for summer camps and after school programs through M4A's agreement with YMCAs; also, caregivers have greater control over respite providers through M4A's agreement with Alabama Lifespan. The Personal Choices Program, which is part of the Elderly and Disabled Waiver, also offers consumers greater flexibility, control and choice. For NCQA accreditation, consumer-direction will be essential.

M4A currently monitors all contracts at least annually. The focus of monitoring is not only to ensure compliance with requirements and standards outlined in the contract or agreement but also to note areas of training the provider may need. Under NCQA accreditation, assessing training needs will be even more critical, plus data (performance reports) will be reviewed to determine deficiencies so that relevant training can be developed. In addition, M4A's own staff will be assessed more frequently under NCQA standards in order to develop professional trainings.

M4A's main partners in serving the older adult population are M4A's County Commissions, municipalities, transportation providers, other Area Agencies on Aging, the Alabama Department of Senior Services, local Adult Protective Services, M4A's contractors, local Disability Rights and Resources, county RSVPs, local Salvation Army, local Red Cross, faith-based organizations, Positive Maturity, and Alzheimer's of Central Alabama. In addition, M4A has strong relationships with home health agencies, nursing home facilities and assisted living facilities, and Medicare plans. Positive Maturity has been the lead organization for the Yellow Dot Program, a vital program which alerts first responders to critical health information in an emergency, and for recruiting volunteers through local RSPVs. Many of the homebound

volunteers in the M4A region are RSVP volunteers. In the past, M4A has asked for help from RSVP to solicit volunteers for SHIP, the Ombudsman Program, and for senior companions. M4A does not use many volunteers except for meal delivery and these volunteers are local volunteers solicited either by RSVP or the local municipality. M4A has a few volunteers in SHIP and the Ombudsman Program.

During FY 2017, M4A had meetings with each of its County Emergency Management Associations in order to determine how M4A could support the local emergency response to disaster. In addition, M4A shared with local EMA officials what M4A does in an emergency, who we contact, how we contact them, and how we follow up. These meetings were very useful and made County EMAs aware of an additional community partner to help verify the safety and whereabouts of vulnerable people. Memorandums of Agreement have been executed with each County EMA. In addition, M4A completed a model emergency plan for use and/or adoption by each municipality for its senior centers. This model plan was reviewed by at least one County EMA Director and has been finalized for distribution to M4A's partners.

To further strengthen M4A's emergency action plan, M4A will reach out to county Public Health offices for meetings. M4A already has a plan to strengthen its relationship with mental health groups and will incorporate emergency planning into the Memorandums of Agreement.

Closing Statement

What the M4A Team does and does not do over the next four years is critical. If M4A successfully meets critical challenges and maximizes opportunities over the next few years, then the M4A Team will lay a strong foundation for the capacity of the organization to satisfy the needs and demands of its growing population of consumers.

M4A has always been flexible and open to change and creative ideas. However, what the administrative staff has learned over the last few years is that change, creativity, and innovation must have a strategic framework that contributes and supports the overall mission of the organization and, therefore, cohesively moves the organization forward. The results of the senior needs assessment and other reports that informed this 4-year strategic plan comprise the strategic goals by which M4A will initiate change, select and implement projects, and develop policies and procedures. All of us at M4A are confident that by working together and strategically, we will accomplish our goals and beyond.

Exhibits

1. **Exhibit 1: Assurances**
2. **Exhibit 2: Planning and Services Area Maps**
3. **Exhibit 3: Board of Directors Membership**
4. **Exhibit 4: Advisory Body Membership**
5. **Exhibit 5: M4A Organizational Chart and Staff Breakdown**
6. **Exhibit 6: Emergency/Disaster/Pandemic Plan**
7. **Exhibit 7: Town Hall Meetings and Community Needs Assessment Outreach Documentation**
8. **Exhibit 8: Board and Advisory Council Approval for Area Plan**
9. **Exhibit 9: Public Hearing Documentation**
10. **Exhibit 10: Cost Sharing Plan**

Exhibit 1: Assurances

Area Plan Assurances FY 2018

Area Plan Assurances and Required Activities

Requirements

1. AAA will give priority to legal assistance related to income, healthcare, long-term care, nutrition, housing, utilities, and protective services, defense of guardianship, abuse, neglect, and age discrimination. [Source: OAA, Sec. 307(a) (11) (E)]

2. AAA providing services for the prevention of abuse of older individuals will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—
   (A) public education to identify and prevent abuse of older individuals;
   (B) receipt of reports of abuse of older individuals;
   (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and referral of complaints to law enforcement or public protective service agencies where appropriate. [Source: OAA, Sec. 307(a) (12)]
   (D) Report immediately any suspected abuse, neglect, and exploitation to the Department of Human Resources as a mandatory reporter as specified in Alabama Code § 38-9-8. [Act 2008-398, p.787)

3. AAA will conduct efforts to facilitate the coordination of community-based, long-term care services and options and benefits counseling, pursuant to OAA §306(a)(7), for older individuals who—
   (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
   (B) are patients in hospitals and are at risk of prolonged institutionalization; or
   (C) are patients in long term care facilities, but who can return to their homes if community based services are provided to them. [Source: OAA, §307 a) (18)]

4. AAA will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self directed care. [Source: OAA, §307(a) 27)]

5. AAA will provide an emergency phone tree and agency memorandum of agreement with the local Emergency Management Association before November 1, 2016 to coordinate activities in the event of a disaster or emergency. [Source: OAA, §306 (a) (17)]

6. AAA is responsible for maintaining compliance with all current ADSS Information Technology policies and procedures applicable to the Operating Agency. The ADSS Information Technology policies and procedures are available on the ADSS intranet.

7. AAA is responsible for monitoring and maintaining compliance with the current Alabama Elderly Nutrition Program Manual as well as Nutrition Policies and Procedures.

8. AAA is responsible for monitoring and maintaining compliance with the current SenioRx guidelines.

9. AAA is responsible for monitoring and maintaining compliance with the current Alabama Cares guidelines.

10. AAA is responsible for monitoring and maintaining compliance with the current State Health Insurance Assistance Program (SHIP) guidelines.

11. AAA is responsible for monitoring and maintaining compliance with the current Long Term Care Ombudsman Program Policies and Procedures.

12. AAA is responsible for monitoring and maintaining compliance with any other contractual agreements as well as program and fiscal guidance to include monitoring of any sub-contractors.

13. AAA agrees to operate under the business model of Aging and Disability Resource Centers as a "No Wrong Door" to services and supports, following guidance and work agreements from ADSS and the Alabama Medicaid Agency (if applicable).

14. AAA is responsible for maintaining compliance with all current ADSS HIPAA training program policies and procedures available on the ADSS intranet. Additionally, each Operating Agency must assure each employee reviews the Operating Agency HIPAA training program annually and provides the executed receipt of HIPAA training form annually to their agency HIPAA officer for the retention in HIPAA and personnel files.

15. AAA is responsible for maintaining compliance with the following requirements concerning conflict of interest, administrative, and fiscal procedures:
    (A) The Area Plan, Assurances, and other Memorandums of Understanding serve as the contractual relationship with the State Unit to provide services to persons' age 60 and over, persons with disabilities where appropriate, and their caregivers.
    (B) Conflict of Interest:
        (i) AAA will not contract with any individual, or member of the immediate family of an individual, subject to a conflict of interest; and ensure that no officer or employee or representative of any entity with which the Operating Agency contracts, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest.
        (ii) If a conflict is found, it will be grounds for immediate termination of the contract between the AAA and the individual or entity and language to that effect must be included in the contract between the AAA and the vendor.
        (iii) Further, each AAA must institute and follow its own conflict of interest policies for its staff, board of directors, and contractors including appropriate procedures for disclosure.
        (iv) The Alabama Ethics Law will be followed by all parties. Alabama Code §36-25-1 et seq.

16. Administrative and Fiscal Procedures:

(A)The AAA, sub-contractors, and providers will abide by the following financial and administrative procedures and guidance documents as applicable:

(i) U.S. Department of Health and Human Services, Administration on Aging, Office of Management, Grants Management Division, AoA Fiscal Guide, OAA, Titles II and VII, 05/2004;

(ii) Generally Accepted Accounting Principles, GAAP;

(iii) Code of Alabama 1975- Chapter 16-Article 2- State Bid Laws; Title 41, Chapter 16;

(iv) 45 CFR, Part 1321 – Grants to Sate and Community Programs on Aging, Authority: 42 U.S.C. 3001 et seq.; Title III, Older Americans Act, as amended;

(v) 45 CFR, Part 75- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards;

(vi) State of Alabama, Act. No. 40, Open Meetings Act; S36-25A-1-11, Code of Alabama 1975, as amended.

Other Requirements (as Applicable)

1. 29 CFR Part 93, Lobbying Certification
2. 29 CFR Part 37, Non-discrimination and Equal Opportunity Requirements
3. 29 CFR Part 98, Debarment and Suspension; Drug Free Workplace
4. 20 CFR Part 652 et al., Workforce Investment Act
5. Wagner-Peyser Act
6. Section 106 (g) of the Trafficking Victims Protection, Act of 2000, as amended (22 U.S.C. §7104)
7. 48 CFR §3.908, implementing section 828 entitled "Pilot Program for Enhancement of Contractor Whistleblower Protections, "of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013 (Pub. L. 112-239, enacted January 2, 2013)
8. All grantees are expected to recognize any same sex marriage legally entered into in a U.S. jurisdiction that recognizes their marriage, including one of the 50 states, the District of Columbia, or a U.S. territory, or in a foreign country so long as that marriage would also be recognized by a U.S. jurisdiction. Any similar familial terminology references in HHS statutes, regulations, or policy transmittals will be interpreted to include same-sex spouses and marriages legally entered into as described herein.

(B)The Operating Agency will have available for inspection the following documents that should be updated at a minimum every three years although they may be updated more frequently as needed:

(I) Accounting and Administrative Procedures to include but not limited to:

(i) Contract development and monitoring procedures

(ii) Personnel policies and procedures

(iii)Grievance procedure for sub-contractors and clients

(C) Organizational charts should be updated annually with any changes. Any employee who is terminated should be reported to ADSS immediately. Employees who are leaving for

other employment, retirement, etc. or new employees or any other employee changes in their positions should be reported to ADSS within 2 business days.

(D) If operating under a Board of Directors, the Operating Agency should have available for inspection the following documents that should be updated at a minimum every three years although they may be updated more frequently as needed:

(i) Board of Directors Training Manual
(ii) Board of Directors Conflict of Interest Policy
(iii) Minutes of all Board meetings
(iv) By-laws

The Operating Agency will comply with the provisions of any and all applicable amendments to the Older Americans Act, its regulations, and other laws and regulations which may become applicable in all its practices, policies, programs, and facilities during the period covered by this Area Plan.

Title III Program Service Guidelines and Assurances

The OAA mandates that an AAA will, through a comprehensive and coordinated system, provide for supportive services, nutrition services and the establishment, construction, and maintenance of senior centers within the planning & service area(s) administered by the AAA. The AAA will evaluate the effectiveness of the use of resources in meeting needs, including the efforts of voluntary organizations in the community, and will enter into agreements with providers of supportive services, nutrition services, and senior center services to meet identified needs. The AAA will engage in efforts to improve its performance, and the performance of its contractors, in measurable ways.

Americans with Disabilities Act:

Each AAA must comply with the Americans with Disabilities Act (ADA) in the development of an area plan and in all planning efforts, including capital requests for renovation of the building to meet ADA compliance and purchase of handicap accessible transportation vehicles. Transportation services are to accommodate seniors with disabilities.

Procurement Procedures:

The Federal and State laws and regulations require competition in all procurement matters (small purchase procedures, sealed bids, and request for proposals as appropriate). See 45CFR Part 92.

Waivers:

AAAs may request authority to provide direct services, reduction of operating days or to waive cost share if they have met the conditions set forth in the OAA and when ADSS has approved such a request. For a Direct Service Waiver, an AAA must provide a request for the waiver and all necessary supplemental documentation. Waivers are not required for Information and Assistance or Case Management services, Disease Prevention and Health Promotion services,

Chore, Legal Assistance, Caregiver Access Information or Caregiver Education/Counseling. An ADSS provided Waiver Request form should be submitted annually, at a minimum 60 days prior to the first day of the fiscal year to the Commissioner for approval.

Cost Sharing and Sliding Fee Scales:

Proposed cost sharing and sliding fee scales related to OAA services must meet the requirements of the Act. The OAA includes a provision for cost sharing, such as implementation of a sliding fee scale, with regard to certain services provided with federal funds. In making application to apply cost sharing to services, AAAs and programs must consider the intent of the OAA to serve targeted populations and must ensure that the application of cost sharing does not prevent the provision of services to the following targeted population groups: low-income, minority, socially isolated, rural, limited English proficiency, and at-risk of institutionalization. Additionally, AAAs shall solicit the views of older individuals, providers, and other stakeholders prior to implementation of cost sharing in each planning and service area of the state.

For services where a sliding fee is charged; such a fee must be based on the recipient's income and the cost of delivering services. Services contracted for in this manner may include, and, if OAA funds are used, are limited to:

- Transportation/Assisted Transportation
- Homemaker/Housekeeping/ Shopping Assistance
- Adult Day Care
- Personal Care
- Home Health
- Respite Care
- Home Repair
- Chore

A fee is defined as a charge allowed by law for a service. A sliding fee scale is a graduated series of fees to be paid based upon the income of the recipient of a service. If a sliding fee scale is implemented, AAAs and providers must protect the privacy and confidentiality of older individuals. The individuals to be served must be informed that the service is provided on a fee-for-service basis and be notified of the sliding fee scale.

With regard to any fees charged for OAA services, determination of a recipient's fee for a service shall be based on the recipient's self-declaration of income, and spouse's income (if applicable), without verification. OAA services may not be denied due to the income of an individual or an individual's failure to make a cost sharing payment.

If a sliding fee scale is to be used, the scale must be posted in high visibility areas. Such postings must include a statement that no services will be denied for failure to pay any fee. Assets, savings, or other property owned may not be considered in determining the fee for a service. Revenues generated by fees for OAA services must be spent to enhance the service that generates such fees.

The basis for a sliding fee scale is to be the U.S. Administration on Aging's annual issuance of "*Estimated Poverty and Near Poverty Thresholds*", revised annually in the month of February. Near-poverty is defined as 125% of poverty. Individuals and families whose income is at or below the near-poverty threshold may not be charged for services. Each and every specific sliding fee scale must be annually reviewed and approved by the ADSS Programs and Planning Division.

Proposed sliding fee scale must meet the following requirements:

- Be reviewed in a public hearing prior to implementation
- Be fully described by an AAA in its area plan
- Be approved by ADSS prior to implementation
- Be implemented based on established policies and procedures (These policies and procedures must address the circumstances that allow a provider to waive the fee and also address the use of net income vs. gross income when determining fees)
- Be administered according to uniform procedures

Fees are to be based on the actual cost of providing a service and cannot exceed the actual cost, as determined by a provider, submitted to an AAA and approved by ADSS.

Voluntary Contributions:

Proposed voluntary contributions must meet the requirements of the OAA. AAAs and programs shall be allowed to solicit voluntary contributions for all services for which funds are received, provided that the method of solicitation is non-coercive. AAAs and providers shall not means test for any service for which contributions are accepted or deny services to any individual who does not contribute. AAAs shall:

- Establish and maintain appropriate policies and procedures for soliciting and accounting for contributions, and ensure that their contract providers establish and maintain such policies and procedures.
- Fully describe contribution policies and procedures in the area plan.
- Ensure all contributions must be spent to expand the service that generates the donation.

NAPIS Reporting:

Area Agencies on Aging are expected to be familiar with all the reporting requirements, service and unit definitions which are provided at the beginning of each Fiscal Year by ADSS. It is important that all fiscal and program reports the AAA submits for Title III and Title VII funds match for NAPIS. Therefore, it is critical to coordinate both the NAPIS program reporting in AIMS and the financial report. Any variances above or below 5 in any NAPIS reporting category for program, demographics, or fiscal reporting must be documented for explanation.

FINANCIAL

I. Funding

While this section includes fiscal requirements that pertain to each of the programs, what is detailed here is not meant to represent all fiscal requirements.

All organizations receiving Federal financial awards (i.e. grant, cooperative agreement, contract) or sub-awards must have a DUNS (Data Universal Numbering System) and be registered with the CCR (Central Contractor Registration) as outlined in 2 CFR Part 25, Financial Assistance use of Universal Identifier and Central Contractor Registration.

A. Title III of the Older Americans Act (OAA)

a. Obligations and Liquidations
   i. Title III funds are required to be allocated to AAA based on the state's Intrastate Funding Formula (IFF). The IFF is described in ADSS' State Plan on Aging.
   ii. The AAA must obligate Title III funds within two years after the year in which the funds were awarded by the state (e.g., funds awarded in federal fiscal year 2017 must be obligated by September 30, 2019).

b. Match Requirements
   i. Area Plan Administration- The non-federal share for area plan administration shall not be less than 25% of the funds expended. Title III expenditures for area plan administration includes the administration of programs, which are consistent with the Older Americans Act.
   ii. Title III Services- The AAA will be required to fund services under Title III B, C, D, and E with no less than a 10% non-federal matching requirement. ADSS will contribute 5% state match to the required non-federal match of no less than 15%.
   iii. Non-federal match requirements may be provided in the form of either cash from local resources or in–kind contributions or a combination of both. In-kind contributions may include volunteers, supplies, donated office space, etc.

c. Participant Contributions
   i. Anyone receiving services shall be given an opportunity to make a voluntary contribution (Program Income). A service provider may not deny a service because the eligible person could or did not contribute to the cost of the service.
   ii. Service contributions collected must be used to expand the services for which the contributions were given.
   iii. Program income cannot be included as match.

d. Transfers Between Title III Parts B and C Subparts 1 and 2:

i. Title III Parts B and C, Subparts 1 and 2, are the only parts between which transfers may be made. The AAA may elect to transfer not more than 40% of its part C funds between subpart 1 and 2. A request for a waiver to transfer amounts over the 40% limitation must be approved by ADSS.
ii. The AAA may elect to transfer not more than 30% between part B and part C. A request for a waiver to transfer amounts over the 30% limitation must be approved by ADSS.

e. Title III Part B Services-Priority Services
   i. Per requirements of the Older Americans Act, AAAs must spend those designated percentages unless the state agency grants a waiver based on a demonstration by the AAA that services being furnished are sufficient to meet the need for such services (Sec. 306(b)).
   ii. Title III-B Social Services expenditures for Priority Services (access, in-home, and legal) must meet or exceed the minimum spending levels established by ADSS as follows:
      1. Access: 29.1% of FY 2017 Title III-B award (plus 10% match)
      2. In-Home: 2.5% of FY 2017 Title III-B award (plus 10% match)
      3. Legal: 6.7% of FY 2017 Title III-B award (plus 10% match)
   iii. Access services are reported in the Assisted Transportation, Transportation, Information and Assistance, Outreach, and Case Management expenditure categories. In-home services are reported in the Personal Care, Homemaker, and Chore expenditure categories. Legal services are reported in the Legal Assistance expenditure category.

f. Title III-E Family Caregiver Program
   i. Title III-E Family Caregiver program budgeted expenditures should not exceed 10% of the federal funding (plus non-federal match) for support services to grandparents and older individuals who are relative caregivers as defined in the law.
   ii. In addition, budgeted expenditures should not exceed 20% of the federal funding (plus non-federal match) for the Supplemental services expenditure category.

g. Part D Prevention Health – Disease Prevention and Health Promotion
   i. Funding Amounts for Title III Part D may only be used for programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective. Further guidance may be found on AoA website: http://www.aoa.acl.gov/AoA_Programs/HPW/Title_IIID/index.aspx.

h. Nutrition Services Incentive Program (NSIP) - The Administration on Aging (AoA) provides funding to states for OAA Title III eligible meals provided to eligible aged participants through Section 311 of the OAA NSIP. Funds are distributed per eligible meal served throughout the state.

B. Title VII of the Older Americans Act (OAA)

a. Obligations and Liquidations
   i. Title VII funds are allocated to AAA based on the state's Intrastate Funding Formula (IFF). The IFF is described in ADSS' State Plan on Aging.
   ii. The AAA must obligate Title VII funds within two years after the year in which the funds were awarded by the state (e.g., funds awarded in federal fiscal year 2017 must be obligated by September 30, 2019).

b. Match Requirements
   i. Title VII - The AAA will be required to fund services under Title VII Elder Abuse and Ombudsman with no less than a 10% non-federal matching requirement. ADSS will contribute 5% state match to the required non-federal match of no less than 15%.
   ii. Non-federal match requirements may be provided in the form of either cash from local resources or in–kind contributions or a combination of both. In-kind contributions may include volunteers, supplies, donated office space, etc.

c. Maintenance of Effort
   i. Title III-B Supportive services, Title VII-Elder Abuse, and Title VII-Ombudsman expenditures for Ombudsman (Complaint Resolution/Ombudsman expenditure category) must meet or exceed FY 2000 expenditure levels.

C. Other ACL Programs

SHIP and MIPPA Grant programs:

a. Obligations and Liquidations
   i. The AAA must obligate funds during the period identified on grant agreement awarded specifically for these programs.
   ii. Grant agreements are typically awarded for a one-year budget period but there could be exceptions.

b. Match Requirements
   i. There is no required match for these programs.

D. Other State Funded Programs

ADRC, Ombudsman, and SenioRx programs

a. Obligations and Liquidations
   i. The AAA must obligate funds during the period identified on grant agreement awarded specifically for these programs.
   ii. Grant agreements are typically awarded for a one-year budget period but there could be exceptions.

b. Match Requirements
   i. There is no required match for these programs.

II. Payment and Financial Reporting

a. **Payment:** Funds will be used for the purpose of the program only and shall be paid upon submission of a cash draw down form.
b. **Reporting:** AAA shall comply with all program reporting requirements. AAA will assume responsibility for the accuracy and completeness of the information contained in all documents and reports. A financial report shall be required in accordance with ADSS policies and procedures. Financial reports will be submitted by the 21st of the month following the end of the program quarter. Reporting will be accurate and true. Reports will cover the funds and activities of the program only.

Title III E Caregiver Assurances and Program Requirements

Caregiver Support Program:

Per the OAA, Title III-E federal funds must be directed towards building a multifaceted system of caregiver support services. No more than 10% of Title III-E funding can be used for the Grandparent program and no more than 20% of funding can be used for supplemental services. AAAs must ensure the development and implementation of a diversified system of services for caregivers that shall include at a minimum:

- information to caregivers about available services
- assistance to caregivers in gaining access to services
- individual counseling, organization of support groups, and caregiver training
- respite care to enable caregivers to be temporarily relieved from their caregiving responsibilities
- Supplemental services, on a limited basis, to complement the care provided by the caregiver

Title III-E Program may serve the following populations:

- Primary caregiver of frail, older adults age 60 +.
- Family caregivers of a person with Alzheimer's disease or a related dementia may be served regardless of the age of the person with dementia. Priority is given to these caregivers.
- Grandparents/Relative caregiver (55+) caring for children age 18 & younger.
- Grandparents/Relative caregiver (55+) caring for children with a severe disability any age. Priority is given to caregivers providing care for an adult child with severe disabilities.

Legal Services Assurances and Program Requirements

1. The AAA shall provide at no cost to client's access to attorneys with the capacity to provide advice and representation in the areas outlined in the Older Americans Act of 1965, as amended.

2. All sub-contractors must be licensed to practice law in Alabama and carry malpractice insurance.
3. The AAA shall use Title IIIB funds or other funds to maintain or increase, to the extent practicable, the level of legal assistance furnished to eligible individuals, and not to supplant funds from other federal or non-federal sources.
4. The provider shall give clients a voluntary opportunity to contribute to the cost of the services they receive and ensure privacy with respect to the clients and contributions.
5. The provider shall have the capacity to provide legal assistance in the principal language spoken by the clients in the areas where a significant number of clients do not speak English as their principal language in accordance with the OAA.
6. The provider and AAA shall provide complete, accurate AIMS programmatic and fiscal reports and other required program data in a timely manner and provide additional information requested while maintaining client confidentiality.
7. The provider shall provide advice and representation to clients of the Long-Term Care Ombudsman program who are 60 years of age or older.
8. The provider shall coordinate with Long-Term Care Ombudsman while maintaining client confidentiality with both programs.
9. In cooperation with the Legal Services developer, the provider shall develop and follow a protocol and a program policy for referral of fee generating cases pursuant to the OAA. Pursuant to 45 CFR 1321.71(g), a fee generating case may not be accepted by a Legal Assistance provider.

Title III–Assurances For Part C-1–Congregate Meals and Part C-2–Home Delivered Meals

ELDERLY NUTRITION PROGRAM

Purpose: To assist in the provision of nutrition of the elderly population to remain independent in the community. The meals provided are in congregate and homebound settings.

Target Population Under OAA for Services and Programs: Age 60+ with greatest social and economic need, especially low-income older people, those residing in rural areas, older people with limited English proficiency, and older people at greatest risk for institutional care (i.e. has at least two activity of daily living impairments)

Services Provided: The client services provided include congregate meals, home-delivered meals, nutrition education, and nutrition counseling. Active senior centers are the central focus for meals, services, and socialization with the participants.

Eligible Participants:

- Age 60 and over
- Spouses of individuals age 60 and o er C 1 congregate meals
- Person with disability residing with eligible participant
- Person with disability at senior centers located in housing facilities primarily occupied by older individuals (can serve individuals with disabilities under age 60)
- Volunteer assisting at mealtime (C 1 congregate meals)

Program Income: Gross income received by the AAA and all sub-grantees such as voluntary contributions or income earned only as a result of the grant project during the grant period.

State Level Program Administration: A team of three Registered Dietitians work with menu production, monitoring of statewide meals contract, monitoring AAAs Nutrition program, and senior centers. The nutrition team also provides technical assistance to the AAA Nutrition Coordinator. The AAA Nutrition Coordinator should be a full-time employee.

Currently, the AAA provides meals in a congregate setting (C-1) and to homebound participants (C-2). ADSS has a statewide contract with Valley Foods to prepare and deliver the meals to each senior center daily and to some homebound participants if they receive frozen meals instead of hot homebound meals served from the center.

Service Definitions: The Contractor shall adhere to the Older Americans Act Nutrition Service definitions. As part of the contract, the Contractor agrees to ensure only participants eligible for nutrition services receive these services and that the units are recorded.

Ineligible Meals: Title III C-1 and C-2 funds can only pay for meals served to eligible participants. If a meal is not served to an eligible participant, it becomes ineligible and the meal cost must be remitted to ADSS to pay the meal provider. The AAA is responsible for ensuring all ineligible meals are correctly marked weekly on the meal certification prior to reconciling and transmitting to the meal provider. The AAA must remit payment to ADSS by the 20th of the following month for any ineligible meals from the prior month based on the final Meal Certifications received from ADSS (example: payment due December 20th based on all final ADSS Meal Certifications received in November – whether the Meal Certification was for September, October, or November ineligible meals).

Alabama Elderly Nutrition Program Manual (ENP): The Contractor will adhere to all program guidelines, policies, and procedures for operation, administration and management of all nutrition services as stated in the current Alabama Elderly Nutrition Program Manual (ENP) provided by ADSS, as well as any updates and revisions made during the contract period.

Senior Center Hours of Operation/Holidays: Senior Centers must be open for normal operations no less than four (4) hours per day, five (5) days per week (Monday – Friday). If operating les than five (5) days a week, Contractor must submit a request for waiver to ADSS for approval sixty (60) days in advance of any change in hours of operation. This waiver must be updated annually no less than 60 days before the start of the next contract year and the final decision will come from the ADSS Commissioner. There are 245 serving days in FY18. The AAA has an option to close 5 of those days countywide.

Senior Centers: Senior Centers are located as close as possible to concentrations of elderly with the greatest s cial and economic need, as well as those eligible older persons and handicapped or disabled persons living in housing facilities occupied primarily by the elderly. Senior Centers are in buildings that are clean, pleasant, and accessible to kitchen, restrooms, and telephones, as well as meet all applicable health, fire, safety, and sanitation regulations and inspections.

<u>ADSS Participant Enrollment Forms</u>: A Participant enrollment form is to be completed for any eligible participant who is to receive a service which requires the participant to be a registered participant. These services are identified in the service definitions under the Unit column as a "Registered Participant." All senior centers must retain the participant enrollment forms at the center on all participants who receive registered, Title III services. This information must be entered in AIMS by the AAA and/or contractors.

<u>Meal Orders:</u> The contractor must receive and serve a minimum of 25 meals per day, five days per week for each senior center. The contractor may shift the number of meals allotted between centers and meal type but must adhere to no less than 25 meals per day out of each respective nutrition center.

<u>Voluntary Contributions</u>: See *Older Americans Act, Section 315(b)*

(b) VOLUNTARY CONTRIBUTIONS. —

(1) IN GENERAL, —Voluntary contributions shall be allowed and may be solicited for all services for which funds are received under this Act ***if*** *the method of solicitation is non-coercive.*

(2) LOCAL DECISION. —The area agency on aging shall consult with the relevant service providers and older individuals in agency's planning and service area in a State to determine the best method for accepting voluntary contributions under this subsection.

(3) PROHIBITED ACTS. —The area agency on aging and service providers shall not means test for any service for which contributions are accepted or deny services to any individual who does not contribute to the cost of the service.

(4) REQUIRED ACTS. —The area agency on aging shall ensure that each service provider will—

(A) provide each recipient with an opportunity to voluntarily contribute to the cost of the service;

(B) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;

(C) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;

(D) establish appropriate procedures to safeguard and account for all contributions; and

(E) use all collected contributions to expand the service for which the contributions were given ***and to supplement (not supplant) funds received under this Act.***

<u>Additional Assurances (Apply to All Programs)</u>

<u>Referral and Coordination:</u> Each program shall establish working relationships with other community agencies for referrals and resource coordination to ensure that participants have the maximum possible choice. Each program must establish, at a minimum, written referral protocols with local Mental Health centers, 3-10 boards, the Department of Rehabilitation, and Home and Community Based Medicaid programs, operating in the region.

Disaster Response: AAA and any subcontractor must have established written emergency protocols for weather emergencies, both responding to disaster and undertaking appropriate activities to assist victims to recover from disaster, depending upon the resources and structures available.

Insurance Coverage: AAA and any subcontractor shall have sufficient insurance to indemnify loss of federal, state and local resources, due to casualty, fraud, or employee theft. All buildings equipment, supplies, and other property purchased in whole or in part with funds awarded are to be covered with sufficient insurance to reimburse the program for the fair market value of the asset at the time of loss. The following types of insurance are required:

- Worker's compensation
- Unemployment
- Property and theft coverage (including employee theft)
- Fidelity bonding (for persons handling cash)
- No-fault vehicle insurance (for applicant owned vehicles)
- General liability and hazard insurance (including facilities coverage)

The following types of insurance are recommended for additional protection:

- Insurance to protect the programs from claims against program drivers and/or passengers
- Professional liability (individual and corporate)
- Umbrella liability
- Errors and Omissions insurance for Board Members
- Special multi-peril

Volunteers: Each program that utilizes volunteers shall have a written procedure governing the recruiting, training, supervising, and management of volunteers consistent with the procedure utilized for paid staff. Volunteers shall receive written position description, orientation training, and a yearly performance evaluation, as appropriate

Staffing: Each AAA and any subcontractor shall employ competent and qualified personnel sufficient to provide services. Each program shall be able to demonstrate an organizational structure including established lines of authority Prior to employment or engagement, all potential employees must be subjected to a statewide criminal background check. No person with a felony conviction may be hired. The safety and security of program clients must be paramount in such considerations to employ those working with any program described in this agreement.

Orientation and Training Participations: All incoming program staff from the AAA and any subcontractor must receive orientation training that includes, at a minimum, introduction to the program, the aging network, maintenance of records and HIPAA compliance, the aging process, ethics, and emergency procedures Issues addressed under the aging process may include though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation

Program staff and subcontractor staff are encouraged, and in some cases required, to participate in relevant ADSS sponsored training workshops, as well as any training done by the AAA, as appropriate. Records that detail dates of training, attendance, and topics covered are to be maintained, as well as noted in employee and volunteer files. Some training expenses may be allowable costs against grant funds per grant agreements.

Contingency Clause: It is expressly understood by both parties and mutually agreed that any commitment of funds herein shall be contingent upon receipt and availability of funds under the program. In the event of the proration of the fund from which payment is to be made, the program will be subject to termination.

Not to Constitute a Debt of the State: Under no circumstances shall any commitments by ADSS constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this grant shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during this grant, be enacted, then that conflicting provision in the grant shall be deemed null and void. The Applicant's/Grantee's sole remedy for the settlement of all disputes arising under the terms of this agreement shall be limited to the filing of a claim against ADSS with the Board of Adjustment for the State of Alabama.

Access To Records and Monitoring: At any time during normal business hours, and as often as ADSS may deem necessary for purposes of monitoring and evaluation, the AAA and any subcontractor shall make available to ADSS the Alabama Department of Examiners of Public Accounts, the Comptroller General or any other authorized designee all records with respect to matters covered by this grant agreement and will permit ADSS or those authorized designees to audit, examine, investigate, or extract excerpts from invoices, materials, documents, papers, records, or other data relating to matters covered by a grant agreement.

HIPAA Compliance: AAA and any subcontractor shall comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and any implementing regulations as adopted. Therefore, all parties agree that this section satisfies HIPAA's requirement for a "business associate agreement" between a covered entity and business associate and applies to PHI provided to or received from the Contractor in electronic, handwritten, typed or digital formats, stored in either magnetic or optical media that is used or disclosed as agreed upon. The AAA acknowledges that the AAA has a federally legislated obligation for compliance with applicable provisions of the HIPAA Privacy and Security regulations regardless of whether those provisions are expressly contained within any future agreement.

Trafficking Victims Protection Act: This award is subject to the requirements of Section 106(g) of the Trafficking Victims Protection Act of 2000, as amended (72 U.S.C. 7104). This grant is subject to the requirements set forth in 45 CFR Part 75 (for non-profit organizations and educational institutions) or 45 CFR Part 75 (for state, local, and federally recognized tribal governments).

Copyright: As a term and condition of a grant award under 45 CFR 75, the grant awarding agency will retain a royalty-free, nonexclusive, irrevocable license to reproduce, publish or otherwise use and authorize others to use, for Federal government purposes, the copyright in any work developed under the grant, or a sub grant or subcontract, and in any rights to a copyright purchased with grant support.

Mandatory Disclosures: The AAA and any subcontractor is required to notify ADSS in writing of all violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting this federal award.

Debarment: The AAA certifies it is not barred from bidding for or entering into this agreement and the AAA acknowledges that ADSS may declare the agreement void if the certification completed is false.

Registration: All organizations receiving Federal financial awards or sub awards must have a DUNS (Data Universal Numbering System) and be registered with the CCR (Central Contractor Registration) as outlined in 2 CFR Part 25, *Financial Assistance Use of Universal Identifier and Central Contractor Registration.*

Whistleblower: AAA is hereby given notice that the 48 CFR §3.908 implementing section 828, entitled "Pilot Program for Enhancement of Contractor Whistleblower Protections," of the National Defense Authorization Act applies to this award.

Immigration Law Compliance: By signing this agreement, the AAA affirms for the duration of the agreement that they will not violate federal immigration law or knowingly employ, hire for employment, or continue to employ an unauthorized alien within the State of Alabama. Furthermore, if AAA is found to be in violation of this provision it shall be deemed in breach of the agreement and shall be responsible for all damages resulting therefrom. The Applicant hereby certifies compliance with the requirements of §31-13-9(a) and (b), Code of Alabama 1975, as amended, and has provided proper documentation to ADSS. This shall apply to any subcontractor hired by AAA, as well.

Confidentiality: AAA and any subcontractor shall treat all information, and in particular information relating to individuals that is obtained by or through its performance under the agreement, as confidential information to the extent confidential treatment is provided under State and Federal laws and regulations. AAA shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and rights under this grant agreement.

The undersigned hereby accepts and agrees to comply with the foregoing Agreement, Assurances and all applicable state and federal laws, regulations and policies.

ALABAMA DEPARTMENT OF SENIOR SERVICES

Todd Cotton, Acting Commissioner

7/28/17
Date

Emily T. Marsal
(for Legal Compliance/Form)

7/27/17
Date

AAA

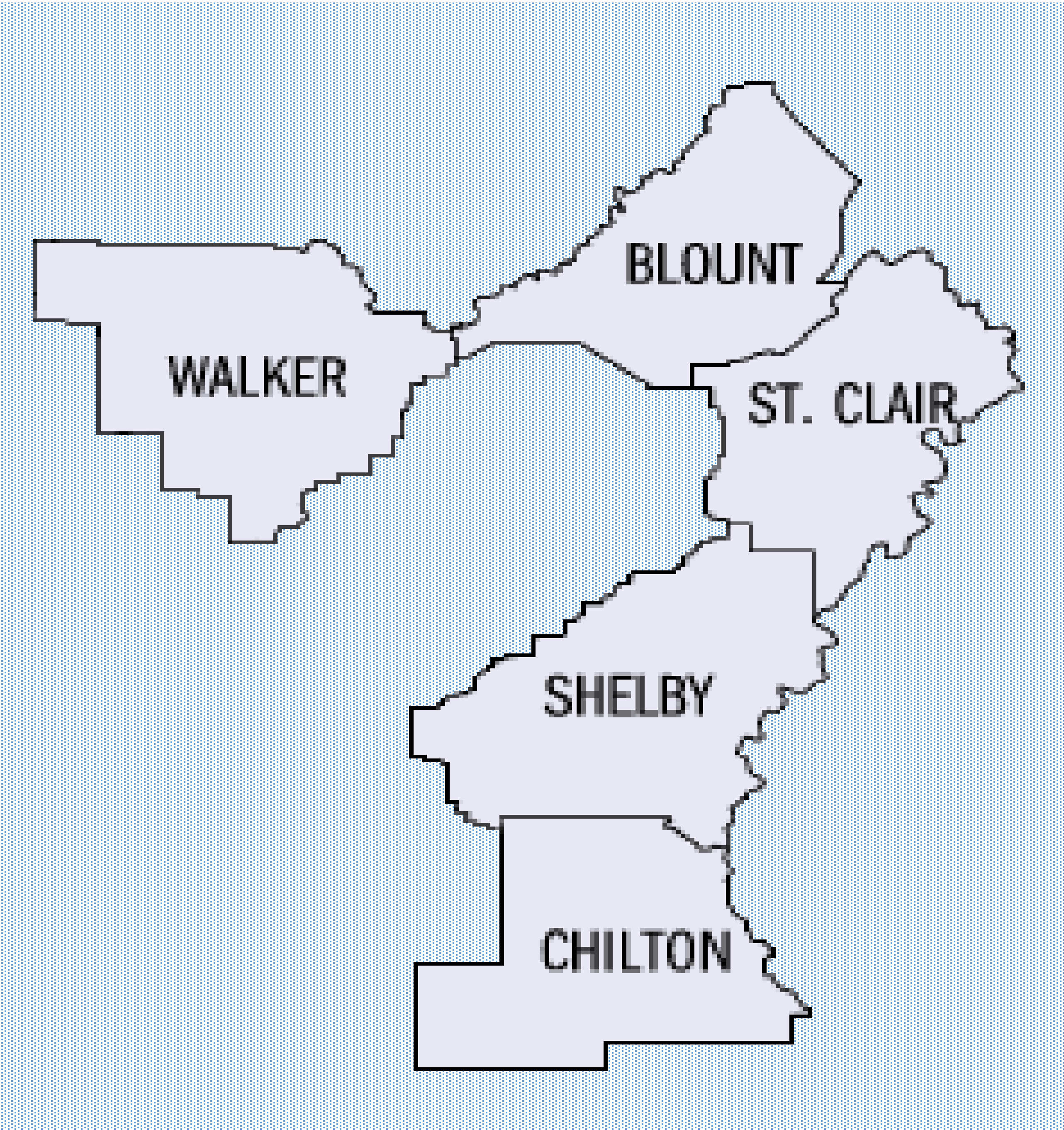
Executive Director

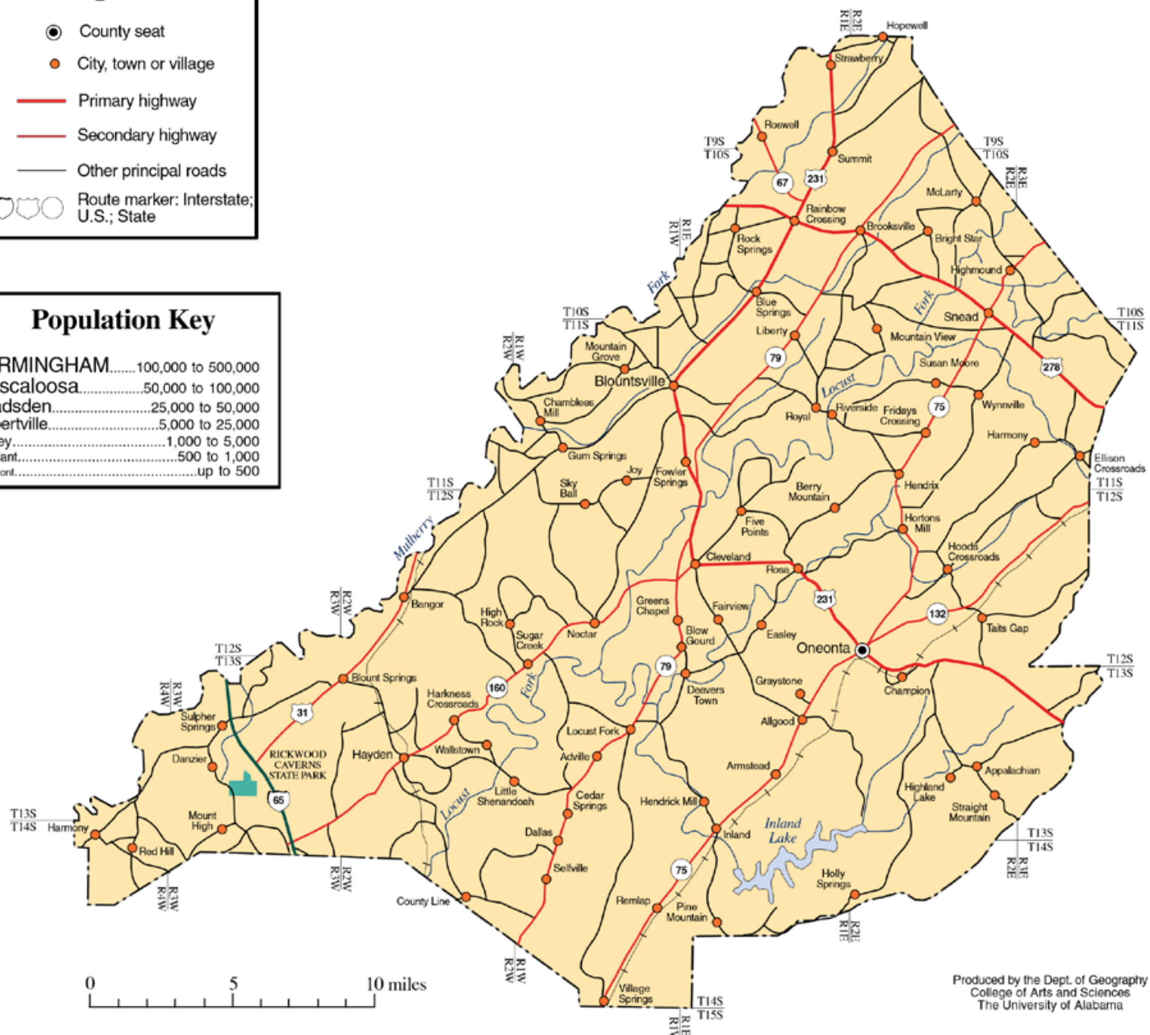
07/24/2017
Date

AAA Director

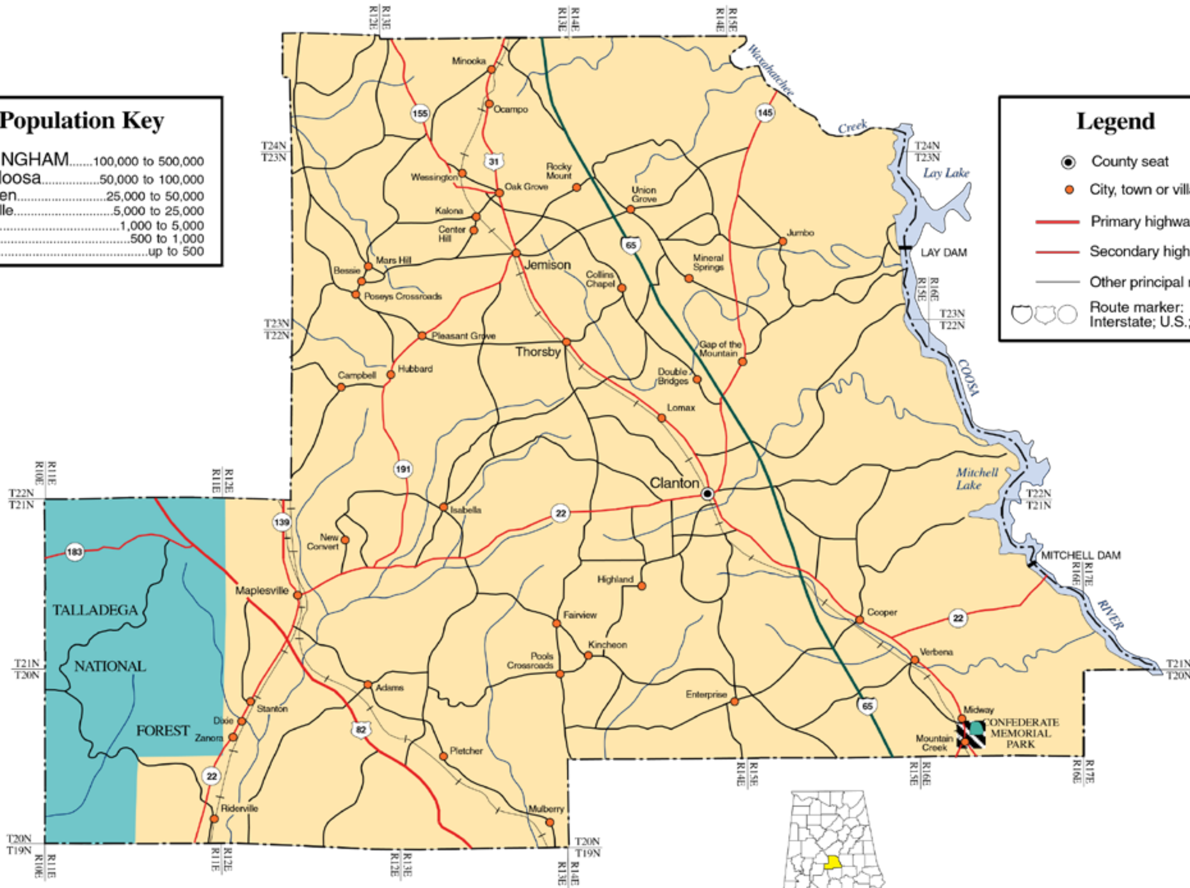
Date

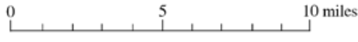
Exhibit 2: Planning and Services Area Maps



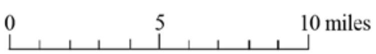

BLOUNT COUNTY
Legend
County seat
City, town or village
Primary highway
Secondary highway
Other principal roads
Route marker: Interstate; U.S.; State
Population Key
BIRMINGHAM.......100,000 to 500,000
Tuscaloosa.................50,000 to 100,000
Gadsden..........................25,000 to 50,000
Albertville............................5,000 to 25,000
Foley.......................................1,000 to 5,000
Brilliant...500 to 1,000
Elkmont...up to 500
Oneonta
Blountsville
Hayden
Snead
RICKWOOD CAVERNS STATE PARK
Inland Lake
0 5 10 miles
Produced by the Dept. of Geography
College of Arts and Sciences
The University of Alabama

CHILTON COUNTY





SHELBY COUNTY



Legend

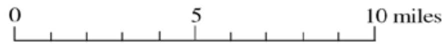
- County seat
- City, town or village
- Primary highway
- Secondary highway
- Other principal roads
- Route marker: Interstate; U.S.; State

Produced by the Dept. of Geography
College of Arts and Sciences
The University of Alabama

Population Key

BIRMINGHAM	100,000 to 500,000
Tuscaloosa	50,000 to 100,000
Gadsden	25,000 to 50,000
Albertville	5,000 to 25,000
Foley	1,000 to 5,000
Brilliant	500 to 1,000
Elkmont	up to 500

ST. CLAIR COUNTY



Legend

- County seat
- City, town or village
- Primary highway
- Secondary highway
- Other principal roads
- Route marker: Interstate; U.S.; State

Population Key

BIRMINGHAM.......100,000 to 500,000
Tuscaloosa.................50,000 to 100,000
Gadsden..........................25,000 to 50,000
Albertville............................5,000 to 25,000
Foley.......................................1,000 to 5,000
Brilliant...500 to 1,000
Elkmont..up to 500

Produced by the Dept of Geography
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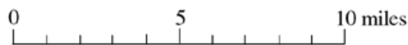
The University of Alabama

WALKER COUNTY

13
Spring Hill
Nauvoo
Slicklizzard
Dogtown
Flatwood
Eldridge
Clarke
Kansas
Carbon Hill
Pocahontas
Prospect
Lupton
Macedonia
Thach
195
Marigold
Curry
Marylee
Lewis Smith Lake
LEWIS SMITH DAM
4
5
Saragossa
Manchester
South Lowell
257
Sunlight
Burrows Crossroads
Powellville
Drummond
Gamble
Five Points
69
Red Rock
Gravlee Junction
Sipsey
Boldo
78
Cedrum
Holly Grove
Townley
Lost
Cane
Jasper
Hillard
New Jagger
McCollum
124
102
Chapel Hill
Union Chapel
Gardiners Gin
Lynns Park
Argo
Campbellville
Owens Chapel
Fork
York Mountain
Dilworth
Creel
Empire
Debardeleben
Pleasant Grove
Calumet
Cameron
Creek
Corinth
Rocky Hollow
Bankhead
269
Hull
Tubbs Hill
Cordova
Kershaw
Sumiton
Appling Bend
Coal Valley
Big Ridge
Deason Hill
Benoit
Pendley
Parrish
America
Dovertown
Kings Mill
Providence
Dora
Key Hill
Oakman
West Corona
Corona
Patton
Stephenson Crossing
Dixie Springs
Gayosa
Barney
Aldridge
Bradleytown
Oakahalla
Burnwell
Wyatt
Bryan
Hayes Crossing
Marietta
Williamstown
Key Camp
Yerkwood
Enon
Wolf
Pleasantfield
Drifton
Goodsprings
Quinton
Reeds Ferry
Gorgas
Bothel
Pumpkin Center
Twilly Town
Wegra
Littletons
The Wye
Fairview
Browntown
Tutwiler
Bankhead Lake

Population Key

BIRMINGHAM.......100,000 to 500,000
Tuscaloosa................50,000 to 100,000
Gadsden.........................25,000 to 50,000
Albertville.............................5,000 to 25,000
Foley.......................................1,000 to 5,000
Brilliant...500 to 1,000
Elkmont..up to 500



Produced by the Dept. of Geography
College of Arts and Sciences
The University of Alabama

Legend

County seat
City, town or village
Primary highway
Secondary highway
Other principal roads
Route marker: Interstate; U.S.; State

Exhibit 3: Board of Directors Membership

Executive Committee

Richard Lovelady, Chairman (Walker County)
- Address: P.O. Box 635 Dora, AL 35062
- Email: carolynlove@charter.net

Reverend Glenn Bynum, Vice Chairman (Blount County)
- Address: 204 Church Street Oneonta, AL 35121
- Email: gbremlap@aol.com

Gay West, Secretary (Chilton County)
- Address: P.O. Box 30 Clanton, AL 35046
- Email: westgay@aces.edu

Board Members: FY 2017

Commissioner Dean Calvert (Blount County)
- Address: 220 2nd Avenue East Room 106 Oneonta, AL 35121
- Email: dcalvert@blountcountyal.gov

Judge Chris Green (Blount County)
- Address: 220 2nd Avenue East Room Oneonta, AL 35121
- Email: cgreen@blountcountyal.gov

Commissioner Allen Caton (Chilton County)
- Address: 625 County Road 8 Jemison, AL 35085
- Email: acaton@chiltoncounty.org or acaton@catonacoustical.com

Commissioner Mike Vest (Shelby County)
- Address: 2344 Lakeside Drive Birmingham, AL 35244
- Email: mikevestshelby@gmail.com

Commissioner Ward Williams (Shelby County)
- Address: 225 Summerbrook Lane Alabaster, AL 35007
- Email: ward@vfsdads.com

Senta Goldman (Shelby County)
- Address: P.O. Box 467 Columbiana, AL 35051
- Email: sgoldman@shelbyal.com

Chairman Paul Manning (St. Clair County)
- Address: 165 5th Avenue Suite 100 Ashville, AL 35953
- Email: pmanning@stclairco.com

Commissioner Tommy Bowers (St. Clair County)
- Address: 70 Mockingbird Circle Pell City, AL 35128
- Email: tbowers@stclairco.com

Ms. Lee Ann Clark (St. Clair County)
- Address: 1815 Cogswell Avenue Suite 103 Pell City, AL 35125
- Email: clarkla@aces.edu

Sherry Reaves (St. Clair County)
- Address: 140 Trellis Circle Springville, AL 35146
- Email: 2006madison@windstream.net

Chairman Jerry Bishop (Walker County)
- Address: 1801 3rd Avenue S – Suite 113 Jasper, AL 35501
- Email: j.bishop@walkercountyal.us

Exhibit 4: Advisory Body Membership

FY 2018 Advisory Council Members

OAA 306(a)(6)(D)

The Area Agency on Aging will establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, representatives of older individuals, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan.

AAA: __Middle Alabama Area Agency on Aging_______ Area Plan FY: __2018_

NAME	OLDER INDIVIDUAL			REP. OF OLDER INDIVIDUAL	LOCAL ELECTED OFFICIAL	PROVIDER OF VETERANS' HEALTH CARE (if appropriate)	GENERAL PUBLIC
	MINORITY	RURAL	CLIENT/ PARTICIPANT?				
Bekah Wood							X (Oneonta Public Library)
Chris Green					X (Blount County Commission)		
Clara Christopher				X (DRR)			
Glenn Bynum							X (M4A Board Member)
Jane Childers				X (Snead Senior Center)			
Kathleen Monaghan				X (Red Cross)			
Melissa Thomas		X		X (Stewarts Chapel UMC Food Panty)			
Patricia Seames				X (Red Cross)			
Sandra Smith		X		X (ASHL)			
Suzanne "Suzy" Shelton				X (Golden Living)			
Jon Head					X Fire Chief		

Kendal Head							X (General Public)
Alexus O'Neal							X (DHR Intern-Student)
Carol Rohling				X (AlaCare)			
Carolyn Thomas				X (Clanton Senior Center)			
Carolyn Fortner		X		X (M4A)			
Dayla Hamilton				X (ADPH)			
Jessie Carter		X		X (Chilton Co. Transit)			
Judy Dean				X (Southern Care Inc.)			
Lagora Lykes							X
Marilyn Colson				X (DHR)			
Melissa Fowler		X		X (M4A)			
Pam Boykin				X (Southern Care Inc.)			
Patty Drake				X (DHR)			
Ryan Leonard				X (M4A)			
Tammy Noah				X (SunCrest Home Health)			

Terry Collier				X (Chilton Emergency Assistance)			
Tim Bryant		X		X (DHR)			
Tim Thompson				X (Lighthouse Church/Senior Center Meal Delivery Driver)			
Barbara Roberts				X (Pelham Library/Senior Center)			
Dayla Hamilton				X (Public Health)			
Beverly Baker							X (City of Alabaster)
Billy Jones		X					X (Bryant Bank)
Carolyn Neiswender							X (KidOne Transport)
Carolyn Williams				X (DHR)			
Corine Matt				X (DHR)			
Ester Graham							X
George Henry		X					X (City of Alabaster)

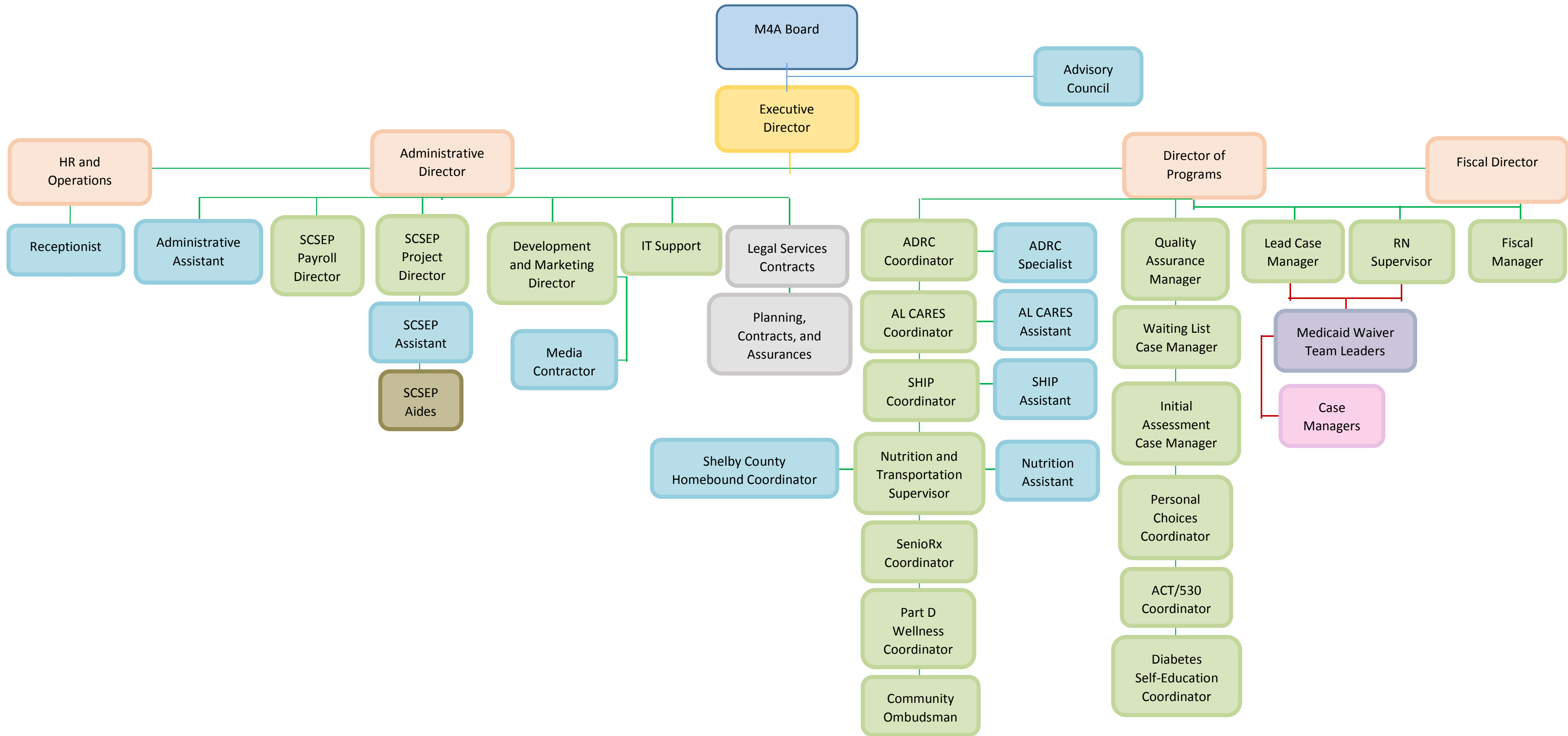
Irene Collins		X					X
Jameka Brooks				X (Shelby Emergency Assistance))			
Kayla Briggs				X (Sunshine Manor)			
Kirby Henderson				X (ARC of Shelby Co.)			
Marty Handlon					X (Mayor of Alabaster)		
Marvin Copes				X (Positive Maturity)			
Mary Piazza							X
Susan Tedford							X
Mary Neff							X
Tiffany Chess				X (Childrens Rehab Service)			
Daisy Washington				X (RSVP)			
Addie Duke				X (Moody Senior Center)			
Aisha Martin				X (St. Clair Co. Extension Office)			

Clara Christopher				X (DRR)			
Ellen Allen		X		X (Community Action Agency)			
Ellen Stephens				X (St. Vincent's)			
Elsie Allen				X (Lakeside Hospice)			
Hiliary Hardwick				X (VA)		X (VA)	
Janet Smith		X		X (St. Clair Public Transportation)			
Jenny Baldone							X (Odenville Drugs)
June Ford		X		X (Senior Center Manager)			
Nina Barnes				X (Community Action Agency)			
Sandi Nicholson				X (DHR)			
Sharon Smith		X		X (Lakeside Hospice)			

Teresa Carden				X (Lakeside Hospice)			
Thelma Richardson				X (DHR)			
Valerie Harp				X (ADPH)			
Melanie Carroll							X
Billy Luster		X			X (Walker County Commission)		
Brian Maloney		X		X (Walker Baptist Hospital)			
Ira Farris				X (Hospice)			
Jami Fike				X (Hope Clinic)			
Joanna Brand		X		X (ARC of Walker Co.)			
Johnnah Baker							X (Walker County Board of Education)
Lona Courington		X					X (Bevill State Community College)
Matthew Mitchell				X (DHR)			

Virginia Rediker				X (Department Rehabilation)			
Mimi Hudson				X (Walker Co. Community Foundation)			
Saderia Morman				X (Salvation Army)			
Louis Vick		X		X (ARC of Walker Co.)			
Rebecca Nelson		X					X
Sandy Sudduth					X (Jasper City Council)		
Steven Aderholt					X (District 4 Commissioner)		
Tammy McGee		X		X (Positive Maturity)			
Trecia Benefield		X		X (M4A-AmeriCorp)			
Vicky Stovall				X (DRR)			

Exhibit 5: M4A Organizational Chart and Staff Breakdown



M4A Staff Breakdown

Executive Director, Carolyn Fortner
Administrative Director, Crystal Crim
Fiscal Director, Tammy White
Human Resources and Operations Manager, Lisa Adams
Director of Programs, Maranda Johnson
Fiscal Manager, Renee Green
Development and Marketing Director, Robyn James
Information and Technology Support, Cody Lewis
SCSEP Project Director, Sheila Baker
SCSEP Payroll Director, Sheila Hogge
SCSEP Assistant, Beverly Boykin
SCSEP Aides, Blane McGlawn and Catherine Kent
Elderly and Disabled/530/ACT Waiver:
Lead Case Manager, Courtney Durden
RN Supervisor, Sherry Wilson
Quality Assurance Manager, Christal Smith
Initial Assessment Case Manager, Rebecca Walden
Waiting List Case Manager, Jennifer Davis
Medicaid Waiver Team Leaders: Lateshia Davidson and Chris McDonald
EDW/530 Case Managers: Cindy Sharp, Tracey Johnson, Washeka Reese, Crystal Whitehead, Cassie Horton, Shamarion Winston, Megan Houston, and Megan Nunnery
Personal Choices Coordinator, Monica Pauling
ACT/530 Waiver Coordinator, Arnita Hicks
ADRC Program Coordinator, Kay Hart
ADRC Specialist, Ellen Brechin
Alabama Cares Coordinator, Lauren Karcher
Alabama Cares Program Assistant, Denise Stamps
Part D Wellness Coordinator, Alexia Barbour
Community Ombudsman, Ryan Leonard
Nutrition and Transportation Supervisor, Laura King
Nutrition Assistant, Delia "Dee" Church
Shelby County Homebound Coordinator, Cheryl Gaines
SenioRx Coordinator, Melissa Fowler
SHIP Coordinator, Latoya Shelton
SHIP Assistant, Diana White
Administrative Assistant, Sharon Echols
Receptionist, Janice Cates
Title III Contractors: Jan Neal Law Firm, LLC; ClasTran; St. Clair County Public Transportation (SCAT)

Exhibit 6: Emergency/Disaster/Pandemic Plan

Office Safety Plan

Middle Alabama Area Agency on Aging

Internal Emergency Action Plan

Precaution and Prevention

(last updated: 1/2017)

Precaution and Prevention

1. No M4A employee or visitor should carry guns or other weapons into the building.
2. The front door is to remain locked at all times outside of business hours.
3. The lobby door and back door are both accessible by key fob. Only full-time and part-time employees should have a key fob.
4. All visitors and volunteers must be signed-in and signed-out of the building.
5. All visitors and volunteers must have badges.
6. Visitors should be retrieved from the lobby and escorted through the building by the employee they are visiting.
7. A code system will be used for alerting employees to intruders/unwelcome visitors in or outside of the building.
8. If an intruder has entered the building, staff not in the office should be alerted.
9. Employees should not let strangers/visitors "piggy back" with them through the door.
10. Employees are required to let their supervisors know where they are going to be when out in the field and to carry pepper spray with them (if needed). If an employee ever feels in danger when in the field, he/she should immediately leave the location and alert M4A management and/or emergency responders if necessary.

Exiting the Building after Office Hours

Precaution and Prevention

1. If there is/are an unfamiliar person(s) in the parking lot, the employee should not exit the building.
2. The employee should see if there are any coworkers still in the building.
3. If there are still coworkers in the building, the employee should check with them to see if they are expecting anyone.
4. If another coworker is expecting someone, the coworker should check from a window to make sure the unfamiliar person is the expected visitor.
5. If no coworker is expecting someone or if there are no other coworkers in the building, then the employee should immediately call the police and any other emergency responder necessary and remain in the building.
6. The employee should never exit the building until it is deemed completely safe.

For all Emergencies, CALL 9-1-1 first!

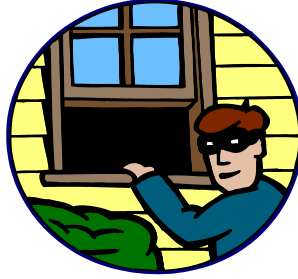
Alabaster Police Department:	**9-1-1**	
	205-663-7401	
Alabaster Fire Department:	**9-1-1**	
	205-664-6818	**Station 1 @ 1st Ave W**
	205-664-6816	**Station 2 @ Butler Road**
	205-664-6827	**Station 3 @ 1st St S**
Shelby County Sheriff:	**9-1-1**	
	205-669-4181	

Visitor Procedures

Precaution and Prevention

1. If someone comes to see an M4A employee, the employee should be called to the front by the (acting) receptionist to let the visitor in and escort visitor through the building.
2. The visitor should be signed-in and given a visitor badge by the employee being visited.
3. If the employee being visited deems the visitor a dangerous or unwelcome visitor, the employee should let the receptionist know not to let the visitor in.
4. If the employee tells the receptionist not to let the visitor in due to danger, the receptionist should calmly tell the visitor that the employee will be right with them. The receptionist should then go to the highest level administration staff member available to tell him/her of the situation.
5. The administration staff member should immediately call the police to remove the unwelcome visitor.
6. An office page should be made indicating the potential danger (see "Intruder" on Quick Chart).
7. When the page is heard by other employees, they should remain in their office with the door locked, lights off, and get under their desk/table. Flashlights may be used for light. If there is a window in the office, the blinds should be closed or shut.
8. If an employee is in another employee's office when the page is heard, the "visiting employee" should remain in that employee's office and lock-down with him/her.
9. If an employee is not in an office or other lockable room, he/she should attempt to make it to the closest lockable room and lock-down.
10. If safe to do so, the receptionist should retrieve the sign-in book and contact staff members who are out of the office to alert them not to return to the office.
11. If an employee knows that another employee is out of the office and might be returning, he/she should contact the employee (if safe to do so) to alert employee not to return to the office.
12. All employees should remain in their offices under lock-down until the police have arrived, the premises are deemed safe, and an M4A administrative staff member knocks on their door to let them know it is safe to end lock-down (see *Who Decides?*).

In Case an Intruder or Unwelcome Visitor Enters the Building: Lock-Down System



If an intruder or unwelcome visitor has entered the building, the following codes will be used to alert employees to the danger and where the intruder is.

- "Mr. Red Walker, please call extension **300"-Intruder in the lobby, inside, or outside the building.**

When employees hear the page, they should remain in the office/room they are in with the door locked, lights off, and under a desk or table if possible. Their flashlight may be used for light. If an employee is not in a lockable room when the page is heard, he/she should quickly and quietly move to their designated lockable room. Once there, he/she should lock the door, turn the lights off, and get under a desk or table if possible. The receptionist should go into the nearby office if safe to do so. The highest level member of the administration staff who is available should contact the police. Employees that know of a coworker who is out of the building and might return to the office should call the employee (if it is safe to do so) to alert the employee not to return to the office. Employees should remain in lock-down until the police have arrived, the premises are deemed safe, and an M4A administrative staff member knocks on their door to let them know it is safe to end lock-down.

LOCATION FOR LOCK-DOWN: UNDER YOUR OFFICE DESK
LOCK YOUR OFFICE and TURN OFF LIGHTS IF POSSIBLE
STAY IN LOCK-DOWN UNTIL POLICE ARRIVE

Fire Safety

Precaution and Prevention

1. Coffee pots and other electronic appliances are tuned off and unplugged nightly.
2. Each long hallway has two smoke alarms, one emergency light, and a fire extinguisher.
3. The entire staff will be trained at an in-service on how to use the fire extinguishers.
4. The smoke alarms will be tested monthly and the batteries will be changed twice a year (at the time change). Smoke alarms will be replaced every ten years. A sticker will be placed on each smoke alarm to indicate date replaced.
5. The Administrative Assistant will be responsible for the maintenance and testing of the smoke alarms, as well as the fire extinguishers and emergency lighting.
6. A staff fire drill will be performed annually. An intercom announcement will be made to announce the beginning of a fire drill.
7. First aid kits will be kept on the bottom of the bookcase in the front hallway by the AED.
8. The staff is required to use the IN/OUT BOARD when they enter/leave the office.
9. Volunteers/visitors will be required to sign-in when entering the building and sign-out when exiting. They will also be asked to wear a badge/nametag. It will be the responsibility of the receptionist to sign them in and give them a badge/name tag. It will be the responsibility of the staff member whom the volunteer/visitor is visiting to make sure the volunteer/visitor signs-out and returns the badge/nametag.

In Case of an Actual Fire!

In the case of an actual fire, please listen for the phrase “FIRE IN THE BUILDING – PLEASE EVACUATE” over the intercom. Currently (as of 1/20/2017), the M4A office does not have a pull-down fire alarm or other fire alarm that can be heard throughout the building. Intercom/page can also be used in case of an actual fire or fire drill. Staff will be instructed that if they hear a smoke alarm going off or see a fire, they should immediately yell “FIRE!” and use the Intercom/page if it is safe to do so.

The evacuation route (or emergency exit route) will be out the closest exit and to the front parking lot. Be aware of fire trucks and other emergency vehicles that may be in or pulling into the parking lot. Do not stand in the parking lot or stand close to the curbs, as this may put you in danger or hinder rescue vehicles.

Once in our evacuation area, staff will begin roll call.

Once in our evacuation area, first aid will be administered to those who are in need.

The highest level administrative staff member is designated to call the fire department, police, and other necessary emergency responders once in the gathering place.

Emergency responders will be alerted to anyone who is unaccounted for.

EVACUATE TO: FRONT PARKING LOT
EVACUATION SIGNAL: ANNOUNCEMENT OF “FIRE – PLEASE EVACUATE.”
BRING YOUR FLASHLIGHT, MARKER AND WHISTLE

In Case of an Actual Weather Emergency!

1. The Executive Director will make the decision to shelter-in-place or evacuate.
2. The staff contact list will be used to locate staff outside of the building and alert them to the situation and procedure.
3. If the decision to shelter-in-place is made, the staff shall shelter-in-place in the Board Room.
4. When sheltering-in-place, staff members will bring their flashlight, marker, and whistle with them.
5. The receptionist will be responsible for bringing the first aid kit.
6. The HR/Operations Manager will be responsible for bringing the EAP binder. The receptionist will be responsible for getting it in the HR/Operations Manager's absence.
7. The disaster kit is located in the cabinet located in the kitchen.
8. Once in the designated shelter-in-place area, staff roll call will be used to account for all staff and visitors/volunteers.
9. The Nutrition Team will check that all Center manager(s) have accounted for all center participants and homebound clients.
10. Receptionist will place the phones on "inclement weather" setting.
11. Once in the designated shelter-in-place area, employees will use their markers to write their names on their arms, as well as any pertinent medical information if needed.
12. Once in the shelter-in-place area, first aid will be administered to those in need.
13. Emergency responders will be called if needed.

After the weather emergency is over and it is safe, a damage/injury/and plan assessment will be completed. The building will be checked for damage and injured people will be tended to. The evacuation plan will be evaluated to see how well it worked in a real emergency.

SHELTER-IN-PLACE: BOARD ROOM
SHELTER-IN-PLACE SIGNAL: ANNOUNCEMENT OF "PLEASE SHELTER IN PLACE"
BRING YOUR FLASHLIGHT, MARKER AND WHISTLE

Hazardous Condition: Outside Building

Precaution and Prevention

Hazardous materials are substances that pose a potential risk to life, health or property when released due to their chemical nature. It can range from an **accidental chemical spill** on a roadway to **an intentional act of terrorism**. The important thing to know is how to prepare for an incident. **Shelby County does not have any designated "bomb fallout" shelters**. The exhibition building and a building behind the city hall in Columbiana are for temporary weather related shelter only.

1. Have a warning signal (Announcement of "HAZARDOUS MATERIAL OUTSIDE – PLEASE SHELTER IN PLACE" over intercom)
2. News and instructions through radio, television or Internet
3. Know evacuation routes from your building
4. Know "in-shelter" area of the building
5. Have hazardous material emergency shelter kit ready and staff trained to use it
6. Teams 1 and 2 will begin sealing building if necessary (see Teams 1 and 2 on Quick Chart).

SHELTER-IN-PLACE: BOARD ROOM
SHELTER-IN-PLACE SIGNAL: ANNOUNCEMENT OF "HAZARDOUS MATERIAL OUTSIDE – PLEASE SHELTER IN PLACE" AND SEVERAL BLOWS OF THE WHISTLE

BRING YOUR FLASHLIGHT, MARKER, AND WHISTLE.

Kit Preparation

Precaution and Prevention

The hazardous material emergency shelter kit should have the following items:

(These items are in the EAP Cabinet located in the M4A Kitchen – UPSTAIRS.)

1. Plastic sheeting (2-4 mil.) for covering the exterior doors and in-shelter area
2. Duct tape for securing the plastic sheeting
3. Masks for each person (consider frequent visitors/volunteers)
4. Plastic bags for disposing of contaminated materials/clothes
5. Rags for spills and stuffing under doors
6. Sheets to wrap injured/exposed persons
7. Scissors to remove contaminated material from clothes and make bandages.

Hazardous Condition: Outside Building

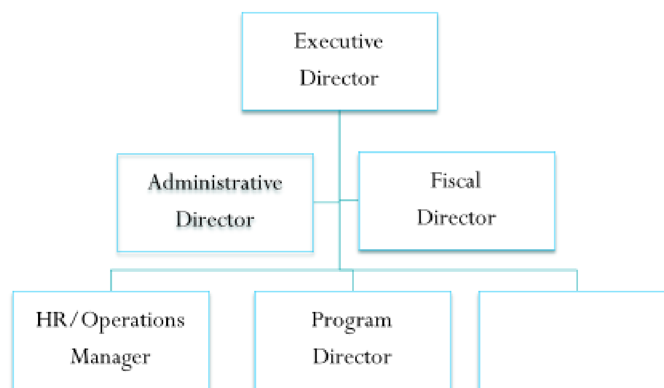
Who Decides?

Depending on circumstances and the nature of the hazard (which could include an attack), the first important decision is whether to evacuate or shelter-in-place. After viewing available information from radio, television, Internet, emergency alerts, and after consultation with key staff, the **decision to shelter-in-place or evacuate will be made by the Executive Director**, who will notify staff.

If the Executive Director Is Not In the Office: Order of Succession

To be used in All Emergencies or Substantive Decision Making Events

When the Executive Director is not in the Office



Hazardous Condition: Inside Building

What if We Evacuate?

If the decision is made to evacuate, the staff will be notified where the hazard/attack is located and where to evacuate, depending on the location of the hazardous event.

Staff should:

1. Keep vehicle **gas tank at least half-full at all times** in case of emergency evacuation.
2. Become familiar with **alternate routes home**, if home is a safe place to evacuate (away from the hazardous condition/attack).
3. If time permits, **notify a family member** as to your evacuation route/location.
4. From a safe place – The Emergency phone tree will be started.

The three ways to minimize exposure to hazardous materials are: Distance-Shielding-Time!

5. **Distance:** The more distance from you and the incident is the safest method.
6. **Shielding:** The more of a heavy, dense material between you and the incident the better.
7. **Time:** Most chemicals and radiation lose its strength with time so staying away from the exposed area for an extended time is the safest route to take.

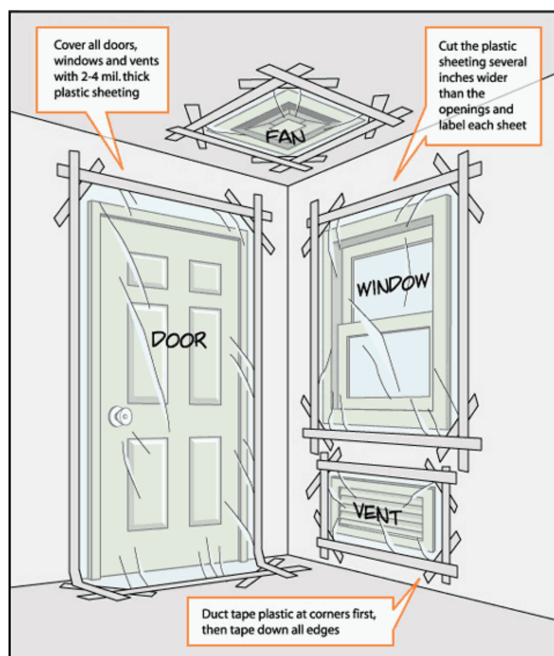
EVACUATE TO: FRONT PARKING LOT
EVACUATION SIGNAL: ANNOUNCEMENT OF “HAZADORUS MATERIAL IN THE BUILDING – PLEASE EVACUATE”.
BRING YOUR FLASHLIGHT, MARKER AND WHISTLE

Hazardous Condition

What if We Shelter-in-Place?

The staff will be notified to shelter-in-place and the designated employees will ready the in-shelter area located in the **M4A BOARD ROOM**:

1. EAP emergency kit and the hazardous material kit are located in the EAP cabinet in the kitchen.
2. Normal air circulation should be turned off by Teams 1 and 2. If available, 100% recirculation is started as soon as possible (not available in the M4A Office Building).
3. Teams 1 and 2: Plastic sheeting is placed with duct tape over both doorways going into the kitchen and any air vents in the building, after the staff and visitors in the building are accounted for and have entered the in-shelter area. Shelter-in place area will be in the board room located on the first floor.
4. Check for any injuries or exposure to hazardous material. If anyone has been exposed to a hazardous material, removing exposed clothing and showering is recommended, if possible.
5. Monitor television or other communications method (cell phone) to know when it is safe to leave the sheltered area.



Source: http://www.ready.gov/america/makeaplan/shelter_in_place.html

What to do when it's Safe to Leave the Shelter Area

1. Staff members who are emergency-trained or certified should check fellow staff members and visitors/volunteers for any injuries or contamination.
2. The Executive Director will determine whether emergency responders should be contacted.
3. If there is damage to the building, then the building should be evacuated immediately. If the building is evacuated, no one should return to the office building until it has been examined and deemed safe. The phone tree will be used to notify staff about when it is safe to return to the office building.

Hazardous Condition

Additional Warnings for Hazardous Materials

Potential mail bombs**:** If a suspicious package is received, it should be left alone-do not shake or empty contents. Keep all persons away from the area and call local law enforcement immediately.

Suspicious packages**:** Suspicious packages may have one or more of the following recognition points: Misspelling of common words, excessive weight for size, protruding wires or foil, lopsided or uneven shape, excessive postage, or no return address.

Bomb threats by phone**:** Never ignore a threat of this nature. Remain calm and make notes of the following:

1. Phone number from caller ID
2. Male or female voice?
3. Young or mature voice?
4. Any foreign or regional sounding accent to voice?
5. Background noises?
6. Any specifics the caller gives about where the bomb is located and when it may detonate?

A bomb threat checklist will be used by employee answering the call (see "Bomb" Section).

Notify Executive Director, who will determine if evacuation and 9-1-1 should be called. If Executive Director is not in the office, then follow the order of succession and notify the next in command. If the building is to be evacuated, follow the fire evacuation procedures.

Responding to a Bomb Threat

General Guidelines

1. Try to get more than one person to listen to call using a covert signaling system.

2. Stay calm and try to get as much information as possible.

3. Record all information possible.

4. Inform caller that the office is occupied and detonation could result in serious injuries or death.

5. Pay close attention to background noises and the voice of the caller (accent, voice quality, mood, tone, speech impediments, and any other potentially identifying or important characteristics).

6. Check the caller ID and record phone number and name. Do not erase.

7. Utilize bomb threat checklist.

Responding to a Bomb Threat

Bomb Threat Checklist

Exact time of call_________________

Date of call______________________

Gender of caller______________________

Caller ID information (phone number/name) _____________________________________

Any identifying characteristics of voice (foreign accent or language, profanity, soft/deep/loud, stressed/calm/excited, laughing/crying, speed, speech impediment, etc…)

____
____
____
____

Background noise(s)

____

Any notable remarks or information from phone call

____
____
____
____

Any information about bomb (type, appearance, location, when will it explode, and what will detonate it)
____ (use back page)

Guidelines for Processing Suspicious Mail

Many people have questions about how mailrooms and offices should handle mail that may contain a written threat of chemical or biological materials inside or mail that may contain some form of powder.

What Constitutes a Suspicious Parcel?
Some typical characteristics Postal Inspectors have detected over the years which should trigger suspicion include parcels that:

1. Are unexpected or from someone unfamiliar to you.
2. Are addressed to someone no longer with your organization or are otherwise outdated.
3. Have no return address or have one that can't be verified as legitimate.
4. Are of unusual weight, given their size, or are lopsided or oddly shaped.
5. Are marked with restrictive endorsements such as "Personal" or "Confidential."
6. Have protruding wires, strange odors, or stains.
7. Show a city or state in the postmark that does not match the return address.

General Precautions for Those Who Handle Large Volumes of Mail:

1. Wash your hands with warm soap and water before and after handling the mail.
2. Do not eat, drink or smoke around the mail.
3. If you have open cuts or skin lesions on your hands, disposable latex gloves may be appropriate.
4. Surgical masks, eye protection or gowns are NOT necessary or recommended.

If a Letter is Received that Contains Powder or Contains a Written Threat:

1. **DO NOT** shake or empty the contents of any suspicious envelope or package.
2. **DO NOT** attempt to clean up any powders or liquids.
3. Place envelope or package in a plastic bag or some other type of container to prevent leakage of contents. If no container is available, then cover with anything (i.e., clothing, paper, trash can, etc.) and do not remove cover.
4. Isolate the specific area of the workplace so that no one disturbs the item.
5. Evacuation of the entire workplace in NOT necessary at this point.
6. Have someone call 9-1-1 and tell them what you received, and what you have done with it. Law enforcement should also place a call to the local office of the FBI and tell them the same information. Indicate whether the envelope contains any visible powder or if powder was released. Also notify building security official or an available supervisor.
7. If possible, LIST all people who were in the room or area when this suspicious letter or package was recognized. Give the list to both the local public health authorities and law enforcement officials for follow-up investigations and advice.
8. Wash your hands with warm water and soap for one minute.
9. Do not allow anyone to leave the office that might have touched the envelope.
10. Remove heavily contaminated clothing and place in a plastic bag that can be sealed; give bag to law enforcement personnel.
11. Shower using ONLY soap and water as soon as possible.
12. When emergency responders arrive, they will provide further instructions on what to do.

Important:

1. Do not panic.
2. Do not walk around with the letter or shake it.
3. Do not merely discard the letter.

NOTE: If you suspect the package to be an explosive device, DO NOT cover, touch, or move the item. Follow your bomb threat procedures and notify the local law enforcement (9-1-1). (*Source: Shelby County EMA Handout: Guidelines for Processing Mail*)

Office Emergency Quick Chart

Threat, Signal, Meeting Place and What to Do

Threat	Warning Sound	Where to Meet	Who to Call	What to Do
Fire in building **Evacuate!**	FIRE - INTERCOM	Front Parking Lot	9-1-1	Bring flashlight / Exit Building Quickly
Bomb in building **Evacuate!**	BOMB INTERCOM	Front Parking Lot	ED calls 9-1-1	Bring flashlight / Exit Building Quickly
Hazardous Material in the building: **Evacuate!**	INTERCOM	Front Parking Lot	ED calls 9-1-1 and/or EMA 669-3999	Bring flashlight, marker and whistle Always keep gas tank half-full Know alt routes home/alt safe place ED will tell where hazard is located Travel away from hazard Contact loved one re your route/destination
Hazardous Material outside of building: **Shelter!**	INTERCOM	Board Room	ED calls 9-1-1 and/or EMA 669-3999	Bring flashlight, marker and whistle HR and Director will turn off all air units **Teams 1 and 2 will close/seal doors and vents Render first aid
Inclement Weather	INTERCOM	Board Room	Phone Tree is Activated	In office: shelter Out of office: caution
Intruder	"MR. RED WALKER PLEASE CALL EXT 300"	Lock-down	ED calls 9-1-1	Go to nearest office and lock door Turn off lights, close shades Get under desk and remain quiet Wait for law enforcement

**Team 1: LISA ADAMS and CHRISTAL SMITH: Team 2: CRYSTAL CRIM, LAURA KING, AND ALEXIA BARBOUR

County Emergency Quick Chart

Emergency Telephone Numbers

County	Sheriff	EMA	Red Cross	Salvation Army	Public Health	Court-house	Transp.	Hospital	Other
Blount	625-4127 625-4913 (dispatch)	625-4121	274-2115	625-4852	274-2120	625-4160	625-6250	274-3000	625-4673 Hope House
Chilton	755-4698	755-0900	755-0707	none	755-1287	755-1555	755-5941	755-2500	755-3188 Baptist Assoc.
Shelby	669-4181	669-3999	987-2792 987-2793	663-7105	664-2470	669-3710	325-8787	620-8100	685-5757 Oak Mtn. Missions 669-7858 Baptist Assoc.
St. Clair	884-6840	884-6800	884-1221	none	338-3357	338-9449	506-8585	338-3301	328-5656 328-2420 Salvation Army (Birmingham)
Walker	384-7218	384-7233	387-1478	221-7737	221-9775	384-7281	325-8787	387-4169 387-4000	384-9231 Jasper Area Family Resource Center

Police and Fire for all Counties: 9-1-1
United Way Information for all Counties except Chilton: 2-1-1
United Way of Chilton County: 755-5875

M4A: EMERGENCY PHONE TREE INSTRUCTIONS (1/4/2017)

When a decision is made regarding inclement weather - **CAROLYN FORTNER** will call –**TEAM LEADERS - LISA ADAMS, RENEE GREEN and SHARON ECHOLS.** Each person is responsible for calling the person below them on the list. **If you cannot reach them, leave a message and then call the next person on the list to keep the phone tree going.** **If you are not at home at the time of inclement weather, call YOUR TEAM LEADER – OR – Carolyn - 299-2470/**299-6802 or **Crystal Crim – 205-572-7390** - if your phone is out of order, then wait for the news reports and use your best judgment as to whether or not you should travel.

Lisa Adams **H/C -777-9821**	**Renee Green** **H 668-0381; C 283-0091**	**Sharon Echols** **H -755-9559; C- 217-2327**
Emily Reed H- 669-3982 ; C – 908-3746	**Cody Lewis** 267-7237	**Tammy White** H- 334-290-0784; C-334-414-3007
Megan Houston C – 789-4617	**Ryan Leonard** 535-4536	**Robyn James** 334-202-0444
Lauren Karcher H/C-534-0765	**Alexia Barbour** 313-303-3099	**Megan Nunnery** 334-468-8774
Denise Stamps C – 370-5422	**Crystal Whitehead** H/C - 249-1723	**Melissa Fowler** C- 217-5633
Jennifer Davis H/C -389-2417	**LaToya Shelton** H/C – 200-7007	**Tracey Johnson** H/ C – 312-8296
Chris McDonald C-516-9751	**Kay Hart** 837-0279	**Janice Cates** H – 688-4829: C - 396-0525
Arnita Hicks H- 672-7308; C- 601-0443	**Laura King** H- 664-9647; C- 451-2082	**Ellen Brechin** H/C - 542-9819
Washeka Reese H/C - 587-7712	**Cheryl Gaines** H- 621-8890; C -746-0665	**Cassie Horton** C – 260-7726
Diana White H/C - 260-9021	**Sheila Baker** H- 780-8271; C- 531-0958	**Dee Church** H / C – 383-8832
Sheila Hogge C – 746-7402	**Beverly Boykin** C/H – 613-0755	**Cindy Sharp** 586-5735
Christal Smith C – 603-6270	**Cathy Kent** 837-8127	**Shamarion Winston** C - 931-801-6501
Lateshia Davidson H/C- 563-1129	**Blane McGlawn** H – 358-7428:C-777-2958	**Sherry Wilson** 217-9594
Courtney Durden H/C -567-7663		**Monica Paulding** H – 815-1013; C – 249-9239
Maranda Johnson H/C - 602-1776		**Rebecca Walden** C- 334-791-3035

All Area codes are "205" unless indicated otherwise.

SEE BACK PAGE FOR ADDITIONAL NUMBERS

Additional Contact Numbers

Alexia Barbour: Andrew – 313-608-7109
Arnita Hicks: Angela Hicks – 913-1423: Charlie Hicks – 240-7330
Blane McGlawn – Juanita (Nita) McGlawn – 427-7835
Carolyn Fortner: Dale - C - 205-299-6802: (WK – 205-755-3737- Clanton Office)
Cassie Horton: Annette Horton – 260-7724
Catherine "Cathy" Kent: Tia Turner (niece) – 222-5581
Chris McDonald: Amber – 520-3797; Parents – 699-8514; Mr. McDonald – W – 699-2656
Christal Smith: Michael Smith – 427-9157
Cindy Sharp: Seneithia Parker – 253-1971
Cody Lewis: Renia Morgan – 229-7632
Courtney Durden: William – 902-7800
Crystal Crim: James – 572-7389
Crystal Whitehead: Jason Wood – 835-8856
Dee Church: Kathy Arthur 283-2313
Denise Stamps: Brandon Stamps – 283-1190
Diana White: Tim White C- 475-2353: Rachel – 417-5843
Ellen Brechin: Kenny – 542-9818
Emily Reed (Intern): Cindy Reed (mom) H- 908-1734 Alt.- 669-3982
Janice Cates: Steve – 369-0526; (Allen Cates – 365-7549; Susan Cates – 515-6430)
Jennifer Davis: Robby- 436-1300
Kay Hart: Thomas – 569-5650
Lateshia Davidson: Montay- C- 229-7543; Eular Berry - H 942-1486/C 413-9562
Laura King: Buddy – 453-3784
Lauren Karcher - Austin Karcher - 770-712-7140
Lisa Adams: David – 369-6344
Maranda Johnson: Colin C-383-0322; Greg Cleveland-Father - 441-6469
Megan Houston: David Johnson – 205-294-0833 or 334-224-7788
Megan Nunnery: David Nunnery (Dad) 706-392-7043
Melissa Fowler: Sally Edwards – H -755-7298/C 217-5280
Monica Paulding: Orlando Paulding – 470-7215
Rebecca Walden: Ruth (mom) – C 334-797-0929 or W 334-774-5480
Renee Green: Jimbo 283-9219
Robyn James: Michael – 334-303-5295
Shamarion Winston: Tabitha Winston – H – 931-801-7440; ALT – 270-798-738
Sharon Echols: James **– work/c -** 287-1249
Sheila Hogge: Chuck – 746-6658
Sherry Wilson: Allen Wilson –C – 955-0327; Diane (Sister) – 478-4144
Tammy White: Michael – 334-290-0784
Tracey Johnson: Tamey Johnson – C-354-9454; W- 664-6194
Washeka Reese: Washington and Lois Reese – 334-875-1514

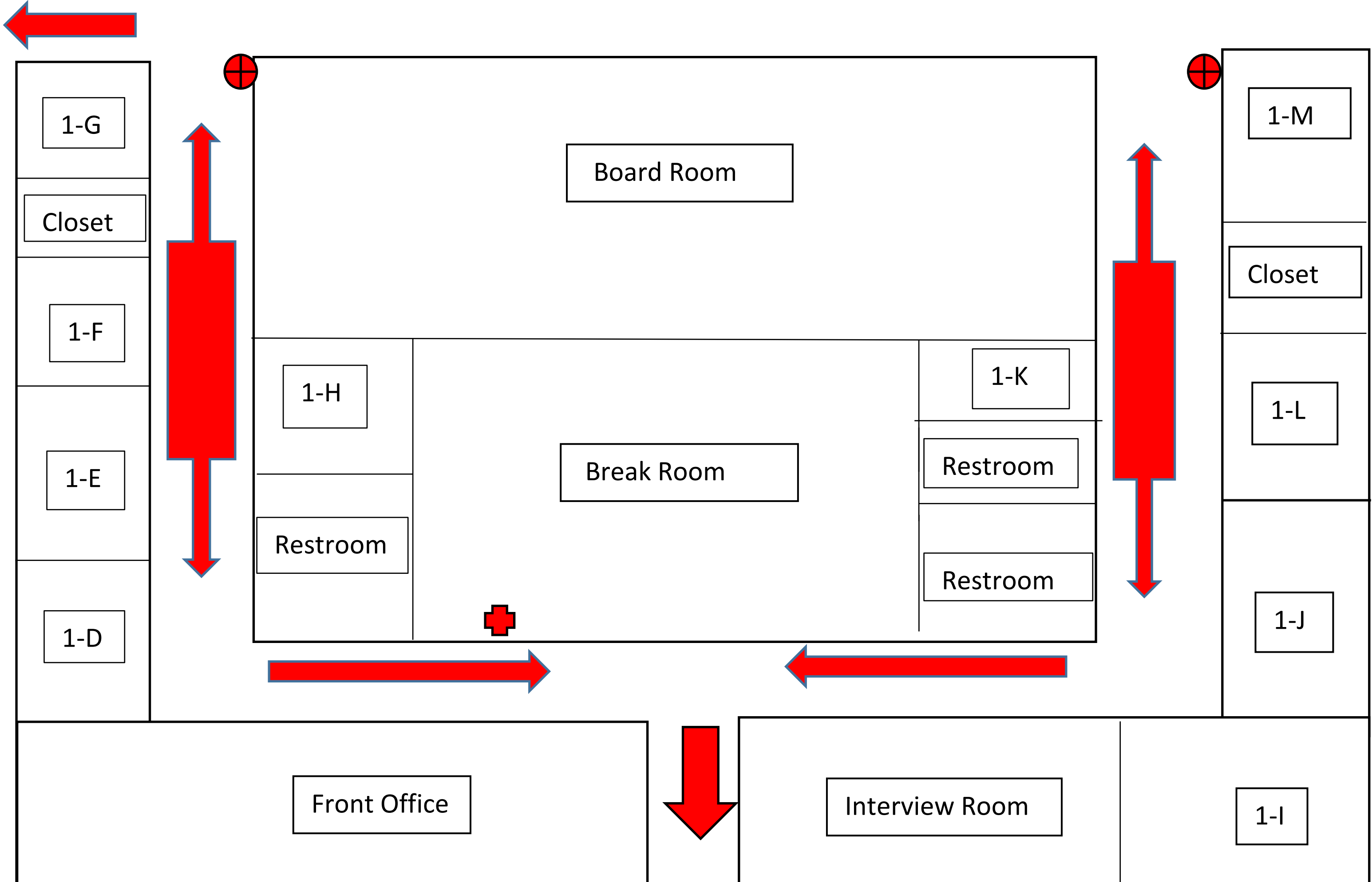
ADDITIONAL CONTACTS:

Lynn Eakin: 205-260-6107

Emergency Exit Plan

First Floor

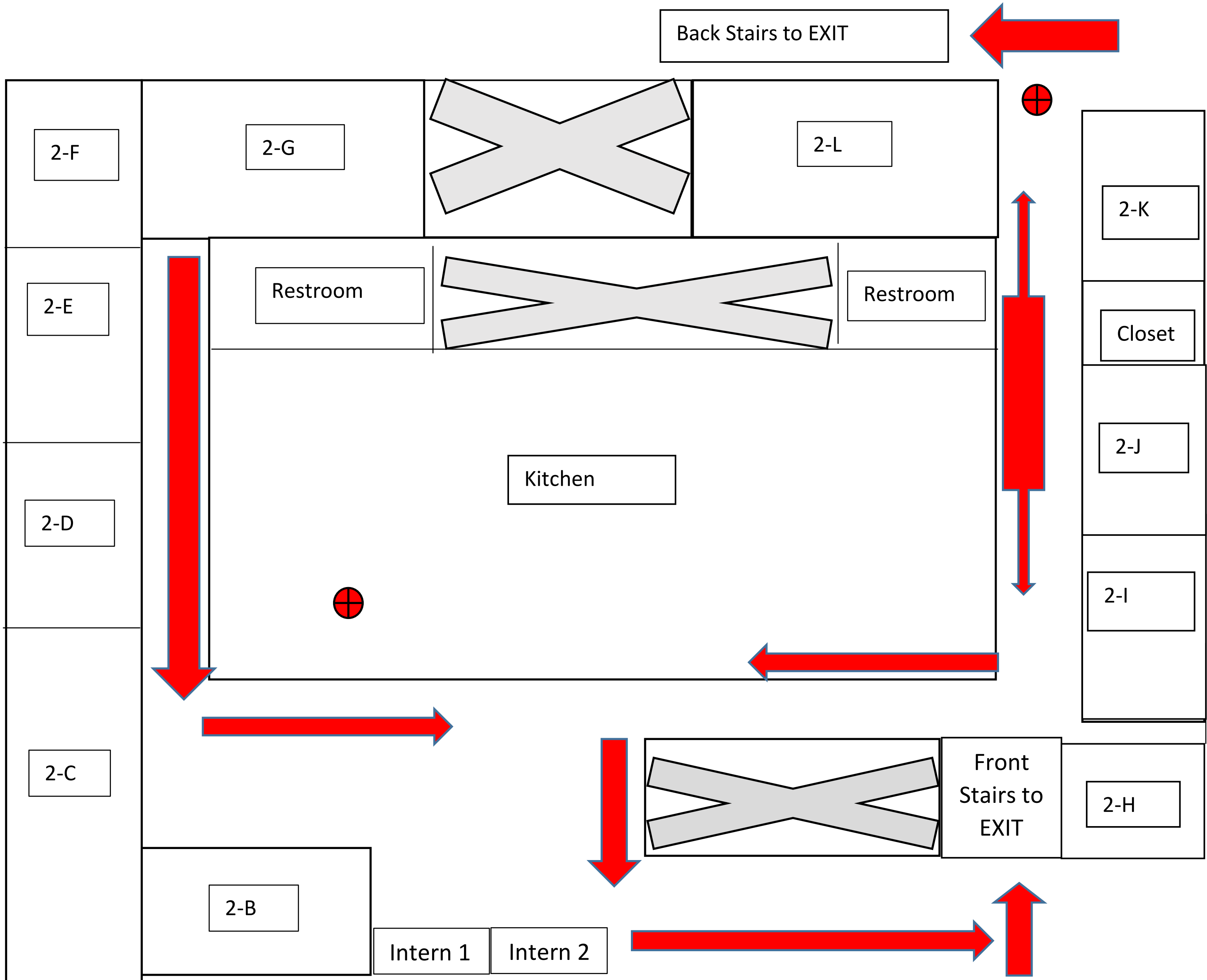
EXITS ARE MARKED WITH RED ARROWS; FIRE EXTINGUISHERS WITH RED DOTS; AND THE AED WITH A RED CROSS. THE ROUTE YOU TAKE WILL DEPEND ON WHERE THE FIRE IS LOCATED AND WHERE YOU ARE WHEN YOU HEAR THE ALERT. IF THE CENTER IS OPEN, THE NEAREST EXIT MAY BE THE SENIOR CENTER. SUGGESTED EXIT ROUTES ARE MARKED IN BLUE. MAP IS NOT TO SCALE!



Emergency Exit Plan

Second Floor

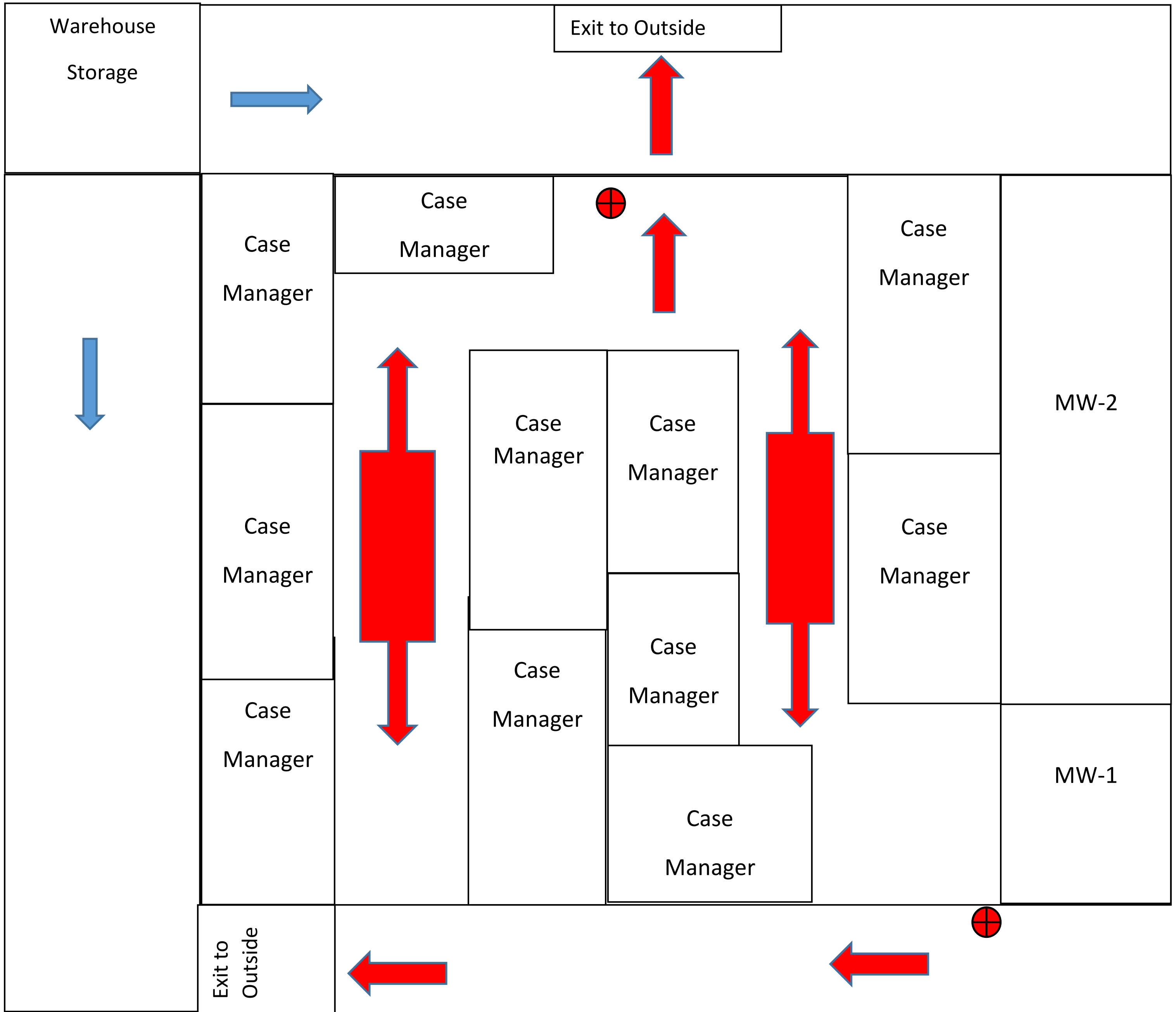
EXITS ARE MARKED WITH RED ARROWS; FIRE EXTINGUISHERS WITH RED DOTS; AND THE AED WITH A RED CROSS. THE ROUTE YOU TAKE WILL DEPEND ON WHERE THE FIRE IS LOCATED AND WHERE YOU ARE WHEN YOU HEAR THE ALERT. IF THE CENTER IS OPEN, THE NEAREST EXIT MAY BE THE SENIOR CENTER. SUGGESTED EXIT ROUTES ARE MARKED IN BLUE. MAP IS NOT TO SCALE!



Emergency Exit Plan

Medicaid Waiver Suite

EXITS ARE MARKED WITH RED ARROWS; FIRE EXTINGUISHERS WITH RED DOTS; AND THE AED WITH A RED CROSS. THE ROUTE YOU TAKE WILL DEPEND ON WHERE THE FIRE IS LOCATED AND WHERE YOU ARE WHEN YOU HEAR THE ALERT. IF THE CENTER IS OPEN, THE NEAREST EXIT MAY BE THE SENIOR CENTER. SUGGESTED EXIT ROUTES ARE MARKED IN BLUE. MAP IS NOT TO SCALE!



Employees Who Are CPR, AED, and/or First Aid Certified

Staff Member	CPR	AED	First Aid	Recertification
Crystal Crim	X	X	X	2/2018
Christal Smith	X	X	X	3/2018
Tammy White	X	X	X	3/2018
Cody Lewis	X	X	X	3/2018
Denise Stamps	X	X	X	3/2018
Janice Cates	X	X	X	3/2018
Sheila Baker	X	X	X	4/2018
Crystal Whitehead	X	X	X	4/2018
Megan Nunnery	X	X	X	4/2018
Sharon Echols	X	X	X	4/2018
Arnita Hicks	X	X	X	4/2018

EAP Cabinet Inventory (Located in the Kitchen)

TO BE REVIEWED: March 2018 **LAST REVIEWED**: March 2017

Quantity	Item	Expiration Date
6 cases	Water - 32/.5 liter	
52 cans	Tuna	*2020*
8 cans	Chicken	2020
3 large cans	Beef stew	2020
1	Can opener	
3	Trash bags	
2	Black markers	
1	Scissors	
2 packs	Leather cords	
1 pack	Whistles	
1	Air horn	
2 boxes	Surgical Masks	
10	Blankets	
1	Bar of soap	
3	Towels/washcloths	
1 bottle	Shampoo	
16	Flashlights	
1 box	Alcohol swabs	
3	Deodorant/Antiperspirant	
2	Hand sanitizer	
2	2 mil. Sheeting to cover doors	
6	2 mil. Sheeting to cover vents	
1 roll	Duct tape	
1 bottle	Ibuprofen	2018
1 box	Latex-free exam gloves	
1	Instant Temple Thermometer	
1 pack	AA Batteries	

Damage Assessment

Immediately following a disaster, it is important to assess any physical harm to the staff and damage to the M4A office building. This form should be used for such an assessment.

Initial Assessment Questions

1. Are staff members injured? Yes or No (circle one)

If yes, complete the *Staff Injury Assessment Form.*

2. Is there any damage or loss to the M4A Office Building? Yes or No (circle one)

If yes, complete the *M4A Office Building Damage Assessment Form.*

3. Date of disaster which caused injury or damage:

____

4. Type of disaster:

____

5. Name of person completing *Damage Assessment*:

____

_____________________________________ _____________________

Signature Date

M4A Staff Injury Assessment Form

Please complete a *Staff Injury Assessment Form* on each staff member who was/is injured as a result of a disaster. (Your initials here: ___________________________ / Date: ________)

Name of injured employee: ____

How was employee injured and on what part of the body:

____

____

____

____

What treatment was provided during shelter-in-place and who provided the treatment:

____

____

____

What is the employee's current status? (Please check)

- ☐ Being attended by emergency personnel
- ☐ En route to hospital: ___________________________________ (Hospital Name)
- ☐ At the hospital: ______________________________________ (Hospital Name)
- ☐ Other (Please explain fully):

____

____

____

Has the employee's emergency contact been notified: Yes or No (circle one) If yes, who was contacted?

____

____

M4A Office Building Damage Assessment Form

As soon as possible after a disaster, please complete the *M4A Office Damage Assessment Form*. (Your initials here: ____________________________ / Date: ________)

1. What disaster has damaged the M4A Office Building (fire, flood, tornado, etc.):
   ____
   ____
2. What part of the office building was damaged (kitchen, reception, lobby, rear storage, etc.):
   ____
   ____
   ____
3. To the best of your ability, describe the damage in as much detail as possible:
   ____
   ____
   ____
   ____
   ____
   ____
   ____
   ____
4. Please list any office equipment damaged, including computers, supplies, furniture, appliances, etc.:
   ____
   ____
   ____
   ____

M4A Emergency Plan Assessment Form

After an actual emergency which requires lock-down, shelter-in-place or evacuation, the M4A HR/Operations Manager shall assess the strengths and weaknesses of the emergency plan that was utilized and issue a written report with recommendations to the Executive Director within 10 business days. The following assessment questions are guidelines for this evaluative process:

What emergency plan was used: ____

When was the plan used: ____

What problems occurred in the implementation of the plan:

____

____

____

____

What may have caused the problems identified in #3:

____

____

____

How will the problems be corrected and when:

____

____

____

What were strengths of the emergency plan:

____

____

____

Middle Alabama Area Agency on Aging

Disaster Response and Recovery Plan Addendum (SCSEP)

In the case of a disaster the following contingency plan will be operational.

1) Organizational Continuity Plan

During or after an emergency, agency management will evaluate the status of its assets, the condition of the community environment and the needs of its staff/participants. Upon the completion of the evaluation, steps are taken to restore services as soon as is practical and possible within the constraints of environmental realities, resource availability, and safety considerations."

- Staff capabilities include carrying out routine activities such as completion of forms, performing intakes, processing payroll and other administrative duties.
  Person responsible: Carolyn Fortner, Executive Director; Crystal Crim. Admin. Director; Tammy White, Fiscal Director.

- SCSEP Project Director and Assistant Director will have access to a laptop computer and hard copy of files containing the names, phone numbers and addresses of all active participants. If SCSEP director is unavailable, Crystal Crim, Admin. Director, will have such resources.

- SCSEP Participants will resume scheduled hours or make modifications in host agencies and schedules to accommodate their continued community service employment.
  Person responsible: Sheila Baker, Project Director and Andrea Carter, Assist Project Director.

2) Property Safeguarded

All fiscal records and other records: Participant fiscal files are kept in the Fiscal office in a locked file cabinet. Participant personnel files are kept in the Project Director's office in a locked file cabinet.

3) Back Up Host Agencies (HA)

Participants should contact Sheila Baker (cell) 205-531-0958 or (office) 205-670-5770 or Andrea Carter, 205-670-5770 if their host agency is not available, if both are unavailable, please contact Crystal Crim, Admin. Director, 205-670-5770.

M4A will work with participants to find temporary placement at: Red Cross, Salvation Army, Community Action, Senior Centers, etc.

Also, an assessment of the potential for additional placements at the following current host agencies has been done to accommodate participants whose HA is unavailable: Yes;

M4A's SCSEP program has roughly 20 HA without participants. These HA are able to act as temporary placements for participants.

4) Back Up Plan (IT)

In the event that network communications are unavailable, hard copy of essential documents are being kept with Sheila Baker, Project Director, in a locked file cabinet.

5 Payroll Continuation

All fiscal records and other records: Participant's fiscal files are kept in the Fiscal office in a locked file cabinet. Participant personnel files are kept in the Project Directors office in a locked file cabinet.

Alternatively, M4A is able to manually write a check to pay a participant if needed.

National Terrorism Advisory System

The National Terrorism Advisory System, or NTAS, replaces the color-coded Homeland Security Advisory System (HSAS). This new system will more effectively communicate information about terrorist threats by providing timely, detailed information to the public, government agencies, first responders, airports and other transportation hubs, and the private sector.

It recognizes that Americans all share responsibility for the nation's security, and should always be aware of the heightened risk of terrorist attack in the United States and what they should do.

Imminent Threat Alert

Warns of a credible, specific, and impending terrorist threat against the United States.

Elevated Threat Alert

Warns of a credible terrorist threat against the United States.

After reviewing the available information, the Secretary of Homeland Security will decide, in coordination with other Federal entities, whether an NTAS Alert should be issued.

NTAS Alerts will only be issued when credible information is available.

These alerts will include a clear statement that there is an imminent threat or elevated threat. Using available information, the alerts will provide a concise summary of the potential threat, information about actions being taken to ensure public safety, and recommended steps that individuals, communities, businesses and governments can take to help prevent, mitigate or respond to the threat.

The NTAS Alerts will be based on the nature of the threat: in some cases, alerts will be sent directly to law enforcement or affected areas of the private sector, while in others, alerts will be issued more broadly to the American people through both official and media channels.

Sunset Provision

An individual threat alert is issued for a specific time period and then automatically expires. It may be extended if new information becomes available or the threat evolves.

NTAS Alerts contain a sunset provision indicating a specific date when the alert expires - there will not be a constant NTAS Alert or blanket warning that there is an overarching threat. If threat information changes for an alert, the Secretary of Homeland Security may announce an updated NTAS Alert. All changes, including the announcement that cancels an NTAS Alert, will be distributed the same way as the original alert.

OSHA EAP Requirements

1. 29 CFR 1910.38 Emergency action plans

To prepare for any contingency, an emergency action plan establishes procedures that prevent fatalities, injuries, and property damage. An emergency action plan is a workplace requirement when another applicable standard requires it. The following standards reference or require compliance with 1910.38: 29 CFR 1910.119, 1910.120, 1910.157, 1910.160, 1910.164, 1910.272, 1910.1047, 1910.1050, and 1910.1051.

Procedural, Program, and/or Equipment Requirements	Identify possible emergency scenarios based on the nature of the workplace and its surroundings. Prepare a written emergency action plan. The plan does not need to be written and may be communicated orally if there are 10 or fewer employees. At a minimum, the plan must include: The fire and emergency reporting procedures; Procedures for emergency evacuation, including the type of evacuation and exit routes; Procedures for those who remain to operate critical operations prior to evacuation; Procedures to account for employees after evacuation; Procedures for employees performing rescue and medical duties; and Names of those to contact for further information or explanation about the plan.
Training Requirements	Review the emergency action plan with each employee when the plan is developed, responsibilities shift, or the emergency procedures change. Provide training to employees who are expected to assist in the evacuation.
Assistance Tools	Standard - 29 CFR 1910.38 Emergency Action Plan. Directive - CPL 02-01-037 Compliance Policy for Emergency Action Plans and Fire Prevention Plans. E-Tools - OSHA's Expert System - Emergency Action Plan. E-Tools - Evacuation Plans and Procedures - Emergency Action Plan Checklist. E-Tools - Evacuation Plans and Procedures - Evacuation Elements. Fact Sheet - Planning and Responding to Workplace Emergencies.

	Fact Sheet - Evacuating High-Rise Buildings. Other Agency Resources - EPA Local Emergency Planning Committee (LEPC) Database.

2. 29 CFR 1910.39 *Fire prevention plans*

This plan requires employers to identify flammable and combustible materials stored in the workplace and ways to control workplace fire hazards. Completing a fire prevention plan and reviewing it with employees reduces the probability that a workplace fire will ignite or spread.

A fire prevention plan is a workplace requirement when another applicable standard requires it. The following standards reference or require compliance with 1910.39: 29 CFR 1910.157, 1910.1047, 1910.1050, and 1910.1051.

Procedural, Program, and/or Equipment Requirements	Prepare a written fire prevention plan. The plan does not need to be written and may be communicated orally if there are 10 or fewer employees. Develop a plan that includes Major fire hazards, hazardous material handling and storage procedures, ignition sources and controls, and necessary fire protection equipment; How flammable and combustible waste material accumulations will be controlled; Maintenance of heat-producing equipment to reduce ignition sources; Names or job title of persons to maintain equipment to reduce ignition sources and fire potential; and Names or job title of persons to help control fuel source hazards.
Training Requirements	Inform employees about relevant fire hazards and self-protection procedures in the fire prevention plan when they are initially assigned to a job.
Assistance Tools	Standard - 29 CFR 1910.39 Fire Prevention Plans. Directive - CPL 02-01-037 Compliance Policy for Emergency Action Plans and Fire Prevention Plans. E-Tools - Evacuation Plans and Procedures - Fire Prevention Plan Requirements.

	Other Agency Resources - National Fire Protection Agency (NFPA) Code - Life Safety Code NFPA 101.

Exhibit 7: Town Hall Meetings and Community Needs Assessment Outreach Documentation

<u>Town Hall Meeting and Community Needs Assessment Outreach</u>

Town Hall Meetings

Blount County Town Hall Meeting
- Location: Lester Memorial UMC
- Date and Time: February 13, 2017 from 10:00am-11:00am
- Number of Participants: 14 representing senior centers, local social service agencies, and community members.

Walker County Town Hall Meeting
- Location: Jasper Civic Center
- Date and Time: February 23, 2017 from 11:30am-12:30pm
- Number of Participants: 7 representing city employees, community members, and educational institutions.

Shelby County Town Hall Meeting
- Location: Alabaster Senior Center
- Date and Time: February 28, 2017 from 10:00am-11:00am
- Number of Participants: 26 representing community members, local social service agencies, senior centers.

St. Clair County Town Hall Meeting
- Location: Pell City Parks and Recreation
- Date and Time: March 7, 2017 from 10:00am-11:00am
- Number of Participants: 13 representing community members and city employees.

Chilton County Town Hall Meeting
- Location: Alabama (Clanton) Conference Center
- Date and Time: March 14, 2017 from 10:00am-11:00am
- Number of Participants: 5 representing local social service agencies and the M4A Board.

Outreach Efforts

On January 25, 2017, Robyn James discussed the St. Clair County Town Hall Meeting with the St. Clair County Advisory Council.

On January 27, 2017, Robyn James discussed the Walker County Town Hall Meeting with the Walker County Advisory Council.

On January, 31, 2017, Robyn James emailed each county “Town Hall Meeting” flyer and “Community Needs Assessment” to the following:

- M4A partners in Blount County. Ms. Clara Christopher with Disability Rights and Resources emailed the flyer and community needs assessment to her partners and colleagues.
- M4A partners in Shelby, St. Clair, Walker, and Chilton

On January 31, 2017, Crystal Crim emailed M4A staff a copy of all 5 county "Town Hall Meeting" flyers, as well as the "Community Needs Assessment," to begin distributing to clients, caregivers, and their community members.

During the month of February, Janice Cates mailed out Town Hall Meeting Flyers to the following:

- Blount County Town Hall Meeting Flyers to the following partners and agencies:
  - Alacare Home Health and Hospice
  - Amedisys
  - Blount County Health Department
  - Brookdale Home Health
  - ISCHH Birmingham
  - Prohealth of North Central AL
  - Patricia Seames (Red Cross)
  - St. Vincent's Home Health
  - Comfort Care Home Health East
  - In Home Care Sitter
  - Oxford Health Care
  - Glenn Bynum
  - Sipsey Home Health Equipment
  - Melissa Thomas (West Blount Food Pantry)
  - Suzanne Shelton (Golden Living Center)
  - Bekah Wood (Oneonta Public Library)
  - Clara Christopher (Disability Rights and Resources)
  - Kathleen Monaghan (American Red Cross)
  - Sandra Smith (ASHL)
  - Blount County RSVP
- Walker County Town Hall Meeting Flyers to the following partners and agencies:
  - New Beacon Hospice
  - RSVP Walker County
  - Alabama Cooperative Extension
  - Capstone Rural Health Center
  - Housing Authority of Walker
  - Disability Rights and Resources
  - Housing Authority (Parrish and Sumiton)
  - Jasper Career Center
  - Walker County DHR
  - Walker County Need School Children Fund
  - Salvation Army (Walker, Winston and Marion Counties Chapter)
  - Walker County Community Action Agency
- St. Clair County Town Hall Meeting Flyers to the following partners and agencies:
  - Christian Love Panty
  - Habitat for Humanity (Pell City)
  - ARC of St. Clair County
  - Housing Authority (Pell City)
  - First Baptist Church of Pell City
  - St. Clair County Community Action Agency
  - St. Clair County DHR

- St. Clair County Health Department
- Ellen Allen (Community Action Agency)
- Nina Barnes (Community Action Agency)
- Teresa Carden (Lakeside Hospice)
- Sharon Sheffield (Lakeside Hospice)
- Addie Duke (Moody Senior Center)
- June Ford
- Hilary Fummine (Col. Robert L. Howard State Veterans Home)
- Janet Smith (St. Clair Public Transportation)

- St. Clair County Town Hall Meeting Flyers to the following partners and agencies:
  - Alabama Elks Trust, Inc.
  - Alabama Federation of Women Clubs
  - Alabama Leadership Foundation
  - Brighter Future
  - Chilton Clanton Literacy Council
  - Chilton County Chamber of Commerce, Inc.
  - Chilton County United Way, Inc.
  - Cross Road Missionary Baptist Church
  - Department of Alabama Ladies Auxiliary to the VFM of the US
  - Disabled American Veterans
  - Families First
  - Free and Accepted Masons of Alabama
  - Heritage Church of the Nazarene
  - Holly Grove Baptist Church
  - Home Builders Chapter of Chilton County
  - Hope for Tomorrow Ministries, Inc.
  - International Association of Lions Clubs
  - Kelsey's Place
  - Kincheon Road Church of God
  - Kiwanis International
  - Alabama Total Health Foundation, Inc.
  - American Legion
  - American Legion Auxiliary
  - Judge Rembert (American Legion Post 343)
  - Mental Health Board of Chilton and Shelby Counties, Inc.
  - National Association for the Advancement of Colored People
  - New Convert Missionary Baptist Church
  - New Hope Assembly of God
  - New Life Assembly of God
  - Order of the Eastern Star
  - Zacchaeus Ministries, Inc.
  - Pilgrim Rest Missionary Baptist
  - Pinedale Assembly of God
  - Sabbath House Ministries
  - Saint Paul Baptist Church
  - Smith-Dale Lodge No. 31 Fraternal Order of Police
  - Son Light Center
  - Sons of the Confederate Veterans, Inc.
  - Sunshine Assembly of God
  - Temple Assembly of God
  - Thorsby Parent Involvement Team
  - Through the Grace of God Ministries
  - Turning Point Foundation

- Union Baptist Church No. 2
- United Daughters of the Confederacy
- United Prison Ministries, Inc.
- Way of the Cross
- Wellness Group Foundation
- West End United Appeal Fund, Inc.
- Westend Neighborhood Watch Program
- Wings of Light, Inc.
- Young Men's Christian Association of Chilton County Alabama, Inc.

From: Robyn James
Sent: Tuesday, January 31, 2017 9:49 AM
To: Crystal Crim; Laura King; Sharon Echols
Subject: FW: [FWD: IMPORTANT - M4A TOWN HALL MEETING]
Attachments: TOWN HALL-Blount.pdf; Community Needs AssessmentFINAL.docx

Importance: High

Clara has shared our Town Hall information also.

From: clara.christopher@drradvocates.org [mailto:clara.christopher@drradvocates.org]
Sent: Tuesday, January 31, 2017 9:48 AM
To: Tankiya Williamson; Myra Shamburger; Kelly Miller; Blount EMA; Melissa Thomas; Rita Thomas; Patricia Patterson; Beth Schumacher; ellen.stephens@stvhs.com; Courtney Newton; Carrie Lea; Heather Bellew; Suzanne Shelton; Laura King; Brenda Miller; Emily Griffith; Danna Melton; Lisa Armstrong; Jan Wynn; Servetrius Booker; Manuel Villegas; Mike Falligant; Byanca Underwood; Rebecca Shew; Erin Dingler; Nieshia Lewis; Sonja England; Vanessa Stevens; Christina Gonzalez; Vanessa Broyles; Carolyn Fortner; Judy Woods; amorton@blountboe.net; Suzy Shelton; Doug Horst; Aryn Gieger-Sedgwick; Yolanda Spencer; Ann Moon; Lauren Wright; Denise Macias; Aleyda Villegas; Rose Prince; Emily Griffith; Kathy Lacks; BRIAN HORSLEY; Robyn James; Candy Ayers
Subject: [FWD: IMPORTANT - M4A TOWN HALL MEETING]
Importance: High

Please share

Clara Christopher, Peer Advocate
Disability Rights & Resources
Serving Blount & St Clair County
1004 2nd Avenue East
Oneonta, Alabama 35121
205-274-0174 office
205-353-5344 cell
clara.christopher@drradvocates.org
www.drradvocates.org

"The Power of Hope & Freedom"

-------- Original Message --------
Subject: IMPORTANT - M4A TOWN HALL MEETING
From: Robyn James <rjames@m4a.org>
Date: Tue, January 31, 2017 9:41 am
To: Bekah Wood <oplib@otelco.net>, Chris Green <ghgreen@co.blount.al.us>, Clara Christopher <clara.christopher@drradvocates.org>, Glenn Bynum <gbremlap@gmail.com>, Jane Childers <jecnsnd@gmail.com>, Kathleen Monaghan <monaghanhouse@gmail.com>, Melissa Thomas <clericalconnection@gmail.com>, Patricia Seames <patseames@yahoo.com>, Sandra Smith <sbsmith@otelco.net>, Suzanne Shelton <suzy.shelton@goldenliving.com>

Hi,

M4A is planning a Town Hall meeting in each of our five counties to gain input from the community on the needs of seniors, people of all ages with disabilities, and their caregivers. The Blount County town hall meeting will be held on Monday, February 13th from 10 – 11. See the flyer **attached**. Please help us distribute the flyer and encourage folks to attend.

We are also asking consumers, professionals, and other community members to complete the **attached** one page Community Assessment form. Please help us distribute this form across your communities. The form can be mailed to M4A when completed.

We value your continued support and partnership!

Robyn L. James
Development & Marketing Director
Middle Alabama Area Agency on Aging (M4A)
209 Cloverdale Circle
Alabaster, AL 35007
Office: 205-670-5770 x 202
Cell: 334-202-0444

Note my new email address is: rjames@m4a.org

Crystal Crim

From:	Robyn James
Sent:	Tuesday, January 31, 2017 11:03 AM
To:	Crystal Crim; Sharon Echols
Subject:	FW: IMPORTANT - M4A TOWN HALL MEETING
Attachments:	Community Needs AssessmentFINAL.docx; TOWN HALL-shelby.pdf
Importance:	High

From: Robyn James
Sent: Tuesday, January 31, 2017 10:58 AM
To: Barbara Roberts; Beverly Baker; Billy Jones; Carolyn Neiswender; Carolyn Williams; Corine Matt; Ester Graham; George Henry; Irene Collins; Jameka Brooks; Kayla Briggs; Kirby Henderson; Marty Handlin; Marvin Copes; Mary Piazza; Susan Tedford
Cc: Laura King
Subject: IMPORTANT - M4A TOWN HALL MEETING
Importance: High

Hi,

M4A is planning a Town Hall meeting in each of our five counties to gain input from the community on the needs of seniors, people of all ages with disabilities, and their caregivers. The Shelby County town hall meeting will be held on Tuesday, February 28th from 10 – 11. See the flyer **attached**. Please help us distribute the flyer and encourage folks to attend.

We are also asking consumers, professionals, and other community members to complete the **attached** one page Community Assessment form. Please help us distribute this form across your communities. The form can be mailed to M4A when completed.

We value your continued support and partnership!

Robyn L. James
Development & Marketing Director
Middle Alabama Area Agency on Aging (M4A)
209 Cloverdale Circle
Alabaster, AL 35007
Office. 205 670 5770 x 202
Cell: 334-202-0444
Note my new email address is: rjames@m4a.org

ASSISTING
ALL AGES AT
ALL STAGES

1

Crystal Crim

From: Robyn James
Sent: Tuesday, January 31, 2017 11:03 AM
To: Crystal Crim; Sharon Echols
Subject: FW: IMPORTANT - M4A TOWN HALL MEETING
Attachments: Community Needs AssessmentFINAL.docx; TOWN HALL St ClairFINAL.pdf

Importance: High

From: Robyn James
Sent: Tuesday, January 31, 2017 11:02 AM
To: Addie Duke; Aisha Martin; Clara Christopher; Elizabeth Thomaston; Ellen Allen; Ellen Stephens; Elsie Allen; Hiliary Hardwick; Janet Smith;-Jenny Baldone; June Ford; Melanie Carroll; Nina Barnes; Sandi Nicholson; Sharon Smith; Teresa Carden; Thelma Richardson; Valerie Harp
Subject: IMPORTANT M4A TOWN HALL MEETING
Importance: High

Hi,

t

M4A is planning a Town Hall meeting in each of our five counties to gain input from the community on the needs of seniors, people of all ages with disabilities, and their caregivers. The S . Clair County town hall meeting will be held on Tuesday, March 7th from 10 – 11. See the flyer **attached**. Please hel us distribute the flyer and encourage folks to attend.

We are also asking consumers, professionals, and other community members to complete the **attached** one page Community Assessment form. Please help us distribute this form across your communities. The form can be mailed to M4A when completed.

We value your continued support and partnership!

Robyn L. James
Development & Marketing Director
Middle Alabama Area Agency on Aging (M4A)
209 Cloverdale Circle
Alabaster, AL 35007
Office: 205 670 5770 x 202
Cell: 334-202-0444
Note my new email address is: rjames@m4a.org

ASSISTING
ALL AGES AT
ALL STAGES

Crystal Crim

From:	Robyn James
Sent:	Tuesday, January 31, 2017 11:04 AM
To:	Crystal Crim; Sharon Echols
Subject:	FW: IMPORTANT - M4A TOWN HALL MEETING
Attachments:	Community Needs AssessmentFINAL.docx; TOWN HALL-walker.pdf
Importance:	High

From: Robyn James
Sent: Tuesday, January 31, 2017 10:55 AM
To: 'Brian Maloney'; 'Irma Louise Farris'; 'Jami Fike'; 'Joanna Brand'; 'Johnnah Baker'; 'Lona Courington'; 'Louis Vick'; 'Matthew Mitchell'; 'Mimi Hudson'; 'Rebecca Nelson'; 'Rebecca Whitten'; 'Saderia Morman'; 'Sandy Sudduth'; 'Steven Aderholt'; 'Tammy McGee'; 'Vickie Stovall'
Cc: Laura King
Subject: IMPORTANT - M4A TOWN HALL MEETING
Importance: High

Hi,

M4A is planning a Town Hall meeting in each of our five counties to gain input from the community on the needs of seniors, people of all ages with disabilities, and their caregivers. The Walker County town hall meeting will be held on Thursday, February 23rd from 10 – 11. See the flyer **attached**. Please help us distribute the flyer and encourage folks to attend.

We are also asking consumers, professionals, and other community members to complete the **attached** one page Community Assessment form. Please help us distribute this form across your communities. The form can be mailed to M4A when completed.

We value your continued support and partnership!

Robyn L. James
Development & Marketing Director
Middle Alabama Area Agency on Aging (M4A)
209 Cloverdale Circle
Alabaster, AL 35007
Office: 205-670-5770 x 202
Cell: 334-202-0444 Note my new email address is: rjames@m4a.org

Crystal Crim

From:	Robyn James
Sent:	Tuesday, January 31, 2017 11:39 AM
To:	Crystal Crim; Laura King; Sharon Echols
Subject:	FW: IMPORTANT - M4A TOWN HALL MEETING
Attachments:	Community Needs AssessmentFINAL.docx; TOWN HALL-Chilton.pdf
Importance:	High

From: Robyn James
Sent: Tuesday, January 31, 2017 11:38 AM
To: Alexus O'Neal; Carol Rohling; Carolyn Fortner; Carolyn Thomas; Dayla Hamilton; Derek Deavers; Jessie Carter; Judy Dean; Lagora Lykes; Larry Felkins; Marilyn Colson (marilyn.colson@dhr.alabama.gov); Melissa Fowler; Pam Boykin; Patty Drake; Ryan Leonard; Tammy Noah; Terry Collier; Tim Bryant (timothy.bryant@dhr.alabama.gov); Tim Thompson
Cc: Melissa Fowler
Subject: IMPORTANT - M4A TOWN HALL MEETING
Importance: High

Hi,

M4A is planning a Town Hall meeting in each of our five counties to gain input from the community on the needs of seniors, people of all ages with disabilities, and their caregivers. The Chilton County town hall meeting will be held on Tuesday, March 14th from 10 – 11 See the flyer **attached**. Please help us distribute the flyer and encourage folks to attend.

We are also asking consumers, professionals, and other community members to complete the **attached** one page Community Assessment form. Please help us distribute this form across your communities. The form can be mailed to M4A when completed.

We value your continued support and partnership!

Robyn L. James
Development & Marketing Director
Middle Alabama Area Agency on Aging (M4A)
209 Cloverdale Circle
Alabaster, AL 35007
Office: 205-670-5770 x 202
Cell: 334-202-0444

Note my new email address is: rjames@m4a.org

Crystal Crim

From: Crystal Crim
Sent: Tuesday, January 31, 2017 4:29 PM
To: Alexia Barbour; Andrea Carter; Arnita Hicks; Ashley Johnson; Beverly Boykin; Carolyn Fortner; Cassie Horton; Catherine Kent; Cheryl Gaines; Chris McDonald; Christal Smith; Cindy Sharp; Cody Lewis; Connie Paulk; Courtney Durden; Crystal Crim; Crystal Whitehead; Dee Church; Denise Stamps; Diana White; Ellen Brechin; Geraldine Jones; Harold Eakin; Janice Cates; Jennifer Davis; Jessica Ulrich; Kay Hart; Lateshia Davidson; Latoya Shelton; Laura King; Lauren Karcher; Lisa Adams; Maranda Johnson; Mary Alice Moore; Mary Gilliland; Megan Nunnery; Melissa Fowler; Nena Morrow; Patricia Roper; Patricia Wells; Renee Green; Robyn James; Ryan Leonard; Sharon Echols; Sheila Baker; Sheila Hogge; Sherry Smith; Tammy White; Tracey Johnson; Washeka Reese; Richard Clark Jr.
Subject: Town Hall Meeting flyers :)
Attachments: TOWN HALL-Blount.pdf; TOWN HALL-walker.pdf; TOWN HALL-shelby.pdf; TOWN HALL-St ClairFINAL.PDF; TOWN HALL-Chilton.pdf

Good Afternoon All!

At this weeks' staff meeting, I let you all know about M4A's 5 town hall meetings that will take place between February 13th and March 13th. Robyn has put together a flyer for each meeting and she will be sending them out to our partners! If you all will, please print the flyers and give a copy to your clients and their families. I also encourage you to let your family, church group, etc., that live in the region, know about the meetings and encourage them to attend. We are hoping to have between 50 and 70 participants at each meeting and Ms. Sharon will be taking RSVPs to keep us on track!

Thank you so much for your help during this time.

Crystal I. Crim, M.Ed.
Administrative Director
Middle Alabama Area Agency on Aging (M4A)
Physical Address: 209 Cloverdale Circle Alabaster, AL 35007
Mailing Address: P.O. Drawer 618 Saginaw, AL 35137
Main Line: (205) 670-5770
Toll-Free: (866) 570-2998
Fax: (205) 378-4198

ASSISTING
ALL AGES AT
ALL STAGES

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Crystal Crim

From:	Crystal Crim
Sent:	Tuesday, January 31, 2017 9:35 AM
To:	M4A Staff
Subject:	Community Needs Assessment for Area Plan
Attachments:	Community Needs Assessment.docx

Good Morning All,

I wanted to go ahead and email you all the Community Needs Assessment we will be using for M4A's 2018 2020 Area Plan. Thank you to all staff members who assisted in creating this document! If you will, please have your client's complete a form and just place it in my box. If you live in our 5 counties and want to fill it out an assessment, please feel free do so and place in my box. Please note that this form is front and back. We appreciate your help!!

Thank you!

Crystal I. Crim, M. Ed.
Administrative Director
Middle Alabama Area Agency on Aging (M4A)
Physical Address: 209 Cloverdale Circle Alabaster, AL 35007
Mailing Address: P.O. Drawer 618 Saginaw, AL 35137
Main Line: (205) 670-5770
Toll-Free: (866) 570-2998
Fax: (205) 378-4198

Town Hall Meeting

Help Identify Community Needs in Blount County for: Seniors, People of all Ages with Disabilities, and their Caregivers.

WHEN: FEBRUARY 13, 2017
10:00 am— 11:00 am

WHERE: Lester Memorial UMC (Fellowship Hall)
108 3rd Avenue E. Oneonta 35121

M4A (Middle Alabama Area Agency on Aging) is hosting a Town Hall meeting to identify community needs in Blount County.

GET INVOLVED AND ATTEND THIS IMPORTANT FREE EVENT.

YOU MUST REGISTER BY CONTACTING SHARON ECHOLS, M4A at 205-670-5770 OR SECHOLS@M4A.ORG

IMPORTANT INFORMATION ON AGING, DISABILITY, AND CAREGIVER ISSUES WILL BE PRESENTED.

LIGHT REFRESHMENTS WILL BE SERVED.

The Mission of M4A is to help all individuals access information, assistance, and resources that will empower them to self – advocate, live independently, and enjoy the highest quality of life. M4A specializes in serving older adults, individuals with disabilities, and their caregivers. We serve Blount, Chilton, Shelby, St. Clair, and Walker Counties.

Help Identify Community Needs in Walker County for: Seniors, People of all Ages with Disabilities, and their Caregivers.

WHEN:	**FEBRUARY 23, 2017** **11:30 am— 12:30 pm**
WHERE:	**JASPER CIVIC CENTER** **204 19TH Street EAST, Jasper 35501**

M4A (Middle Alabama Area Agency on Aging) is hosting a Town Hall meeting to identify community needs in Walker County.

GET INVOLVED AND ATTEND THIS IMPORTANT FREE EVENT.

YOU MUST REGISTER BY CONTACTING SHARON ECHOLS, M4A at 205-670-5770 OR SECHOLS@M4A.ORG

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LIGHT REFRESHMENTS WILL BE SERVED.

The Mission of M4A is to help all individuals access information, assistance, and resources that will empower them to self – advocate, live independently, and enjoy the highest quality of life. M4A specializes in serving older adults, individuals with disabilities, and their caregivers. We serve Blount, Chilton, Shelby, St. Clair, and Walker Counties.

Town Hall Meeting

Help Identify Community Needs in Shelby County for:
Seniors, People of all Ages with Disabilities, and their Caregivers.

WHEN: FEBRUARY 28, 2017
10:00 am— 11:00 am

WHERE: ALABASTER SENIOR CENTER
1097 7th Street, SW, Alabaster AL 35007

M4A (Middle Alabama Area Agency on Aging) is hosting a Town Hall meeting to identify community needs in Shelby County.

GET INVOLVED AND ATTEND THIS IMPORTANT FREE EVENT.

YOU MUST REGISTER BY CONTACTING SHARON ECHOLS, M4A at
205-670-5770 OR SECHOLS@M4A.ORG

IMPORTANT INFORMATION ON AGING, DISABILITY, AND CAREGIVER ISSUES WILL BE PRESENTED.

LIGHT REFRESHMENTS WILL BE SERVED.

The Mission of M4A is to help all individuals access information, assistance, and resources that will empower them to self – advocate, live independently, and enjoy the highest quality of life. M4A specializes in serving older adults, individuals with disabilities, and their caregivers. We serve Blount, Chilton, Shelby, St. Clair, and Walker Counties.

Help Identify Community Needs in St. Clair County for: Seniors, People of all Ages with Disabilities, and their Caregivers.

WHEN: **MARCH 7, 2017**
10:00 am— 11:00 am

WHERE: **Pell City Parks & Recreation**
2801 Stemley Bridge Road, Pell City 35128

M4A (Middle Alabama Area Agency on Aging) is hosting a Town Hall meeting to identify community needs in St. Clair County.

GET INVOLVED AND ATTEND THIS IMPORTANT FREE EVENT.

YOU MUST REGISTER BY CONTACTING SHARON ECHOLS, M4A at

205-670-5770 OR SECHOLS@M4A.ORG

IMPORTANT INFORMATION ON AGING, DISABILITY, AND CAREGIVER ISSUES WILL BE PRESENTED.

LIGHT REFRESHMENTS WILL BE SERVED.

The Mission of M4A is to help all individuals access information, assistance, and resources that will empower them to self – advocate, live independently, and enjoy the highest quality of life. M4A specializes in serving older adults, individuals with disabilities, and their caregivers. We serve Blount, Chilton, Shelby, St. Clair, and Walker Counties.

Town Hall Meeting

Help Identify Community Needs in Chilton County for: Seniors, People of all Ages with Disabilities, and their Caregivers.

WHEN: **MARCH 14, 2017**
10:00 am— 11:00 am

WHERE: **Alabama Power Building**
2030 7th Street S, Clanton 35045

M4A (Middle Alabama Area Agency on Aging) is hosting a Town Hall meeting to identify community needs in Chilton County.

GET INVOLVED AND ATTEND THIS IMPORTANT FREE EVENT.

YOU MUST REGISTER BY CONTACTING SHARON ECHOLS, M4A at

205-670-5770 OR SECHOLS@M4A.ORG

IMPORTANT INFORMATION ON AGING, DISABILITY, AND CAREGIVER ISSUES WILL BE PRESENTED.

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The Mission of M4A is to help all individuals access information, assistance, and resources that will empower them to self – advocate, live independently, and enjoy the highest quality of life. M4A specializes in serving older adults, individuals with disabilities, and their caregivers. We serve Blount, Chilton, Shelby, St. Clair, and Walker Counties.

BLOUNT COUNTY TOWN HALL MINUTES-LESTER MEMORIAL UMC
ONEONTA, AL ON FEBRUARY 13, 2017-10AM – 11AM

Carolyn Fortner, Executive Director of M4A, called the meeting to order.

She stated the purpose of the Town Hall Meeting.

Asked the attending M4A staff to introduce themselves and their job @ the agency.

Attending Staff –

Carolyn Fortner, Executive Director
Laura King, Nutrition and Transportation Coordinator
Robyn James, Marketing and Outreach
Ryan Leonard, LTC Ombudsman
Crystal Crim, Administrative Director
Sharon Echols, Administrative Assistant

Carolyn Fortner introduced Ryan Leonard, LTC Ombudsman, and he spoke on the purpose and the services of the ombudsman. He talked about the Gateway Program – the program that allows a person to transition from the Nursing Home - back to their home or an apartment where they can live on their own with some assistance: help with housekeeping – personal care - and transportation assistance if needed.

Carolyn Fortner went over the M4A handout of the power point.

FUNDING – how M4A is funded from the Federal – AOA – Administration on Aging: State – ADSS – Alabama Department of Senior Services; Local - M4A – Middle Alabama Area Agency on Aging.
AREA – Blount, Chilton, Shelby, St. Clair and Walker Counties.
PROGRAMS – MEALS; MEDICATION ASSISTANCE; MEDICARE/INSURANCE COUNSELING; LEGAL SERVICES; HOMEMANER SERVICES; TRANSPORTATION; SUPPORT FOR CAREGIVERS; COMMUNITY OMBUDSMAN; OPTIONS and BENEFITS COUNSELING (BENEFITS ASSESSMENT); CASE MANAGEMENT.
TOWN HALL and HOW YOU CAN HELP – Every 4 years M4A develops an Area Plan with our strategic goals and objectives to be achieved. You can help M4A with information and feedback to develop meaningful goals for a strong Area Plan.
GOALS – GUIDEANCE FROM THE GOALS OF THE AL DEPT. OF SENIOR SERVCES.

1. Older Adults, individuals with disabilities and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long term support and services.
2. Empower older adults and individuals with disabilities to remain in the least restrictive with a high quality of life through the provision of options counseling, home and community-based services and support for family caregivers.

3. Empower older adults to stay active and healthy through Older Americans Act services – Medicare Prevention benefits, recreation, jobs, and volunteer opportunities.
4. Enable more Alabamians to live with dig by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.
5. Promote proactive, progressive management and accountability of State Unit On Aging and its contracting agencies.

Carolyn asked the attendees – "WHAT SHOULD WE BE DOING?"

a. We need to get the word out about M4A – what we do and what services we can offer.
b. It's hard to get some people to use the services, and to access the services.
c. Food, housing and medications are 3 things that people need to be able to live.
d. Filling the medication gap - physicians – get samples from the doctor, cheaper drugs from the pharmacy and pharmaceutical companies.
e. Persons getting scam information in the mail that looks official – but it turns out to be a scam. Getting information out about what scams are going on. Information on how to keep family members from scamming the elderly.
f. Government accountability – persons need to contact their elected officials
g. Staying active and health is a positive thing for older persons.
h. Staying engaged and being social is important and it also keeps your mind healthy.
i. Living in a good environment – least restrictive for their needs Maybe they can live at home with some help.
j. Assisting a person in their home is much less expensive than paying for a person in a facility.

Carolyn Fortner closed the meeting by thanking everyone for coming and asking for the Community Needs Assessment to be filled out and turned in.

WALKER COUNTY TOWN HALL MEETING MINUTES -JASPER CIVIC CENTER
JASPER, AL ON FEBRUARY 23. 2017-11:30am-12:30pm

Carolyn Fortner, Executive Director of M4A, called the meeting to order.

She stated the purpose of the Town Hall Meeting.

Asked the attending Guest (see attached Sign-in Sheet) and M4A staff to introduce themselves and their job at the agency.

Attending Staff –

Carolyn Fortner, Executive Director
Laura King, Nutrition and Transportation Coordinator
Robyn James, Marketing and Outreach
Ryan Leonard, LTC Ombudsman
Crystal Crim, Administrative Director
Sharon Echols, Administrative Assistant

Carolyn Fortner introduced Ryan Leonard, LTC Ombudsman, and he spoke on the purpose and the services of the ombudsman. He talked about the Gateway Program – the program that allows a person to transition from the Nursing Home - back to their home or an apartment where they can live on their own with some assistance: help with housekeeping – personal care - and transportation assistance if needed.

Carolyn Fortner went over the M4A handout of the power point.

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TOWN HALL and HOW YOU CAN HELP – Every 4 years M4A develops an Area Plan with our strategic goals and objectives to be achieved. You can help M4A with information and feedback to develop meaningful goals for a strong Area Plan.
GOALS – GUIDEANCE FROM THE GOALS OF THE AL DEPT. OF SENIOR SERVCES.

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3. Empower older adults to stay active and healthy through Older Americans Act services – Medicare Prevention benefits, recreation, jobs, and volunteer opportunities.
4. Enable more Alabamians to live with dig by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.
5. Promote proactive, progressive management and accountability of State Unit On Aging and its contracting agencies.

Carolyn Fortner asked the question – "What are some of the things that we need to be doing and also, "What are some of the things that we shouldn't be doing?"
There wasn't anything specific that was mentioned – just some general observations from the attendees:

1. People do sometimes fall through the cracks – especially in the rural areas and that's the problem in trying to get the word out to people.
2. We (all agencies) have to go to the people.
3. Walker County Career Center has a mobile unit – maybe using that to get to the people to get the service information out to the public.
4. Find community partners and work with them.
5. Laura King is looking to work with a Food Bank that will be going out into the community with fresh fruits, vegetables and meats.
6. Have "someone" in a community that everyone seems to go to find out information and train them on what to look for and how to do I and R (Information and Referral).
7. It's great to have a coordinated effort between agencies to work together to reach out to families.

Carolyn Fortner closed the meeting by thanking everyone for coming. She asked them to fill out their Community Needs Assessment and turn it in.

SHELBY COUNTY TOWN HALL MEETING MINUTES-ALABASTER SENIOR CENTER

ALABASTER, AL ON FEBRUARY 28, 2017-10am – 11am

Alicia Walters introduced M4A to the center participants who attended and told them about who we are and what we do.

Carolyn Fortner, Executive Director of M4A, called the meeting to order.

She stated the purpose of the Town Hall Meeting.

Asked the M4A staff to introduce themselves and their job at the agency.

Attending Staff –

Carolyn Fortner, Executive Director
Laura King, Nutrition and Transportation Coordinator
Robyn James, Marketing and Outreach
Ryan Leonard, LTC Ombudsman
Crystal Crim, Administrative Director
Sharon Echols, Administrative Assistant
Maranda Johnson, Program Manager
Lauren Karcher, AL Cares Coordinator
Denise Stamps, AL Cares Assistant
Connie Paulk, Nutrition Assistant, LTC Ombudsman
Rebecca Walden, Montevallo Student Intern

Carolyn Fortner introduced Ryan Leonard, LTC Ombudsman, and he spoke on the purpose and the services of the ombudsman. He talked about the Gateway Program – the program that allows a person to transition from the Nursing Home - back to their home or an apartment where they can live on their own with some assistance: help with housekeeping – personal care - and transportation assistance if needed.

Carolyn Fortner went over the M4A handout of the power point.

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GOALS – GUIDEANCE FROM THE GOALS OF THE AL DEPT. OF SENIOR SERVCES.

1. **1.** Older Adults, individuals with disabilities and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long term support and services.
2. **2.** Empower older adults and individuals with disabilities to remain in the least restrictive with a high quality of life through the provision of options counseling, home and community-based services and support for family caregivers.
3. **3.** Empower older adults to stay active and healthy through Older Americans Act services – Medicare Prevention benefits, recreation, jobs, and volunteer opportunities.
4. **4.** Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.
5. **5.** Promote proactive, progressive management and accountability of State Unit On Aging and its contracting agencies.

Carolyn Fortner explained M4A wants to:

A. Help persons find the answers that they need and how to get started with the help referrals that are needed.
B. Be the first port of call to help person with their needs.

Carolyn Fortner asked the attendees if there was anything that we should or shouldn't be doing. There were no specific things that were mentioned, but there were some other concerns that were brought up:

- Being accountable to the community and government
- Transportation – sometimes there are too many boxes that have to be followed – certain routes that sometimes don't include where you want/need to go - times schedules that don't coordinate with your schedule. Marvin Copes, RSVP, also gave information about how hard it is to get volunteer drivers for his program – due to gas prices, insurance liabilities and abuse of the volunteers generosity,
- Financial exploitation for seniors - what can be done if someone-relative- has POA and is exploiting the senior – Carolyn suggested that maybe can change the POA to another person in the family.
    - There can also be an allowance set up the help the care recipient.
- There are alternative things that can done to protect the senior.

Crystal Crim explained the Community Needs Assessment and asked everyone to fill out and turn in in before leaving.

ST. CLAIR COUNTY TOWN HALL MEETING MINTUES-PELL CITY CIVIC CENTER
PELL CITY, AL ON MARCH 7, 2017-9.30am-11.00am

Crystal Crim, Administrative Director of M4A, called the meeting to order.

She stated the purpose of the Town Hall Meeting.

Asked the M4A staff to introduce themselves and their job @ the agency.

Attending Staff –

Laura King, Nutrition and Transportation Coordinator
Robyn James, Marketing and Outreach
Ryan Leonard, LTC Ombudsman
Crystal Crim, Administrative Director
Sharon Echols, Administrative Assistant

Crystal Crim introduced Ryan Leonard, LTC Ombudsman, and he spoke on the purpose and the services of the ombudsman. He talked about the Gateway Program – the program that allows a person to transition from the Nursing Home - back to their home or an apartment where they can live on their own with some assistance: help with housekeeping – personal care - and transportation assistance if needed.

Crystal Crim went over the M4A handout of the power point.

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4. Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.
5. Promote proactive, progressive management and accountability of State Unit On Aging and its contracting agencies.

Being healthy doesn’t just mean being physically healthy it can also mean being socially healthy.

The question was asked – “Does income factor into a person getting help?” on some programs there are income limits, but most programs are at no charge.

M4A wants to be the first place that a person calls for any questions or concerns regarding senior issues.

Crystal Crim thanked everyone for coming and asked them to please turn in the Community Needs Assessment Sheet.

CHILTON COUNTY TOWN HALL MEETING MINUTES-ALABAMA POWER COMPANY
CLANTON, AL ON MARCH 14, 2017-9.30-10.30

Carolyn Fortner, Executive Director of M4A, called the meeting to order.

She stated the purpose of the Town Hall Meeting.

Asked the attending M4A staff to introduce themselves and their job @ the agency.

Attending Staff –

Carolyn Fortner, Executive Director
Laura King, Nutrition and Transportation Coordinator
Robyn James, Marketing and Outreach
Ryan Leonard, LTC Ombudsman
Crystal Crim, Administrative Director
Sharon Echols, Administrative Assistant
Melissa Fowler, SRx Coordinator

Carolyn Fortner introduced Ryan Leonard, LTC Ombudsman, and he spoke on the purpose and the services of the ombudsman. He talked about the Gateway Program – the program that allows a person to transition from the Nursing Home - back to their home or an apartment where they can live on their own with some assistance: help with housekeeping – personal care - and transportation assistance if needed.

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4. Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.
5. Promote proactive, progressive management and accountability of State Unit On Aging and its contracting agencies.

Carolyn Fortner opened the floor for discussion and questions:

- Help finding resources – CALL M4A – if we don't do the services we usually have a referral that we can give the client the #.
- Tim Bryant – DHR/APS has 3 cases on his books now of financial exploitation f of elders.
- Medicaid is going through a transition in the next couple of years. Then there may be a few more slots available for new clients.
- Tim Bryant said that Chilton County has a need for Adult foster care for adults that just need a little help (there are only 7 Adult Foster Homes in the state).
- Emergency housing for persons
- All agencies need to transparent and accountable with government dollars
- Tammy Noah said that there are only a few places that will take Medicaid Waiver clients.

Lori Patterson, Chilton YMCA Director, wants to increase the senior exercise program at the Y. Attendees gave her some suggestions on how she could increase participation.

Gay West – Transportation for out of town Doctor's visits at reasonable cost. Right now trips are running anywhere from $20-$60 one way (estimated cost).

Carolyn Fortner spoke on the state wide accreditation that M4A is going to be doing.

Carolyn Fortner thanked everyone for coming and asked them to turn in their Community Needs Assessment Sheet.

Exhibit 8: Board and Advisory Council Approval for Area Plan

Joint County Advisory Council

M4A Advisory Councils do not have chairpersons or other officers.

American Village (Carriage House)
Wednesday, July 19, 2017

Members Present: Sandra Smith, Mary Piazza, Daisy Washington, Vanessa McKinney, Daniel Lord, Carolyn Thomas, Susan Tedford, Frances Phelps, Tim Thompson, LeAnne Knight, Martha Pszyk, Eric McLemore, Von Hales, Tiffany Chess, Virginia Rediker, Robin DeMonia, Gail Pollock, Allie Green, Dayla Hamilton, Tim Bryant, Paige Landry, Nancy Tempel, Saderia Mormon, Kendal Head, Jon Head, Terry Collier, Andrea Carter, Tammy Noah, Matthew Haynes, Steve Griffin, Jane Griffin, Lauren Jones, and Kaitlyn Puzzitiello

M4A Staff Present: Carolyn Fortner, Crystal Crim, Maranda Johnson, Robyn James, Laura King, Cody Lewis and Melissa Fowler

Carolyn Fortner called the meeting to order at approximately 10:00 am. Mrs. Fortner welcomed everyone and gave some house instructions on where to locate bottles of water and the restrooms. She had attendees introduce themselves.

Robyn James gave a quick demonstration on the M4A fans. Ms. James recognized Paige Landry with Southern Care/New Beacon Hospice as the sponsor. Robyn gave an overview/background of the advisory council and the role that it plays with/for M4A. She also mentioned the need to increase its membership. Ms. James instructed members on what their role would be as an M4A Messenger. She also let them know what M4A would do for them and their agency. She provided them with M4A bags, fans and The Book to take with them to distribute in the community. She also has gave them a brief overview of M4A's annual activities as well as the upcoming potential M4A messengers meeting schedule. Ms. James said that we are a team and our goal is networking-partnerships-outreach and awareness.

Carolyn Fortner presented M4A's Area Plan. She gave an overview of the purpose of the Area Plan. She also discussed the Area Plan's four goals: 1. Consumers know where to go and who to call. 2. Consumers have resources to remain safe and independent in their own home. 3. Consumers have the opportunity to stay physically, mentally and emotionally active. 4. Consumers will live free of abuse and exploitation. 5. Consumers will have a government that is accountable, efficient and invasive. Ms. Fortner also gave an overview of other goals and objectives based on a survey: 1. Food 2. Home modifications and home safety. 3. Funds to help pay for utilities. 4. Transportation. She spoke briefly on the public hearing and said she would be asking for a motion at the end of the day to accept the Area Plan as presented to them.

Steve Griffin, Speaker of the House, House District 63, presented on The Role of the Alabama Silver Haired Legislature (ASHL.) He gave a very detailed overview and history of the organization, as well as his own personal role throughout his career. He presented on legislative bills and specific topics/areas that the ASHL would be advocating for and their influence on past things that have taken place due to the efforts of the ASHL. He also spoke of things needed due

to surveys taken, including: 504 Home and Loan Grants for Seniors, dental/hearing assistance, substance abuse counseling as well as job placement for Seniors.

Dan Lord presented on behalf of Alabama Securities Commission.

Lunch was provided by Southern Care/New Beacon Hospice from Honey Baked Hams.

Paige Landry with Southern Care/New Beacon Hospice gave handouts and presented on the differences between home health and hospice. She also spoke about misconceptions about hospice and the role that hospice can and cannot play when working with families. Ms. Landry is very educated and extremely passionate about what she does and helping families through difficult times in their lives.

Robin DeMonia spoke about the Medication Review Initiative. This is a program where she can present to a group or meet one-on-one with individuals to help them determine if the medicines they are taking are appropriate for their conditions, as well as help them determine if the medications are working well together or not. Ms. DeMonia also stated that she will create flyers and promote the events, as well as make contact with needed individuals; she only needs dates and times and a contact name for the events.

Cody Lewis represented M4A's Community Ombudsman Program during the meeting. He spoke about the role that the program plays within the community and what the Ombudsman Program can and cannot do and when Alabama Department of Public Health must step in and take over. Mr. Lewis also talked about the Gateway to Community program that is being implemented within our region.

Laura King presented on upcoming events in the area. She gave an overview of how many individuals we have currently on the waiting lists in Blount, Chilton, St. Clair and Walker County. She gave an update on the Feeding Frenzy that was held in St. Clair County and how successful it was in that it brought in over $13,000 to be used to help feed seniors. She also spoke about the upcoming event in Chilton County, The Souper Feeding Event, to help raise money for the seniors in the area to provide meals to them and she showed them the bowls that individuals would receive for the event. Ms. King raised $40 at the meeting for the upcoming event.

Carolyn Fortner gave everyone time to ask questions and make comments from the information provided to them during the meeting. Ms. Sue Tedford commented that she felt like if the transportation issue was addressed and that some of the other issues would take care of themselves as this is a major issue across the board in all counties. It was mentioned that two transportation resources that could be utilized for seniors were Lyft and Go-Go Grandparent. A question was raised about resources available as far as doing small home projects, such as building a ramp. Maranda Johnson mentioned available funds to help with materials if the labor was donated. It was noted that the Civitan clubs will build ramps and help with small projects if the material was donated. Jon Head said that Blount County has local churches that will provided materials and labor for home repair projects as long as resources are available to them. It was asked if the other agencies in surrounding areas functioned like M4A, to which Carolyn Fortner said yes. Another guest suggested that we go to building supply companies and ask for material to be donated for projects, as well as a monetary donation to purchase things needed. It was stated the Blount and St. Clair partner with the American Red Cross regarding home safety and

they can go in and provided some help such as replacing smoke detector batteries and well as install fire extinguishers. Ms. Fortner stated that individuals could write down their suggestions or questions as well as email them if they didn't want to ask at the meeting, or if they thought about something after they left meeting.

Carolyn Fortner asked for motions to accept M4A's Area Plan as presented:

Sue Tedford made a motion to accept the plan and it was seconded by Fran Phelps.

All were in favor. No one opposed.

The meeting was adjourned by Carolyn Fortner at approximately 1:30pm.

M4A JOINT COUNTY ADVISORY MEETING
WEDNESDAY, JULY 19, 2017
AMERICAN VILLAGE (Carriage House)
3727 HWY 119, Montevallo AL 35115

AGENDA

10:00 A.M.	Welcome & Introductions	Carolyn Fortner
10:15 – 10:30	The Role of M4A Messengers	Robyn James
10:30 – 11:00	M4A's Area Plan	Carolyn Fortner
11:00 – 11:30	The Role of the Alabama Silver Haired Legislatures (ASHL)	Steve Griffin, Speaker of the House, House District 63
11:30 – 11:40	Alabama Securities Commission	Dan Lord
11:40 – 12:00	Southern Care/New Beacon Hospice	Paige Landry
12:00 – 12:30	CATERED LUNCH (Provided by SouthernCare/New Beacon)	
12:30 - 12:45	Medication Review Initiative	Robin DeMonia
12:45 -1:00	M4A's Community Ombudsman Program	Cody Lewis
1:00 – 1:20	County Specific Events & Initiatives	Laura King
1:20 – 1:30	Questions & Answer Session	Carolyn Fortner
1:30 P.M.	Adjournment	

SouthernCare New Beacon

THIS EVENT IS SPONSORED BY
SOUTHERNCARE/NEW BEACON HOSPICE SERVICES

Board Meeting

Middle Alabama Area Agency on Aging (M4A)
Board Meeting Minutes
Wednesday, July 26, 2017

The M4A Board of Directors met on Wednesday, July 26, 2017. Board members in attendance: Mr. Richard Lovelady (Chairman), Rev. Glenn Bynum (Vice-Chair), Ms. Gay West (Secretary), Mr. Dean Calvert, Ms. Lee Ann Clark, Ms. Senta Goldman, and Ms. Sherry Reaves. M4A Staff members in attendance: Ms. Carolyn Fortner (Executive Director), Ms. Tammy White (Fiscal Director), Ms. Crystal Crim (Administrative Director), and Robyn James (Development and Marketing Director).

The meeting was called to order by Chairman Richard Lovelady at 10:07am. Opening prayer was led by Rev. Bynum. A quorum was declared. There were no proxies.

A. A motion to approve the agenda was made by Rev. Bynum and seconded by Ms. Clark. All others were in favor; no one opposed.
B. A motion to approve the minutes from the May 3, 2017 Board meeting was made by Rev. Bynum and seconded by Ms. West. All others were in favor; no one opposed.
C. Executive Director's Report by Carolyn Fortner
    1. Changes at ADSS: Ms. Fortner updated the Board that the ADSS Commissioner has changed from Commissioner Neal Morrison to Acting Commissioner Todd Cotton.
    2. Letter from Retirement Systems of Alabama (RSA) (handout): Ms. Fortner discussed a request from the RSA regarding a Board Resolution for a one-time $616 lump sum payment for former Executive Director Frances McCullough. The Board took no action on creating a Board Resolution for the RSA request.
    3. Letters of Support (handout): Ms. Fortner discussed two letters of support requests M4A received. One request was from the Alabama Department of Senior Services (ADSS) regarding the State Health Insurance Assistance Program (SHIP) and the other request was from the City of Harpersville regarding their plans to open a new senior center. Ms. Fortner shared the importance of both programs and that M4A provided a letter of support to both entities.
    4. Nutrition Update (handout): Ms. Fortner shared with the Board the serving days for each senior center in M4A's region. Ms. Fortner also shared that M4A's FY 2018 Nutrition funding projection does not look good and that M4A is still waiting on the finalized budget from ADSS. Currently, the federal government is working under a continuing resolution which level funds the program through the end of September 2017. She shared that she will keep the Board updated. Carolyn shared with the Board that M4A received $170,000 in state funds from ADSS for meals. This money was provided to M4A due M4A's aggressive plan to feed seniors in its region. It is uncertain whether M4A will receive the same $170,000 in state funds in FY 2018. In addition, although ADSS provided the additional state meal funds,

M4A's nutrition budget is still projected to be over-budget. Ms. Fortner will keep the Board updated.

5. Potential Program Cuts: Ms. Fortner shared with the Board that, due to a Senate proposed budget, M4A, as well as other AAA's, may have to cut both the SHIP and SCSEP programs due to funding. She shared the importance of both programs with the Board. Presently, M4A will continue to operate as usual. Ms. Fortner will continue to keep the Board updated. The Senate currently proposes to eliminate funding to the SHIP program.
6. Development and Marketing Update (Robyn James) (handout):
    i. Tools and Strategies: Ms. James discussed M4A's marketing strategy and marketing tools. She shared how the tools and products M4A has purchased and/or developed, such as bags, shirts, "The Book," website, and Facebook page has reached the community and continues to encourage individuals and organizations to contact M4A. She shared that, in just 5 months, M4A has distributed over 5,000 copies of "The Book." Ms. James discussed that M4A's website and Facebook page continue to receive new visitors weekly. She shared that M4A's weekly newsletter, both the weekly e-newsletter (759 readers) and monthly hardcopy newsletter (over 100 readers), continues to grow in readership.
    ii. Advisory Council (handout): Ms. James discussed how M4A has revamped the Advisory Council meetings, as well as engaged them to participate more in agency outreach. She discussed the "M4A Messengers" initiative which encourages Advisory Council members, as well as other community members, to conduct outreach for M4A. This initiative will also allow M4A to promote the participating members' organizations. Robyn discussed the recent Advisory Council meeting where she began promoting the M4A Messengers. Robyn shared with the Board that the response, overall, was good.
    iii. Legal Document Bootcamp (handout): Ms. James discussed M4A's partnership with Jan Neal for the Legal Document Bootcamp in September. She discussed the potential for more boot camps in the future.
    iv. Dementia Friendly Professionals and Caregivers Book (handout): Ms. James discussed the "Dementia Friendly Professionals and Caregivers" book that Jan Neal developed for M4A. This is one of four books the Jan Neal Law Firm will create for M4A. The second

book is called "Designing a Long-term Care Plan." The second book is still in development and Robyn will update the Board once it is completed.

7. M4A Update on Efforts to Diversify Funding (Robyn James) (handouts):
   i. Fundraisers (handout): Ms. James discussed M4A's fundraising efforts. She shared that, in May 2017, M4A had its first fundraising event in St. Clair County (BBQ Feeding Frenzy), where M4A raised $15,784.30 (gross). The proceeds were used to feed seniors in St. Clair County. Ms. James shared that M4A is gearing up for its second fundraising event in Chilton County (Soup-er Feeding Frenzy "Cook-Off"). This event will have local home health and hospice providers compete against each other in a County-wide cook-off. Community members are encouraged to purchase a feeding frenzy ticket for $15, which covers unlimited soup and an "End Senior Hunger" bowl and spoon. All proceeds from this event will be used to help feed seniors in Chilton County.
   ii. Dementia Grants (handout): Ms. James shared the "Creating Dementia Friendly Communities" Toolkit with the Board. She shared with the Board the various trainings she and the grant team have conducted across Shelby County. Ms. James also shared that M4A recently applied for the "Alzheimer's Disease Initiative: Specialized Supportive Services Project" grant with the Administration for Community Living (ACL). This grant will allow M4A to expand its current work with law enforcement officers, and other first responders, regarding creating Dementia Friendly Communities. Ms. James will keep the Board updated.
   iii. Ms. Fortner shared that M4A is looking to apply for CAWACO and CFGB grants in order to expand the current work with Dementia Friendly Communities in all of its counties.
   iv. Ms. Fortner updated the Board that M4A received certification for the Veterans-Directed Home and Community Based Services (VD-HCBS) program. At this time however, the VA in Birmingham has placed a hold on the program. Ms. Fortner will update the Board as she receives information.

   v. Ms. Fortner updated the Board that the Medicare Reimbursed Diabetes Self-Management Training (DSMT) start date was pushed to October due to NCQA accreditation process that is happening statewide. M4A still needs to hire a Registered Dietician for this program.
   vi. Ms. Tammy White discussed Private Pay opportunities for M4A.

Currently, M4A is developing its private pay program. Recently, M4A's Part D Wellness Coordinator was contacted by Blue Cross and Blue Shield to provide group Arthritis and Group Diabetes Self-Management classes to groups outside of those served by M4A. Ms. White requested that the Board approve a fee schedule for M4A to charge for such classes. The funds received from the classes would be placed into the Part D Wellness program. Ms. White also discussed the Board approving an Administrative Copy/Fax fee schedule.

8. Area Plan Update (handout): Ms. Fortner shared with the Board that all AAAs are required to complete an Area Plan every four years and that this year is Area Plan year. Ms. Fortner reviewed the following: Executive Summary, Narrative, Verification of Intent and Assurances. Ms. Fortner also discussed the regional projected growth in M4A's region between 2010 and 2020. She shared the following: Blount County would increase by 97.7%, Chilton County would increase by 81.7%, Shelby County would increase by 248.8%, St. Clair County would increase by 162.9%, and Walker County would increase by 27.7%. Ms. Fortner provided the Board with a breakdown of the Rural, Race, Poverty and Disability, Health Indicators, and Food Desert information for each county in M4A's region as well. She shared M4A's five primary goals, as well as its four additional goals which address the Community Needs Assessment results. These additional goals include: Food, Home modifications/Home safety, Funds to help pay for utilities, and Transpiration. Ms. Fortner requested that the Board approve the Verification of Intent, Assurance, and Area Plan.
9. Tax Tribunal and Circuit Court Appeal (handout): Ms. Fortner updated the Board that M4A received its tax-free status from the Department of Revenue Tax Tribunal and will not have to go to court.
10. Program Report (handout)
    i. Ms. Fortner updated the Board about M4A's programs and services for FY 2017 (3rd Quarter). For the first three quarters of FY 2017, M4A provided direct services to 6,711 consumers. Alabama Cares served 94 caregivers with respite and 73 caregivers with supplemental services. Medicaid Waiver served 418 Elderly and Disabled Waiver (E&D) consumers, 4 consumers in the 530 Waiver, 8 ACT Waiver consumers, and 21 Personal Choices consumers. Nutrition served 1,561 seniors with 106,554 congregate meals and 1,381 seniors with 217,264 homebound meals. SenioRx assisted 402 clients and SHIP assisted 2,387 clients. Legal services assisted 304 seniors and Ombudsman opened 56 new complaint cases. Ms. Robyn James discussed the medication education agency she is partnering with to educate individuals in M4A's region about medication compliance.

D. Fiscal Report (handout): Ms. Tammy White presented the fiscal report. Ms. White shared that M4A is currently on track regarding its grants; a few programs have gone over and M4A had to use local funds to cover the overages. The SHIP program was provided $24,114.00 of the next plan years' funding up front. Due to the changes in SHIP in April 2017, a small amount of

funding was released at this time. Pending ADSS budget approvals, Ms. White has created a budget for SHIP based on the current released funding. Ms. White provided the Board with a Profit & Loss by Class for the St. Clair County BBQ Feeding Frenzy event. M4A made $8,210.17 (net) on this event. Ms. White also provided the Board with projected FY 2018 budgets for Title V and SHIP. She shared that M4A has made adjustments to cover administrative costs of both programs, such as changing where employees are placed and what funding streams they are paid from, in order to alleviate financial burdens to both programs.

E. Old Business: None

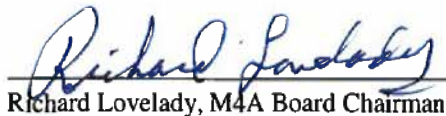
F. New Business:

1. Mr. Calvert made a motion that the M4A Board approve M4A's fee schedule. This schedule allows the following: charging for copies of documents provided to any person or business entity outside of the scope of service ($1.00 per page), charging $75 for Group Arthritis Exercise Classes outside of the Part D program, and charging $75 for Group Diabetes Self-Management Classes outside any grant funding. This motion was seconded by Ms. West. There was no opposition; the motion was carried.
2. Mr. Bynum made a motion that the M4A Board approve the Area Plan, Verification of Intent and Assurance for FY 2018-FY 2021. The motion was seconded by Ms. Clark. There was no opposition; the motion was carried.

There being no additional business, Mr. Calvert made a motion to adjourn the meeting and it was seconded by Ms. West. All were in favor and no one opposed.

The next Board meeting will be on Wednesday, September 27, 2017 at M4A and will begin at 10:00 am.

Approved:



Richard Lovelady, M4A Board Chairman

Date

Exhibit 9: Public Hearing Documentation

Middle Alabama Area Agency on Aging
Public Hearing
Shelby County Services Building (Community Room)
Pelham, AL

August 9, 2017
Area Agency on Aging FY 18 – FY 21 Plan
AGENDA

I.	Welcome and Introductions	Crystal Crim
II.	Brief Introduction to M4A	Robyn James
III.	Purpose of the Public Hearing	Carolyn Fortner
	a. Goals of the FY 18 – FY 21 Area Plan	
	b. Summary of the FY 2017 Needs Assessment	
IV.	Comments from Attendees	Crystal Crim
V.	Closing Remarks	Carolyn Fortner

PUBLIC HEARING

Shelby County Services Building (Community Room)

(1123 County Services Drive Pelham, AL 35124)

Wednesday, August 9, 2017

1:00PM-2:30PM

The purpose of the Public Hearing is for individuals in each of M4A's 5 counties to make comments about the Area Plan which guides M4A's work for the next three years.

R.S.V.P. by contacting Crystal Crim at (205) 670-5770 or ccrim@m4a.org.

Crystal Crim

From:	Sharon Echols
Sent:	Tuesday, July 11, 2017 9:17 AM
To:	Crystal Crim
Subject:	FW: public hearing for the Area Plan
Attachments:	Board Memo-Public Hearing.doc; Public Hearing Flyer-final.pdf

THIS IS THE EMAIL THAT I SENT OUT TO THE BOARD MEMBERS FOR THE PUBLIC HEARING.

From: Sharon Echols
Sent: Tuesday, June 27, 2017 2:01 PM
To: Chris Green (cgreen@blountcountyal.gov) <cgreen@blountcountyal.gov>; COMM. WARD WILLIAMS <ward@vfsdads.com>; COMM. ALLEN CATON - CHILTON COUNTY COMMISSION <acaton@chiltoncounty.org>; Comm. Chrmn Jerry Bishop <j.bishop@walkercountyal.us>; COMM. CHRMN PAUL MANNING <pmanning@stclairco.com>; Comm. Dean Calvert (dcalvert@blountcountyal.gov) <dcalvert@blountcountyal.gov>; COMM. MIKE VEST (mikevestshelby@gmail.com) <mikevestshelby@gmail.com>; Comm. Tommy Bowers (allelectri@gmail.com) <allelectri@gmail.com>; 'Gay West ' <westgay@auburn.edu>; 'LeeAnn Clark (clarkla@auburn.edu)' <clarkla@auburn.edu>; 'Rev. Glenn Bynum (BdMem)' <gbremlap@gmail.com>; 'Senta Goldman (sgoldman@shelbyal.com)' <sgoldman@shelbyal.com>; Sherry Reaves (2006madison@windstream.net) <2006madison@windstream.net>; Zach Marsh (zmarsh@blountcountyal.gov) <zmarsh@blountcountyal.gov>
Cc: 'Alex Dudchock (adudchock@shelbyal.com)' <adudchock@shelbyal.com>; Bonnie Monte (bmonte@blountcountyal.gov) <bmonte@blountcountyal.gov>; Cheryl Ganey - Walker County Administrator (c.ganey@walkercountyal.us) <c.ganey@walkercountyal.us>; Laura Lawley <lmlawley@stclairco.com>; Whitney Gammon (wgammon@blountcountyal.gov) <wgammon@blountcountyal.gov>
Subject: public hearing for the Area Plan

Good Afternoon,

M4A will be hosting a Public Hearing for the FY 18-21 Area Plan on August 9th, 2017 at the Shelby County Services Building in Pelham, AL. During the next Board Meeting (July 26th), Carolyn will discuss M4A's Area Plan with you all. The Public Hearing is for individuals in M4A's 5 counties to provide comments on the Area Plan. We hope you will join us!

If you will be attending the Public Hearing, please let me know. I have attached the flyer which contains the address of the Public Hearing for you as well.

Thank you,

Sharon Echols, CIRS-A/D
Admin. Assistant
Middle Al Area Agency on Aging - M4A
209 Cloverdale Circle - Alabaster, AL 35007
P O Drawer 618 – Saginaw, Al 35137
205-670-5770 ; 1-866-570-2998

Crystal Crim

From:	Sharon Echols
Sent:	Tuesday, July 11, 2017 10:06 AM
To:	Sue Tedford (suetedford@bellsouth.net)
Cc:	Crystal Crim
Subject:	M4A PUBLIC HEARING FOR FY 18-21 AREA PLAN
Attachments:	Public Hearing Flyer-final.pdf

Good Morning,

Ms. Sue, please send out to all of the ASHL for the M4A PUBLIC HEARING ON AUGUST 9, 2017.
Please see attached flyer.

M4A will be hosting a Public Hearing for the FY 18-21 Area Plan on August 9th, 2017 at the Shelby County Services Building in Pelham, AL. The Public Hearing is for individuals in M4A's 5 counties to provide comments on the Area Plan. We hope you will join us!

If you will be attending the Public Hearing, please let me know. I have attached the flyer which contains the address of the Public Hearing for you as well.

Thank you,

Crystal I. Crim

Sharon Echols, CIRS-A/D
Admin. Assistant
Middle Al Area Agency on Aging - M4A
209 Cloverdale Circle - Alabaster, AL 35007
P O Drawer 618 – Saginaw, Al 35137
205-670-5770 ; 1-866-570-2998
Fax – 205-378-4199
sechols@m4a.org
www.m4a.org

"Be who you are and say what you feel because those who mind don't matter and those who matter don't mind." Dr. Seuss

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Crystal Crim

From:	Sharon Echols
Sent:	Wednesday, July 12, 2017 9:25 AM
To:	Alabaster - Georg Henry (ghenry@cityofalabaster.com); Alabaster Senior Center - Alicia Walters; Ashville - Chrystal St. John (cstjohn@cityofashville.org); Blountsville - Aletha Bailey ; Calera - Connie Payton; Carbon Hill - Janice Pendley (chclerk2011@gmail.com); Clanton -Debbie Orange (dorange@cityofclanton.com); Columbiana - Mark Frey (mfrey@cityofcolumbiana.com); Cordova - Leanne Dawkins ; Heardmont - Kay Mundy; Jasper - Kathy Chambless (kchambless@jaspercity.com); Maplesville - Dawn Smitherman ; Montevallo - Herman Lehman (hlehman@cityofmontevallo.com); Moody - Tracy Patterson - (tpatterson@moodyalabama.gov); Nectar - Sue Gaither ; Oakman - Lisa Lockhart; Odenville - Cassie Roberson (croberson@cityofodenville.net); Oneonta - Tamy Noland ; Parrish - Donna Beavers ; Pell City - Penny Isbell (pisbell@cityofpellcity.net); Ragland - Penny Owens (townclerk@ragland.net); Snead - Rae Ware (aqua4@hopper.net); Springville - Kelli Lee; Steele - Patricia Coffee ; Sumiton - Judy Glover ; Vincent Sr. Ctr. - James Clark (chavha@bellsouth.net)
Cc:	Crystal Crim
Subject:	M4A PUBLIC HEARING FOR FY 18-21 AREA PLAN
Attachments:	Public Hearing Flyer-final.pdf

Good Morning,

Please forward to the Mayor & all Community Leaders .

M4A will be hosting a Public Hearing for the FY 18-21 Area Plan on August 9th, 2017 at the Shelby County Services Building in Pelham, AL. The Public Hearing is for individuals in M4A's 5 counties to provide comments on the Area Plan. We hope you will join us!

If you will be attending the Public Hearing, please let me know. I have attached the flyer which contains the address of the Public Hearing for you as well.

Thank you,

Crystal I. Crim

Sharon Echols, CIRS-A/D

Admin. Assistant
Middle Al Area Agency on Aging - M4A
209 Cloverdale Circle - Alabaster, AL 35007
P O Drawer 618 – Saginaw, Al 35137
205-670-5770 ; 1-866-570-2998
Fax – 205-378-4199
sechols@m4a.org
www.m4a.org

Crystal Crim

From:	Sharon Echols
Sent:	Wednesday, July 12, 2017 11:03 AM
To:	Alabaster - Brian Binzer (bbinzer@cityofalabaster.com); Nectar - Sue Gaither (townclk@otelco.net)
Cc:	Crystal Crim
Subject:	FW: M4A PUBLIC HEARING FOR FY 18-21 AREA PLAN
Attachments:	Public Hearing Flyer-final.pdf

Good Morning,

Please forward to the Mayor & all Community Leaders .

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If you will be attending the Public Hearing, please let me know. I have attached the flyer which contains the address of the Public Hearing for you as well.

Thank you,

Crystal I. Crim

Sharon Echols, CIRS-A/D
Admin. Assistant
Middle Al Area Agency on Aging - M4A
209 Cloverdale Circle - Alabaster, AL 35007
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205-670-5770 ; 1-866-570-2998
Fax – 205-378-4199
sechols@m4a.org
www.m4a.org

"Be who you are and say what you feel because those who mind don't matter and those who matter don't mind." Dr. Seuss

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Crystal Crim

From:	Sharon Echols
Sent:	Wednesday, July 12, 2017 5:35 PM
To:	Sen. Clyde Chambliss (clyde.chambliss@alsenate.gov); Rep. Will Ainsworth (willainsworth@mclo.org)
Cc:	Crystal Crim
Subject:	FW: public hearing
Attachments:	Public Hearing Flyer-final.pdf

Good afternoon

M4A will be hosting a Public Hearing for the FY 18-21 Area Plan on August 9th, 2017 at the Shelby County Services Building in Pelham, AL. The Public Hearing is for individuals in M4A's 5 counties to provide comments on the Area Plan. We hope you will join us!

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Thank you,

Crystal I. Crim

Sharon Echols, CIRS-A/D
Admin. Assistant
Middle Al Area Agency on Aging - M4A
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sechols@m4a.org
www.m4a.org

"Be who you are and say what you feel because those who mind don't matter and those who matter don't mind." Dr. Seuss

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Crystal Crim

From:	Sharon Echols
Sent:	Wednesday, July 12, 2017 5:24 PM
To:	(april.weaver@alhouse.gov); (david.standridge@alhouse.gov); (randy.wood@alhouse.gov); Rep. Allen Farley; Rep. Arnold Mooney; Rep. Connie Rowe; Rep. Corley Ellis ; Rep. Jim Carnes; Rep. Jim Hill; Rep. Jimmy Martin ; Rep. Mack Butler (mack.butler@alhouse.gov); Rep. Mark Tuggle; Rep. Matt Fridy; REP. RANDALL SHEDD (randall.shedd@alhouse.gov); Rep. Richard "Dickie" Drake (ddrake1080@aol.com); Rep. Tim Wadsworth; Rep. Willl Ainsworth; (jabo.waggoner@alsenate.gov); Sen. Cam Ward (camjulward@aol.com); Sen. Clay Scofield (clay.scofield@alsenate.gov); Sen. Clyde Chambliss; Sen. Jim McClendon (jimmcc@windstream.net); Sen. Phillip W. Williams; Sen. Shay Shelnut; Sen. Slade Blackwell (sb@sladeblackwell.com); Senator Greg Reed (greg.reed@alsenate.gov)
Cc:	Crystal Crim
Subject:	public hearing
Attachments:	Public Hearing Flyer-final.pdf

Good afternoon

M4A will be hosting a Public Hearing for the FY 18-21 Area Plan on August 9th, 2017 at the Shelby County Services Building in Pelham, AL. The Public Hearing is for individuals in M4A's 5 counties to provide comments on the Area Plan. We hope you will join us!

If you will be attending the Public Hearing, please let me know. I have attached the flyer which contains the address of the Public Hearing for you as well.

Thank you,

Crystal I. Crim

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"Be who you are and say what you feel because those who mind don't matter and those who matter don't mind." Dr. Seuss

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M4A Area Plan 2018-2021
Public Hearing
Shelby Services Building, Community Room
August 9, 2017, 1:00 pm – 2:30 pm

Crystal Crim called the meeting to order and explained the purpose of the Area Plan; she then asked for introductions.

Those in attendance included: Senta Goldman; Reginald Holloway; Gwendolyn Brown; Matt Haynes; Marvin Shackleford; Shannon Williams; Jennifer Atkins; and Marvin Copes. M4A Staff in attendance included: Carolyn Fortner; Crystal Crim; Sharon Echols; Cody Lewis; and Robyn James.

Robyn James spoke about the new initiatives that are being implemented at M4A:

1. A grant to develop Dementia Friendly Communities: This grant has enabled M4A to train law enforcement officers and first responders on how to be dementia friendly by being dementia aware, dementia sensitive, and dementia responsive. M4A is developing a training tool kit that can used statewide/nationwide to train law enforcement officers and first responders to be dementia friendly.
2. Jan Neal, Legal Services Provider for M4A, has developed booklets on dementia/dementia responsiveness and also on long-term care planning. She will develop 2 additional booklets for a total of 4 booklets in this series.
3. M4A Messengers: M4A Messengers will be promoting M4A and M4A events. M4A will help to promote programs and events of M4A Messenger partners through our e-newsletter and Facebook.

Carolyn Fortner, using a PowerPoint presentation and handouts, went over the goals and purpose of the Area Plan. She asked the audience for feedback on M4A's goals/objectives and for their feedback on additional goals. Then the floor was opened for comments:

Summary of Public Comments on Transportation:
M4A needs to update its list of transportation resources to reflect other types of transportation that are available to assist older individuals and people living with disabilities. For example, the following transportation options are available in the M4A region: Lyft, Uber, and Go-Go Grandparent. In addition, M4A needs to dig deeper into what types of transportation are needed in its counties.

M4A Response:
Agreed. M4A's ADRC is always updating resources and M4A appreciates learning about these transportation options in its region. During FY 2018, M4A will develop a transportation survey to delve more deeply into transportation needs. In its Area Plan, M4A will examine transportation needs and seek funding to implement one pilot transportation program in the M4A region.

Summary of Public Comments on Food/Nutrition:
The goal for the M4A region should be to eliminate senior hunger and, thereby, the homebound meal waiting list. To do this, M4A should consider other food options for seniors such as local food banks, new community-based ministries or initiatives to deliver food to rural, isolated areas, and services which deliver food to the homes. Examples of these types of services include Katz Food Delivery in Shelby County; Many Infinities, also in Shelby County; the faith-based food delivery services in Nauvoo (Walker County) and in Shelby County (by the Shelby County Baptist Association); and food banks such as Hope House in Blount County and the Chilton Emergency Relief Center in Chilton County; and others.

M4A Response:
M4A appreciates feedback on food resources in the M4A region. In order to combat senior hunger in the M4A region, M4A has implemented the "End Senior Hunger" project which has the dual goals of raising community awareness of senior needs and raising funds to feed homebound seniors. Since ensuring the safety and health of older individuals in their homes is the hallmark of M4A's mission, M4A Team Members have participated in many initiatives and studies on senior nutrition. Based on the comments of other food ministries and organizations and the comments of its Advisory Committee members and public hearing attendees, M4A concludes that the challenge of feeding people (including older individuals) includes the challenge of distribution which seems to be echoed in studies pertaining to food deserts. M4A will continue to develop its End Senior Hunger project while working with community based organizations focused on bridging the food distribution gap.

Summary of Public Comments on Preventing Duplication of Services and Encouraging Better Communication Amongst Community-Based Organizations:
There is a lack of communication between agencies and the faith based communities. Greater efforts need to be made to reduce duplication of services and duplication of meetings while also making the faith-based community aware of senior needs.

M4A Response:
Many of the counties in the M4A region have a social service round table meeting which are designed to improve communication amongst county social service organizations and to share resources. M4A participates in these while also participating in the organizational meetings of community organizations such as Positive Maturity, Disability Rights and Resources, American Red Cross, Community Foundation, etc. While no organization should meet for the sake of meeting, many organizations are required by their by-laws to have organizational specific meetings focused on the projects of the organization. As much as possible and as much as it is within M4A's authority, M4A will avoid duplication of meetings and services. M4A agrees that the faith-based community plays a critical role in assisting people of all ages who are in need. Churches and church members volunteer to deliver homebound meals and to provide much needed home repairs and modifications. Faith organizations are involved in feeding people and much more throughout the M4A region.

Summary of Public Comments on Addressing Social Isolation of Older Individuals:
Some suggestions to address social isolation in older individuals: expansion of Senior Companion and/or Foster Grandparent Program; develop an "Adopt-A-Grandparent" program; and educating high school students and other age groups in schools about older individuals.

M4A Response:
M4A appreciates the suggestions made by the Public Hearing attendees. Expansion of existing programs such as Senior Companions and Foster Grandparents will require funds. In addition, in its home repair projects, M4A encourages faith-based organizations to take a holistic interest in individuals—beyond the home repair. M4A piloted a project designed to increase awareness of senior citizens in public schools while also introducing high school students to careers in gerontology. This project was successful but was funded by a grant.

Summary of Public Comments on Increasing Awareness of Senior Citizens and Their Needs and Value to the Community:
The following suggestions were made to increase community awareness of senior citizen needs: regularly attend and present at the County Commission and City Council meetings; provide an annual report to County Commissions and municipalities; and incorporate consumers into presentations and outreach (consumers who are being or who have been helped by M4A).

M4A Response:
Agreed. Through its End Senior Hunger Initiative, M4A is already meeting more frequently with county commissioners and municipal leaders. M4A currently provides an annual report to its County Commissions but, with a new Marketing Department, will look at developing a professional annual report that can be distributed to the public as well as its local partners. M4A agrees, further, that no one speaks best for a consumer than the consumer. M4A will proactively incorporate consumers into its outreach and messaging.

Carolyn Fortner asked if there were any more comments or suggestions for the agency.

There were none.

Carolyn Fortner thanked everyone for coming and dismissed the meeting.

Middle Alabama Area Agency on Aging

Regional Plan on Aging Fiscal Years 2018 — 2021

M4A Regional Plan on Aging Fiscal Years 2018 — 2021 Comments by Shelby County Department of Community Services staff.

Carolyn, the Shelby County Department of Community Services finds the M4A area plan to be right on point and supports the service delivery plan, goals, objectives, strategies as well as the outcomes found in Section Il of your plan. We think the plan is very satisfactory but if the service delivery plan is implemented and accomplished, it will provide the seniors in our region the elder care support that they need. However, we do have some comments we would like to share with you.

The Area Plan mentioned branding, better visibility and recognition of what of M4A does. In large measure, we believe what will help M4A be better recognized in what it offers to its consumers is to ensure all senior center managers, staff and participants are knowledgeable in the mission and duties of M4A. The better informed your senior center managers and participants are in what M4A offers the better the average citizens will be informed. The Senior Center is the hub for senior information, M4A should start at the senior center to ensure everyone is well versed on services that M4A provides to seniors. Every year M4A should conduct a class at each senior center to inform them what M4A offers.

M4A Summary of Comment: M4A should conduct a class at each senior center each year to inform center participants and staff about M4A and its services.

M4A Response: M4A will take this suggestion under advisement. The senior centers are the local hubs for senior services in the M4A region and it is important that the senior center participants and the staff members are familiar with M4A and its services.

The M4A plan has identified transportation as a need. M4A as well as others need to find out specifically what is really being meant. Transportation is a broad subject and M4A needs to determine exactly what residents are saying when they say "we need transportation." Are they saying we lack public transportation, or are they saying "I lack private transportation" to go when and where I want to go at the time I want to go; or are they saying we need a taxi service, Uber or Lift service. Many who are saying "we need transportation" are going to their doctor appointments, going grocery shopping, going to the pharmacy in addition to going to recreational activities; they are being taken by: relatives, neighbors, church members, ClasTran and Shelby County RSVP bus etc... If you are going to tackle the transportation issue M4A needs to pin-point exactly what is meant when it is being addressed, "we need transportation." It has not been publicized that a senior passed away because they were unable to get to their doctor's appointment or to the pharmacy to obtain their medication, or to go purchase groceries; meaning seniors are being transported to their appointment in some way. If what is meant by we "need transportation" a means in which impromptu schedules and or appointments can be met then that is an issue that should be expressed. We now specifically know what is needed, a more organized

community oriented system to meet impromptu schedules and appointments. In metropolitan areas where there are buses, light rail, street cars etc., they all run on a schedule and the rider must meet the schedule of the transport. There may not be an abundance of public transportation modes available in our region but it is all about scheduling whether it is with your relative, neighbor, church member, ClasTran or the RSVP bus. What is actually meant by "we need transportation?" This needs to be defined so that the right technology and resources can be put into place in order to meet the need. The Shelby County Community Services staff has some suggestions that could help once the problem of "we need transportation" can be specifically defined.

M4A Summary of Comment: M4A should further examine what is meant when respondents to its senior needs survey identified "transportation" as a need. To understand what respondents meant when they identified "transportation" as a top need is important as M4A moves forward with its plan to address transportation needs.

M4A Response: Agreed. The respondents to the senior needs survey are primarily those consumers who currently receive services from M4A and, therefore, already have some familiarity with the types of services available in the M4A region and the consumers' respective counties. During FY18, M4A will develop and distribute a follow-up transportation survey to better gauge what types of transportation are needed or what types of transportation consumers feel is lacking in their communities. It may also be helpful to try to gauge whether consumers know what transportation services are available in their community and the consumers' assessment of those transportation services. In the Area Plan, M4A will also explore transportation models and try to obtain funding to implement one model.

The Area Plan's Outcomes for each of your goals all lack the same item which is "what is the measurement?" What is the metric that says you met or achieved your outcome? I saw nowhere how M4A was going to measure any of their objectives in which to achieve their outcomes. How can you know that your outcome has been met without it being measured? For instance: Objective 1.1 Outcome states "more consumers in the M4A region will recognize M4A as the organization to "assist all ages at all stages." How are we going to know more consumers will recognize M4A? Do we know the number of people now that don't recognize M4A? As compared to 2 years from now more do recognize M4A? Will a survey be conducted to determine how many consumers do not know as compared to a survey to be given 2020 to determine if more seniors recognize M4A? Objective 2.3 the Outcome states "There will be fewer hungry older individuals in the M4A region. How do you know that there will be fewer? Will you review the waiting list now and compare it to the waiting list in 2020/2021? I think if that is the metric we need to state it. Personally, I think the Outcome is not bold enough. I think the Outcome should be "There will be no hungry people in the M4A region by the end of the area plan end date." I think that is a doable outcome many of your strategies that you mention in the plan will assist you in reaching that outcome. The last example I want to bring to your attention Objective 5.3 "Improve its intra-organization communications" with the Outcome being "M4A will effectively address internal concerns about communication and any staff members feeling marginalized." How will you know this was accomplished? Will a survey be given to determine how employees feel after the strategies have been implemented?

M4A Summary of Comment: How will M4A gauge whether the goals of its Area Plan are being met?

M4A Response: M4A will gauge whether goals are being accomplished by AIMS data. AIMS is the State reporting system for senior services. Through AIMS, M4A can compare data from prior fiscal years to see if more people are being assisted through ADRC (Aging and Disability Resource Center or Information and Referral), nutrition, SHIP (health insurance counseling), etc. The challenge for M4A and most social service organizations is how to continue to increase the number of people we serve with less funding. To meet this challenge requires creativity, collaboration and a willingness to change and innovate. As far as the valuable concerns and input of M4A staff members, M4A periodically surveys staff members as part of the Area Plan to gauge the internal strengths and weaknesses of the Agency. M4A will continue to do this in order to determine whether the administrative staff members have successfully addressed concerns of staff members. In addition, M4A will continue to have monthly meetings with each coordinator to strengthen communication and team work and to gauge whether (fiscal and programmatic) goals of individual programs are being met.

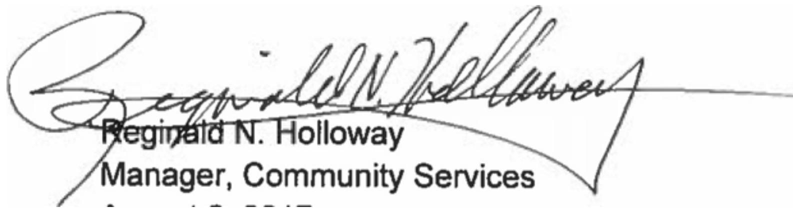
If you're going to create/have collaborating partnerships, create a strong working relation with the other agency. Hopefully we are all trying to reach one goal, it's not a competition. If you find, hear or see the need of a senior then make the necessary referral. If you're truly concerned about the seniors, then follow-up to make sure that they followed through on their referral. Sometimes many of them may need a little assistance or a push to get the referral or to just take the first step. It's a pride thing for many of them.

M4A Summary of Comment: M4A is encouraged to understand its strengths in the field of organizations that serve older individuals and to avoid duplication of services by making appropriate referrals to other organizations. M4A is encouraged to have the training and expertise to know when an individual consumer may need assistance to connect with a resource. Finally, M4A is encouraged to follow-up with referrals.

M4A Response: Approximately 300 first-time callers who require full Universal Assessments contact M4A each month. M4A engages in quality assurance through its Aging and Disability Resource Center to gauge whether consumers are not only connecting with referrals but also whether consumers feel they have been assisted professionally and compassionately. This is done through sampling and through follow-up through the ADRC. In addition, M4A is working on partnerships that will allow M4A to provide care management to more consumers who have been identified as at-risk.

Bottom-line: The M4A Area Plan is a solid plan but to be a great plan that is seen as comprehensive and complete it should contain some metrics that indicates your objectives and outcomes have been achieved.

M4A Response: Thank you for your comments.



August 8, 2017

Exhibit 10: Cost Sharing Plan

Cost Share {Section 315(a)}

The OAA allows cost sharing for all OAA services except those for which the OAA prohibits cost sharing. This policy is designed to ensure participation of low-income older individuals (with particular attention to low-income minority individuals) receiving services will not decrease with the implementation of cost-sharing. When developing and reviewing the cost sharing policy, the annually published DHHS Poverty Guidelines will be used to update the existing cost share plan.

Eligible Population

Individuals age 60 years and over whose self-declared, individual incomes are above poverty, and individuals of any age who are caregivers of persons age 60 years and over if the care recipient's self-declared income is above poverty, are eligible to participate in cost sharing for OAA services. Clients whose incomes are near poverty and considered "low-income" will be excluded. The person performing the intake/enrollment will verify that the client meets the definition of eligibility listed above and as stated in the law.

Allowable Services	Excluded Services
Cost sharing may be implemented for any OAA service, including the following:	**Cost sharing is not permitted for the following services:**
Personal care	Information and assistance
Homemaker	Outreach
Chore	Benefits counseling
Adult day care	Case management
Assisted transportation	Ombudsman
Transportation	Elder abuse prevention
Caregiver Respite	Legal assistance and other consumer protection services
Caregiver Supplemental Services	Meals (congregate and home-delivered)
	Services delivered through tribal organizations

Cost Sharing and Contributions

In utilizing the cost sharing plan, ADSS and the AAAs assure they will:

- Protect the privacy and confidentiality of each older individual with respect to the declaration or non-declaration of individual income and to any share of costs paid or unpaid by an individual;
- Establish appropriate procedures to safeguard and account for cost share payments;
- Use each collected cost share payment to expand the service for which such payment was given;
- Not consider assets, savings, or other property owned by an older individual in determining whether cost sharing is permitted;
- Not deny any service for which funds are received under this Act for an older individual due to the income of such individual or such individual's failure to make a cost sharing payment;
- Determine the eligibility of older individuals to cost share solely by a confidential declaration of income and with no requirement for verification; and
- Widely distribute State created written materials in languages reflecting the reading abilities of older individuals that describe the criteria for cost sharing, the State's sliding scale, and the mandate described under paragraph (e) above.

Clients Eligible for Cost Sharing

In the event the confidential assessment reveals the family has financial resources above the poverty line, the following may apply:

- Using the DHHS 2017 Poverty Guidelines, which was approved by ADSS and expanded by M4A, personnel performing the intake may ask clients for fees; however, a client who is unwilling or unable to pay may not be denied services;
- Cost sharing options should be discussed with eligible clients before starting services; and
- All fees/contributions should be logged, according to AAA policy, and used to expand services for which such payment was given.

AAA Waivers

An AAA may request a waiver to ADSS' cost sharing policy, and ADSS shall approve such a waiver if the AAA can adequately demonstrate that:

- A significant proportion of persons receiving services under this Act subject to cost sharing in the PSA have incomes below the threshold established in State policy; or
- Cost sharing would be an unreasonable administrative or financial burden upon the AAA.

M4A Poverty Guideline
Cost Sharing for Older Americans Act Services
(Based on 2017 DHHS Poverty Guidelines)

effective 08/01/2017

Percent of Federal Poverty Level			*Gross Monthly Income			Percent per $100 Cost of Service	Cost/Fee per $100 Cost of Service
0.00%	-	100.00%	$ -	-	$ 1,015	0%	$ -
100.01%	-	110.00%	$1,015.01	-	$ 1,116	0%	$ -
110.01%	-	125.00%	$1,116.01	-	$ 1,268	5%	$ 5.00
125.01%		133.00%	$1,268.01	-	$ 1,336	5%	$ 5.00
133.01%	-	150.00%	$1,336.01	-	$ 1,508	10%	$ 10.00
150.01%	-	175.00%	$1,508.01	-	$ 1,776	10%	$ 10.00
175.01%	-	185.00%	$1,776.01	-	$ 1,878	10%	$ 10.00
185.01%	-	200.00%	$1,878.01	-	$ 2,010	15%	$ 15.00
200.01%		225.00%	$2,010.01	-	$ 2,284	15%	$ 15.00
225.01%		250.00%	$2,284.01	-	$ 2,513	20%	$ 20.00
250.01%		275.00%	$2,513.01	-	$ 2,791	30%	$ 30.00
275.01%	-	300.00%	$2,791.01	-	$ 3,015	40%	$ 40.00
300.01%	-	325.00%	$3,015.01	-	$ 3,299	45%	$ 45.00
325.01%	-	350.00%	$3,299.01	-	$ 3,553	50%	$ 50.00
350.01%	-	375.00%	$3,553.01	-	$ 3,806	55%	$ 55.00
375.01%	-	400.00%	$3,806.01	-	$ 4,020	60%	$ 60.00
400.01%	-	425.00%	$4,020.01	-	$ 4,314	65%	$ 65.00
425.01%	-	450.00%	$4,314.01	-	$ 4,568	70%	$ 70.00
450.01%	-	475.00%	$4,568.01	-	$ 4,821	75%	$ 75.00
475.01%	-	500.00%	$4,821.01	-	$ 5,015	80%	$ 80.00
500.01%	-	over	$5,015.01	-	over	100%	$ 100.00

* Gross monthly income is presented for a family size of one (1)

** add $345.00 per each additional family unit member.

Table -1 updated 2017

Cost Sharing System for Older Americans Act Services

(Based on 2017 DHHS Poverty Guidelines)

Percent of Federal Poverty Level	Gross Annual Income	Percent per $100 Cost of Service	Cost/Fee per $100 Cost of Service
101 - 133%	$12,181 - $16,040	5 %	$ 5.00
134 - 150%	$16,041 - $18,090	10 %	$ 10.00
151 - 200%	$18,091 - $24,120	15 %	$ 15.00
201 - 250%	$24,121 - $30,150	20 %	$ 20.00
251 - 300%	$30,151 - $36,180	40 %	$ 40.00
300 - 400%	$36,181 - $48,240	60 %	$ 60.00
400% - 499%	$48,241 -$60,179	80 %	$ 80.00
500% and over	$60,180 and over	100 %	$ 100.00

Individuals who have an income at or below $1,015.00 per month or $12,180.00 gross annual income may not be asked to cost share; however, they may be provided an opportunity to voluntarily contribute to the cost of the service.

Appendices

1. **Appendix A: Demographic Profile: M4A 2009-2013**
2. **Appendix B: Services Delivery Plan and Goals, Objectives, Strategies and Outcomes**
3. **Appendix C: M4A SWOT Analysis**
4. **Appendix D: Summary of Community Needs Assessment**
5. **Appendix E: ADPH Health Status Indicators by County**
6. **Appendix F: EngAge Report**
7. **Appendix G: Food Deserts Report by County**
8. **Appendix H: Food for Every Child Report**
9. **Appendix I: M4A Marketing Plan Results**
10. **Appendix J: "Senior Feeding Frenzy" Flyer**
11. **Appendix K: WIAT News Article**

Appendix A: Demographic Profile: M4A 2009-2013

Age, Gender, Race and
Ethnicity
American Community Survey 5-Year Estimates: Age: 2016 Pop.
Estimates

M4A Region													
	Population Estimate (as of July 1)												
	2011		2012		2013		2014		2015		2016		% Change 2011-2015
Age	Both Sexes	% of Total	Both Sexes	% of Total	Both Sexes	% of Total	Both Sexes	% of Total	Both Sexes	% of Total	Both Sexes	% of Total	
Total	450,452		453,633		457,499		459,531		462,289		465,253		3.29%
Under 60	363,221	81%	363,244	80%	364,135	80%	363,018	79%	362,750	78%	362,732	78%	-0.13%
60 to 64 years	27,613	6%	27,418	6%	27,670	6%	28,032	6%	28,571	6%	29,121	6%	5.46%
65 to 69 years	20,452	5%	22,202	5%	23,133	5%	24,277	5%	25,148	5%	26,235	6%	28.28%
70 to 74 years	15,174	3%	15,991	4%	16,974	4%	17,649	4%	18,395	4%	18,905	4%	24.59%
75 to 79 years	10,868	2%	11,162	2%	11,595	3%	12,087	3%	12,469	3%	12,964	3%	19.29%
80 to 84 years	7,465	2%	7,562	2%	7,626	2%	7,784	2%	8,005	2%	8,333	2%	11.63%
85 years and over	5,659	1%	6,054	1%	6,366	1%	6,684	1%	6,951	2%	7,106	2%	25.57%
65 years and over	59,618	13%	62,971	14%	65,694	14%	68,481	15%	70,968	15%	73,543	16%	23.36%
85 years and over	5,659	1%	6,054	1%	6,366	1%	6,684	1%	6,951	2%	7,106	2%	25.57%

Age, Gender, Race and Ethnicity
American Community Survey 5-Year Estimates: Age: 2016 Pop. Estimates

M4A Region								
	2011				2015			
Age and Gender	Male	% OF 60+	Female	% OF 60+	Male	% OF 60+	Female	% OF 60+
TOTAL	39,628	45%	47,603	55%	45,232	45%	54,307	55%
60 to 64 years	13,243	15%	14,370	16%	13,558	14%	15,013	15%
65 to 69 years	9,672	11%	10,780	12%	11,847	12%	13,301	13%
70 to 74 years	7,080	8%	8,094	9%	8,423	8%	9,972	10%
75 to 79 years	4,856	6%	6,012	7%	5,712	6%	6,757	7%
80 to 84 years	2,949	3%	4,516	5%	3,372	3%	4,633	5%
85 years and over	1,828	2%	3,831	4%	2,320	2%	4,631	5%

ALL 60+ 87,231 99,539

Ethnicity	2011	2012	2013	2014	2015	
Total population	441,960	446,860	450,876	454,047	456,846	
White	393,478	395,263	396,494	397,258	397,986	
Black or African American	38,288	39,338	41,036	42,556	43,875	
Hispanic or Latino (of any race)	21,073	22,148	19,698	23,437	23,638	
White	89%	88%	88%	87%	87%	
Black or African American	9%	9%	9%	9%	10%	9%
Hispanic or Latino (of any race)	5%	5%	4%	5%	5%	5%

Alabama 2009-2013

Age, Poverty and Disability

Age	60+	60-64	65-74	75-84	85+
TOTAL	86,515	27,635	32,610	17,630	5,040
Disability	32,460	7,390	11,740	9,405	3,925
% Disabled	38%	27%	36%	53%	78%
TOTAL	3,455	1,205	1,215	760	290
% Poverty and Disabled	11%	16%	10%	8%	7%

Alabama 2009-2013

Table S21040 - Hispanic or Latino and Race by Poverty Status in the Past 12 Months for the Population 60 Years and Over for Whom Poverty Status is Determined

	Total 60+												
		Total 60+ Poverty			White alone:					Black or African American alone:			
	Total 60+	Income in the past 12 months below poverty level	% of 60+ Poverty by County to Total 60+ Poverty	White alone, Subtotal	Income in the past 12 months below poverty level	% White Poverty alone, to Total 60+	% White Poverty alone, to Subtotal	% White 60+ Poverty to Total 60+ Poverty	Black or African American alone, Subtotal	Income in the past 12 months below poverty level	% Black or African American Poverty alone, to Total 60+	% Black or African American Poverty alone, to Subtotal	% Black or African American Poverty to Total 60+ Poverty
	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.
PSA 3	86,515	6,740	100%	80,125	5,695	6.58%	7.11%	Over	4,090	730	0.84%	17.85%	10.83%
Blount	12,605	1,195	18%	12,055	1,135	1.31%	9.42%	94.98%	175	30	0.03%	17.14%	2.51%
Chilton	8,660	910	14%	7,745	775	0.90%	10.01%	85.16%	685	110	0.13%	16.06%	12.09%
St. Clair	16,685	1,454	22%	15,510	1,180	1.36%	7.61%	81.16%	810	130	0.15%	16.05%	8.94%
Shelby	32,830	1,440	21%	29,870	1,025	1.18%	3.43%	71.18%	1,850	330	0.38%	17.84%	22.92%
Walker	15,740	1,744	26%	14,950	1,585	1.83%	10.60%	90.88%	575	130	0.15%	22.61%	7.45%
	M4A 60+ Poverty	Walker	Shelby	St. Clair	Blount	Chilton							
	6,740	1,744	1,454	1,440	1,195	910		8%	2%	2%	2%	1%	1%

Hispanic or Latino, Subtotal	Hispanic or Latino: Income in the past 12 months below poverty level	% Hispanic or Latino Poverty alone, to Total 60+	% Hispanic or Latino Poverty alone, to Subtotal	% Hispanic or Latino Poverty to Total 60+ Poverty	All Other Races alone, Subtotal	All Other Races alone: Income in the past 12 months below poverty level	% All Other Races Poverty alone, to Total 60+	% All Other Races Poverty alone, to Subtotal	% All Other Races Poverty to Total 60+ Poverty
Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.
935	65	0.08%	6.95%	0.96%	1,370	250	0.29%	18.25%	3.71%
190	-	0.00%	0.00%	0.00%	190	30	0.03%	15.79%	2.51%
100	-	0.00%	0.00%	0.00%	130	25	0.03%	19.23%	2.75%
135	55	0.06%	40.74%	3.78%	235	89	0.10%	37.87%	6.12%
455	-	0.00%	0.00%	0.00%	655	85	0.10%	12.98%	5.90%
55	10	0.01%	18.18%	0.57%	159	19	0.02%	11.95%	1.09%

PSA LEVEL STATISTICS FROM 2010 ACL AGID: TOTAL 60+ RURAL

Year	PSA	Rural Count 60+	% of Rural 60+ Population that is Rural	% of M4A's Total 60+ Rural Population		
2010	M4A	49,181	59%	100%	Blount and Chilton County Average Rural	87%
2010	Blount	10,685	89%	22%	St. Clair and Walker Average Rural	72%
2010	Chilton	7,133	85%	15%	Shelby Rural	28%
2010	St. Clair	11,386	72%	23%	Blount, St. Clair and Walker Average Rural	11,100
2010	Shelby	8,749	28%	18%	Chilton and Shelby Average Rural	7,941
2010	Walker	11,228	73%	23%		

Alabama 2009-2013
Table S21055 - Poverty Status in the Past 12 Months for Individuals 60 Years and Over

	Total:	Total, Population 60 years and over for whom poverty status is determined	
		Income in the past 12 months below poverty level	Income in the past 12 months at or above poverty level
	Estimate	Estimate	Estimate
M4A	86515	6735	79780
Blount	12605	1195	11410
Chilton	8660	910	7750
St. Clair	16685	1450	15235
Shelby	32830	1445	31385
Walker	15740	1735	14000

Alabama 2009-2013
Table S21021B - Educational Attainment for the Population 60 Years and Over

	Total:	Total, Population 60 years and over						
		Less than HS graduate	High school graduate (includes equivalency)	% with HS or equivalent	Some college, no degree / Associate degree	% With Some college, no degree / Associate degree	Bachelor's degree or higher	% With Bachelor's degree or higher
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
M4A	88050	19530	30350	34%	21475	24%	16695	19%
Blount	12845	3550	5215	41%	2785	22%	1295	10%
Chilton	8805	3110	3080	35%	1760	20%	855	10%
St. Clair	16975	4085	6365	37%	4400	26%	2130	13%
Shelby	33265	4010	9375	28%	8900	27%	10985	33%
Walker	16160	4775	6315	39%	3630	22%	1430	9%

Alabama 2009-2013
Table S21023 - Employment Status for the Population 60 Years and Over

		Total, Population 60 years and over					
			In labor force:		Not in labor force		
					Civilian:		
	Total:	In labor force, Subtotal	In Armed Forces	Civilian, Subtotal	Employed	Unemployed	
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
M4A	88050	23300	0	23300	21880	1420	64750
Blount	12845	3145	0	3145	3050	95	9695
Chilton	8805	2075	0	2075	1915	155	6730
St. Clair	16975	4165	0	4165	3780	385	12810
Shelby	33265	10640	0	10640	10005	635	22625
Walker	16160	3275	0	3275	3130	145	12880

Alabama 2009-2013
Table S21013 - Sex by Grandparents Living with Own Grandchildren Under 18 Years by Responsibility for Own Grandchildren for the Population 60 Years and Over in Households

	Total, Population 60 years and over in households								
			Male:				Female:		
	Total:	Male, Subtotal	Living with own grandchildren under 18 years, Subtotal	Grandparent responsible for own grandchildren under 18 years	Grandparent not responsible for own grandchildren under 18 years	Female, Subtotal	Living with own grandchildren under 18 years, Subtotal	Grandparent responsible for own grandchildren under 18 years	Grandparent not responsible for own grandchildren under 18 years
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
M4A	86440	39575	2475	1110	1370	46865	3340	1220	2120
Blount	12585	5830	475	210	260	6760	475	110	360
Chilton	8645	3880	265	115	150	4760	420	180	245
St. Clair	16675	7680	635	300	335	9000	665	325	345
Shelby	32810	15035	685	260	425	17775	1240	345	895
Walker	15725	7155	415	220	195	8570	540	260	280

Alabama 2009-2013

Table S21014B - Ability to Speak English for the Population 60 Years and Over

		Total, Population 60 years and over							
				Speak language other than English:					
	Total:	Speak only English	Speak language other than English, Subtotal	Speak English "very well"	Speak English "well"	Speak English "not well"	Speak English "not at all"		
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate		
M4A	88050	86070	1980	1115	220	320	325	645	1%
Blount	12845	12560	285	75	40	60	110		
Chilton	8805	8710	95	25	25	45	0		
St. Clair	16975	16745	230	135	4	45	45		
Shelby	33265	32010	1255	790	140	150	170		
Walker	16160	16045	115	90	10	15	0		

Alabama
2009-2013
Table S21011B - Sex by Marital Status for the Population 60 Years and Over

		Total, Population 60 years and over														
			Male:							Female:						
					Now married:								Now married:			
	Total:	Male, Subtotal	Never married	Now married, Subtotal	Married, spouse present	Married, spouse absent	Widowed	Divorced	Female, Subtotal	Never married	Now married, Subtotal	Married, spouse present	Married, spouse absent	Widowed	Divorced
	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.	Est.
PSA 3	88050	40025	890	31740	30620	1125	3550	3845	48025	1295	24765	23850	915	15830	6135
Blount	12845	5870	135	4655	4485	170	520	560	6975	210	3665	3535	130	2430	670
Chilton	8805	3960	130	3025	2975	50	375	430	4845	110	2445	2360	90	1570	710
St. Clair	16975	7770	145	6050	5800	250	645	925	9205	340	4740	4460	280	3180	945
Shelby	33265	15130	240	12385	12045	345	1335	1165	18140	320	9690	9415	275	5345	2785
Walker	16160	7295	240	5620	5315	305	670	765	8865	315	4225	4085	140	3305	1020

ADPH Selected Health Indicators; AGID: Special Tabulation

	Alabama	Blount	Chilton	Shelby	St. Clair	Walker	M4A Region	
AFRICAN AMERICAN	26.50%	1.90%	10.30%	11.40%	9.10%	6.10%	8%	
HISPANIC	4.00%	8.60%	7.80%	6.00%	2.20%	2.10%	5%	7.5%
65+	14%	15.00%	14.10%	11.10%	13.60%	16.70%	14%	
CHANGE 2010-2040 65+	82.40%	97.70%	81.70%	248.80%	162.90%	24.70%	123%	
BELOW POVERTY	19.10%	14.90%	18.30%	8.10%	17.30%	22.10%	16%	
200% BELOW POVERTY	38.50%	36.50%	41.20%	20.40%	33.80%	42.80%	35%	
INCOME	$34,880.00	$27,220.00	$28,844.00	$44,734.00	$32,240.00	$33,167.00	$33,241.00	
DM PER 100K	26.8	13.3	15.3	8.2	13.9	35.8	17.3	
ALZHEIMERS DISEASE 100K	31.4	14.5	26.7	13.3	25.1	36.3	23.18	
OBESITY	33%	32%	35%	28%	36%	35%	33%	
LIFE EXPECTANCY AT BIRTH	74.8 years	75.6 years	74.5 years	79.0 years	75.2 years	70.1 years	74.88	
AMBULATORY DIFFICULTY 60+	248,860 OR 26%	3,035 OR 24%	2,600 OR 30%	3,940 OR 24%	6,945 OR 21%	4,795 OR 30%		
SELF-CARE OR INDEPENDENT LIVING DIFFICULTY 60+	96,305 OR 10%	1,420 OR 11%	950 OR 11%	2,495 OR 8%	1,735 OR 10%	2,130 OR 14%		
COGNITIVE DECLINE 60+	101,060 OR 11%	1,375 OR 11%	1,080 OR 12%	2,370 OR 7%	1,580 OR 9%	2,070 OR 13%		
WITH AT LEAST ONE DISABILITY 60+	158,185 OR 17%	2,280 OR 18%	1,520 OR 18%	4,995 OR 15%	3,130 OR 19%	2,890 OR 18%		

Alabama
2009-2013
Table S21007B - Hispanic or Latino and Race for the Population 60 Years and Over

	Total Estimate	White alone	% White alone	Black or African American alone	% Black or African American alone	American Indian and Alaska Native alone	% American Indian and Alaska Native alone	Asian alone	% Asian alone	Native Hawaiian and Other Pacific Islander alone	% Native Hawaiian and Other Pacific Islander alone	Some other race alone or Two or more races	% Some other race alone or Two or more races	Hispanic or Latino	% Hispanic or Latino
PSA 3	88,050	81,455	93%	4,285	5%	200	0%	465	1%	10	0%	695	1%	945	1%
Blount	12,845	12,280	96%	185	1%	40	0%	30	0%	-	0%	120	1%	190	1%
Chilton	8,805	7,880	89%	695	8%	20	0%	20	0%	-	0%	90	1%	100	1%
St. Clair	16,975	15,710	93%	900	5%	80	0%	35	0%	10	0%	110	1%	135	1%
Shelby	33,265	30,260	91%	1,885	6%	55	0%	360	1%	-	0%	240	1%	465	1%
Walker	16,160	15,325	95%	620	4%	4	0%	20	0%	-	0%	135	1%	55	0%
				7%											

Alabama 2009-2013

Table S210DIS09 - Age by Number of Disabilities

60 + with Disability					
	Estimate	Total: All disabilities	With One Type of disability	With Two Types of disabilities	With Three or More Types of disabilities
PSA 3	445,780	32,465	14,810	7,210	10,445
Blount County	57,165	4,910	2,280	1,065	1,565
Chilton County	43,415	3,580	1,520	755	1,305
St. Clair County	82,475	6,345	3,130	1,380	1,835
Shelby County	196,950	10,425	4,995	2,225	3,205
Walker County	65,770	7,215	2,890	1,785	2,540

Alabama 2009-2013
Table S210DIS13 - Age by Disability
Status by Poverty Status

		60 years and over:					
			With a disability:		% With a disability:		
	60 years and over, Subtotal	With a disability, Subtotal	Income in the past 12 months- below poverty level	Income in the past 12 months- at or above poverty level	% With a disability to 60+	% Income in the past 12 months- below poverty level	% Income in the past 12 months- at or above poverty level
	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate	Estimate
PSA 3	86,515	32,460	3,455	29,005	38%	11%	89%
Blount County	12,605	4,905	580	4,325	39%	12%	88%
Chilton County	8,660	3,580	465	3,115	41%	13%	87%
St. Clair County	16,685	6,340	760	5,575	38%	12%	88%
Shelby County	32,830	10,430	610	9,820	32%	6%	94%
Walker County	15,740	7,210	1,040	6,170	46%	14%	86%

Appendix B: Service Delivery Plan and Goals, Objectives, Strategies and Outcomes

Area Plan Goals and Objectives Chart

GOAL 1.0: Older adults, individuals with disabilities, and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long-term supports and services.

OBJECTIVE 1.1: Increase the number of people who contact the Aging and Disability Resource Center (ADRC) and who know who/what M4A is.

<table>
<tr><td colspan="3">Strategies:
• Promote the ADRC and M4A in print and other media.
• Increase the number of subscribers to M4A's e-newsletter.
• Continue to host events (workshops and conferences), participate in community outreaches and roundtables, disseminate M4A outreach materials, and utilize M4A Messengers.</td></tr>
<tr><td>Outcomes:</td><td>Progress</td><td>Next Steps</td></tr>
<tr><td>• M4A will increase the visibility of its ADRC as a trusted resource for information and assistance in the M4A region.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 1.0: Older adults, individuals with disabilities, and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long-term supports and services.

OBJECTIVE 1.2: Sign Memorandums of Agreements with Mental Health, 310 Boards and Independent Living to strengthen outreach of the ADRC.

Strategies:

- Enlist the help of members of the Advisory Council and community groups who work for or with mental health to obtain meetings with mental health representatives.
- Meet with mental health representatives, members of 310 boards and independent living to discuss mutually beneficial partnerships.
- Formalize partnerships.
- Invite mental health representatives and independent living representatives to participate in M4A's Advisory Council.

Outcomes:	Progress	Next Steps
• More consumers in the M4A region will recognize M4A as the organization to "assist all ages at all stages."		
• M4A will increase its knowledge base of the needs of the populations served by mental health, 310 boards and independent living thereby strengthening M4A and M4A's ADRC.		
• M4A's ADRC will have increased opportunities to provide assistance and support to those living with disabilities.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 1.0: Older adults, individuals with disabilities, and their caregivers shall have access to reliable information, helping them to make informed decisions regarding long-term supports and services.

OBJECTIVE 1.3: Increase minority participation in M4A's planning and outreach.

Strategies: • M4A will partner with other social service and public organizations to target areas of the M4A region where minority older individuals live and/or work. • M4A will seek out partnerships and meetings with organizations who already successfully reach minority older individuals in the M4A region. M4A will develop outreach strategies for this target population based upon input from various partners.		
Outcomes:	Progress	Next Steps
• More minority older individuals will receive assistance from M4A.		
• M4A will have effective strategies to reach minority older individuals, including minority older individuals living in rural areas.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.1: Promote Medicaid Waivers Programs which are designed to provide in-home services and case management to enable consumers, who are nursing home eligible, to live at home.

<table>
<tr><td colspan="3">Strategies:
M4A will continue its current outreach efforts but, because of estate recovery, M4A will target outreach to housing authorities and senior housing.
Strengthen relationships with local doctors’ offices and Medicaid District Offices.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>More consumers will be aware of Medicaid Waivers.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.2: Evaluate the current effectiveness of M4A's home repair and home safety program which has helped older individuals and individuals living with disabilities live safely and independently in their own homes.

<table>
<tr><td colspan="3">Strategies:
Contact organizations (civic, faith-based, nonprofit, government, public) to determine who is doing what by way of home repair and safety.
Through meetings, surveys, etc., determine whether there is an organization charged with or who wants to spearhead the coordination of volunteers and/or the evaluation of referrals (i.e., for home repairs).
Determine funding that is available for home repairs.
If there is no organization charged with or who wants to coordinate volunteers and evaluate referrals, then determine next steps to develop an action plan or report of findings with recommendations.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>Home repair and home safety are essential to older individuals who want to remain in their own homes; yet, there is no reliable funding stream to support the coordination of these services and to pay for materials for home repair and safety. So, the outcome of this objective is to determine the status of home repair/safety in the region and to develop a realistic work plan or recommendations to address this critical need.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.3: Provide food options to older individuals so that they can remain in their own homes.

<table>
<tr><td colspan="3">Strategies:
• Continue to provide SNAP outreach and farmers market voucher sign-up opportunities to older individuals which will provide them with resources to obtain healthy foods such as meats, fresh fruit, and fresh vegetables.
• Continue to work with food pantries, food ministries, and senior centers in the M4A region.
• Continue to strengthen M4A's "fight to end senior hunger" and "feeding frenzy" fundraisers.
• Target outreach in "food deserts" identified by the USDA.
• Increase the public's awareness of senior hunger and food deserts.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>• There will be fewer hungry older individuals in the M4A region.</td><td></td><td></td></tr>
<tr><td>• Local communities will have greater awareness of senior hunger and food deserts.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.4: Continue to provide information, access services and supplemental services to caregivers; increase respite options available to caregivers and offer educational opportunities to caregivers.

<table>
<tr><td colspan="3">Strategies:
• Through the ADRC and Alabama Cares Program, caregivers will continue to receive access services and information. Information will continue to be provided through outreaches.
• Continue to provide supplemental services to support caregivers, including grandparents who need school supplies, clothing, and summer or after school programs.
• Increase the number of partners who provide after school programs or summer programs for grandparents raising grandchildren. Currently, M4A has agreements with the YMCA and Boys and Girls Clubs to offer after school programs which assist grandparents with respite and helps children with study skills, social skills, and self-confidence.
• Increase respite options to caregivers through agreements with the Alabama Lifespan Resource Network.
• Promote and encourage cost-sharing for caregivers when appropriate/allowed.
• Provide educational opportunities to caregivers so that they can learn better how to care for themselves and their loved ones and offer respite services to caregivers so that attending these events is convenient.</td></tr>
<tr><td>Outcomes:</td><td>Progress</td><td>Next Steps</td></tr>
<tr><td>• Caregivers will have greater awareness of resources available to them and have tools to help manage the responsibilities of caregiving.</td><td></td><td></td></tr>
<tr><td>• Caregivers will have more choices for respite and supplemental services.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.5: Work with other Area Agencies on Aging to implement Veterans-Directed Home and Community Based Services (VDHCBS): M4A has already completed the certification process for VDHCBS; however, the Veterans Administration is not currently making referrals for this service. Once the Veterans Administration approves veterans for VDHCBS, M4A will implement the following strategies:

Strategies: • Hire a qualified licensed social worker to oversee the VDHCBS, receive referrals, meet with veterans, implement services, and monitor care plan. • Educate ADRC staff members and other M4A program staff on the VDHCBS program so that they can begin to educate veterans and other consumers about this program.		
Outcomes:	Progress	Next Steps
• Veterans will have a service to help them remain independently and safely in their own homes.		
• Veterans will have choices for home and community based services and self-directed care.		
• M4A will diversify its funding sources.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 2.0: Empower older adults and individuals with disabilities to remain in the least restrictive environment with a high quality of life through the provision of options counseling, home and community-based services, and support for family caregivers.

OBJECTIVE 2.6: Continue to enhance the economic security of older individuals through Older Americans Act programs and through local partnerships which enable older individuals to have resources to live safely and independently in their own homes and communities.

Strategies:

- Continue to promote and achieve the goals and objectives of the Senior Community Service Employment Program, including recruiting new host agencies and making contacts with potential employers.
- Continue to make referrals to community-based organizations (such as Community Action Agency, County Emergencies Relief Agencies, and Project Share) and faith-based organizations that provide financial assistance for utilities, copays, and medical bills.
- Continue to promote the Aging and Disability Resource Center which screens consumers and assists them in applying for public benefits such as the Medicare Savings Program, the Limited Income Subsidy, the Supplemental Nutrition Assistance Program, Farmer Market Vouchers, and M4A core OAA services.

Outcomes:	Progress	Next Steps
• Older individuals and other consumers who contact M4A will have access to public benefits that will improve their economic security.		
• Older individuals and other consumers who contact M4A will have resources to help them live independently and safely in their own homes.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

OBJECTIVE 3.1: Continue to offer existing Part D programs (such as A Matter of Balance, Arthritis Foundation Exercise Program, Arthritis Foundation Walk with Ease, and Tai Chi) and pilot diabetes education and medical nutrition therapy.

<table>
<tr><td colspan="3">Strategies:
M4A will continue to employ a Part D or Wellness Coordinator who will be responsible for administering (coordinating and training) Part-D programs such as A Matter of Balance, Arthritis Foundation Exercise Program, Arthritis Foundation Walk with Ease, and Tai Chi.
M4A's Wellness Coordinator will increase the number of community volunteers who are trained to provide Part D evidence-based disease prevention and health promotion to address the anticipated lower Part D units of service brought about by the end of M4A's AmeriCorps Project.
M4A will employ a Registered Nurse and a Registered Dietician for diabetes education and medical nutrition therapy. Until there is written clarification as to whether these two Medicare-reimbursed services are Part D supported programs, M4A will support these programs with local funds.
M4A will pilot at least one diabetes education class and medical nutrition therapy class in FY 2018.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>Older individuals in the M4A region will have opportunities to improve their health through wellness programs offered by M4A.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

OBJECTIVE 3.2: Educate consumers about the preventive services available through Medicare and medication assistance available through the state-funded SenioRx Program.

<table>
<tr><td colspan="3">Strategies:
• The SHIP and SenioRx Coordinators will continue to be cross-trained and promote each other's programs.
• SenioRx, SHIP and Medicare preventive services information will be available on M4A's website and shared periodically in M4A's e-newsletter.
• SHIP and SenioRx will target counties that have high populations of dual-eligibles for outreach.
SHIP and SenioRx will promote volunteer opportunities available with SHIP as well as promote M4A and its ADRC.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>• More consumers, especially dual eligibles, will know about SHIP, SenioRx and Medicare preventive services.</td><td></td><td></td></tr>
<tr><td>• SHIP will increase its number of volunteers.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

OBJECTIVE 3.3: Achieve the performance measures, as outlined by ADSS and SSAI, for the Senior Community Service Employment Program (SCSEP).

Strategies: • The marketing team will work with the SCSEP Project Director on outreach. • The administrative team will support SCSEP Project Director to meet goals for unsubsidized employment and develop strategies to increase employment opportunities for SCSEP participants.		
Outcomes:	Progress	Next Steps
• The SCSEP Program has a waiting list of participants and also host agencies who have requested a SCSEP participant; therefore, the Area Plan focuses on increasing the success of current SCEP participants to meet the goals outlined in their individual employment plan and to obtain unsubsidized employment.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 3.0: Empower older adults to stay active and healthy through Older Americans Act services, Medicare prevention benefits, recreation, job, and volunteer opportunities.

OBJECTIVE 3.4: Examine models to address transportation needs of older individuals in the M4A region.

<table>
<tr><td colspan="3">Strategies:
• Develop a follow-up transportation survey to better understand the transportation needs in the M4A region.
• Research successful models to address senior transportation needs in rural areas.
• Present at least two models to a senior transportation steering committee (or similar group convened by M4A).
• Gauge community interest and support of a pilot senior transportation program.
• If there is interest and defined support then develop work plan to implement a pilot senior transportation program looking at factors such as funding, coordination, referral, implementation, measurement, outcomes, and sustainability.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>• The community and community-based organizations will better understand senior transportation needs, options for addressing senior transportation needs, and have at least one option to pilot a project to address one or more senior transportation needs.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 4.0: Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.

OBJECTIVE 4.1: M4A will work closely with its Legal Services Provider to provide outreach and education on elder abuse and fraud.

Strategies: • M4A and the Legal Services Provider will provide educational materials for publication on M4A's website, for use in M4A's e-newsletter, and for distribution to the public on topics that will educate older individuals on elder abuse (neglect and exploitation, their rights and remedies) and on frauds/scams which target older individuals. • M4A and the Legal Services Provider will increase the number of older individuals who receive legal services.		
Outcomes:	Progress	Next Steps
• More older individuals in the M4A region will be empowered to report abuse and to know where to report abuse and to get help.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 4.0: Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.

OBJECTIVE 4.2: The Ombudsman Program will provide outreach and education on elder abuse, elder rights, and residents' rights.

<table>
<tr><td colspan="3">Strategies:
• The Community Ombudsman Representative will utilize the Ombudsman Advisory Council to disseminate information in local communities on elder abuse and elder rights.
• The Community Ombudsman Representative will increase the number of ombudsman program volunteers by recruiting from the community and by outreach in coordination with other M4A coordinators and departments.
• The Community Ombudsman Representative will increase the number of ombudsman volunteers who visit long-term care facilities and educate residents, family members, and long-term care employee on residents' rights.
• The Community Ombudsman Representative will continue to work with the Alabama Cares Coordinator on an annual caregiver workshop which focuses on a systemic long-term care but also educates attendees on residents' rights and elder rights.</td></tr>
<tr><th>Outcomes:</th><th>Progress</th><th>Next Steps</th></tr>
<tr><td>• The Ombudsman Program will have at least 3 additional volunteers by FY 2020 who are fully trained and assigned to facilities.</td><td></td><td></td></tr>
<tr><td>• Those who live and work in long-term care will have a greater awareness of elder abuse, what it is and how to report it, plus residents' rights and how to contact the Community Ombudsman Representative.</td><td></td><td></td></tr>
<tr><td>• More residents and their loved ones will be aware of the Ombudsman Program which will be measured by the number of outreach activities completed by the Community Ombudsman Representative, volunteers, and Advisory Council members; and by the number of closed or resolved cases.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 4.0: Enable more Alabamians to live with dignity by promoting elder rights and reducing the incidents of abuse, neglect, and exploitation.

OBJECTIVE 4.3: M4A will continue to expand dementia friendly communities and aging sensitivity.

- M4A will continue to participate in World Elder Abuse Awareness Day and Memory Screening events.
- M4A will continue to partner with local law enforcement, first responders, and Adult Protect Services in Shelby County to develop training programs and materials for a dementia friendly community. These materials will be made available throughout the M4A region and training will be offered to Sheriff's Offices in each of M4A's counties.
- M4A will sustain and expand Dementia Friendly Communities by disseminating law enforcement and first responder training materials and tools developed with funding from the Dementia Friendly mini-grant. In addition, in the summer of 2017, M4A had the opportunity to address law enforcement officers at the Alabama Sheriffs Association Summer Conference at Orange Beach. The response to M4A's training materials was positive and may open doors for full workshops at the Alabama Sheriffs Association Winter Conference in 2018. To help to sustain and expand this project, M4A is working with local law enforcement on strategies to train training officers. In addition, M4A plans to apply for another Dementia Friendly Communities mini-grant and M4A has applied for an Alzheimer's and dementia-related disorders grant from ACL.
- M4A will offer Virtual Dementia Tours in its region.
  M4A will disseminate materials developed from its dementia friendly mini-grant to other communities and provide technical assistance to implement dementia friendly communities throughout the region.

Outcomes:	Progress	Next Steps
• Communities in the M4A region will have a greater understanding of the aging process, dementia, and the needs of the elderly making M4A a more dementia friendly region.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

OBJECTIVE 5.1: M4A will increase the quality and accuracy of the data it collects.

Strategies:

- Full implementation of PeerPlace for ADRC and for SHIP. (M4A already ensures the quality of data in PeerPlace by monthly review of PeerPlace and AIMS reports).
- Implementation of FAMCare for Medicaid Waivers and for other programs which provide case management.
- Monthly review of FAMCare data.

Outcomes:	Progress	Next Steps
• Because M4A (and the other Area Agencies on Aging in Alabama) is undergoing preparation for NCQA (National Council for Quality Assurance) accreditation, M4A must address the need for tracking client outcomes, ensuring HIPAA compliance, and ensuring appropriate staff training which complement Goal 5. So, the Outcome M4A plans to achieve for Goal 5 and its Objectives is successful NCQA accreditation and compliance.		
• M4A will have reporting systems in place that capture and monitor outcomes.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

OBJECTIVE 5.2: M4A will improve the security and efficiency of the technology that supports the organization and safeguards electronic protected health information.

Strategies:

- M4A will require relevant IT training and certification of its IT Support/Security Officer and its Privacy Officer.
- M4A will provide annual HIPAA and confidentiality training to all employees.
- M4A will alert staff to security breaches and provide ongoing security training and reminders to guard against potential breaches.

Outcomes:	Progress	Next Steps
• All M4A staff members will have greater understanding of HIPAA compliance.		
• M4A staff members will know how to accurately input data into the reporting, case management and data gathering systems used by M4A.		
• M4A will have employees with relevant expertise to ensure M4A's compliance and the integrity of client and employee information.		

Area Plan Goals and Objectives Chart (Continued)

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

OBJECTIVE 5.3: M4A will improve its intra-organization communication.

<table>
<tr><td colspan="3">Strategies:
M4A will continue to provide its coordinators with annual program budgets, including fiscal and programmatic benchmarks, and copies of contracts or agreements. M4A will continue to have monthly staff meetings where information from ADSS is shared with staff members and where program information and staff training can take place. M4A will also continue to have monthly program meetings in which administrative and program staff meet to determine, in addition to other things, whether and how programmatic and fiscal goals are being met. During these meetings, Program Coordinators can also share concerns/opportunities/new ideas with the administrative team so that strategies can be developed to address concerns/share opportunities with other coordinators or leverage opportunities and partnerships/deny or approve new projects/develop plans for new projects
M4A will eliminate any unnecessary administrative layers so that staff members will have a clear chain of command.
Supervisors will be encouraged to meet with staff members regularly and administrative staff members will meet with all staff at least monthly but more often if necessary.
Information will be shared with all staff members either through email, memo, and/or at mandatory monthly staff meetings.
M4A's administrative team will respond proactively and promptly to concerns of program staff with clear actions.</td></tr>
<tr><td>Outcomes:</td><td>Progress</td><td>Next Steps</td></tr>
<tr><td>M4A will effectively address internal concerns about communication and any staff members feeling marginalized.</td><td></td><td></td></tr>
</table>

Area Plan Goals and Objectives Chart (Continued)

GOAL 5.0: Promote proactive, progressive management and accountability of State Unit on Aging and its contracting agencies.

OBJECTIVE 5.4: M4A will improve the expertise and professional growth opportunities of its employees.

<table>
<tr><td colspan="3">Strategies:
Program staff will be encouraged to explore state, regional or national workshops and conferences that will enhance their skillset, professional knowledge, or that will address a professional or client need for training and expertise.
Program staff members will be required to achieve CIRS-A/D certification and attend continuing education classes to maintain and enhance this certification.</td></tr>
<tr><td>Outcomes:</td><td>Progress</td><td>Next Steps</td></tr>
<tr><td>Improved employee morale by providing each employee the opportunity for professional growth.</td><td></td><td></td></tr>
</table>

Appendix C: M4A SWOT Analysis

In preparation for the Area Plan, M4A conducted a SWOT analysis in the form a survey. The survey was emailed to 54 recipients with 50% responding to some or all of the SWOT questions which included: What are M4A's strengths? What are M4A's weaknesses? What are M4A's threats? What opportunities do you see for M4A in the next 6 -12 months? What opportunities do you see for M4A in the next 1-3 years?

To the first question about strengths, M4A received 77 separate responses. These responses focused on the compassion that M4A employees incorporate into the case management and services provided to clients as well as the quality (experience, creativity, resourcefulness) of the staff members who provide the services. Another common strength cited by respondents was the openness and flexibility of M4A's leadership and the willingness of leadership to undertake new challenges. Other strengths of M4A were teamwork amongst staff; staff members' knowledge of other programs, services and resources; and the friendly atmosphere and teamwork at M4A. The most common strength cited by the respondents is that M4A and all its employees are focused on helping people which is at the heart of the mission and vision of M4A.

To the second question about weaknesses, M4A received 52 responses. Almost half of these responses (22) expressed respondents' concerns about funding which impact both employee salaries and M4A's ability to provide services to people on waiting lists. There were 8 responses that expressed concern about the limited ability of M4A to provide upward mobility for employees. Five responses addressed "attitude" and feelings of being "unappreciated" and treated "unfairly." Five other responses indicated that communication at M4A needs to be improved or strengthened.

To the third and fourth questions about opportunities, M4A received 57 and 52 responses, respectively. The responses for the 6-12 month opportunities and the 1-3 year opportunities were very similar. For example, about 50% of responses indicated that the greatest opportunities for M4A were in the change in HCBS (Medicaid Managed Care) and the necessity to create other funding streams in order to mitigate the vulnerability of the AAAs and in order to continue to meet the growing demand for OAA and other services. Change will provide opportunities for professional growth and professional opportunities. Plus, additional funding (diversifying funding streams) will increase services, enhance the quality of services, and increase client choice. About 30% of the survey responses cited partnerships, marketing and outreach to strengthen the M4A brand and to get the M4A message out as opportunities. Outreach and marketing will enhance opportunities for partnerships and allow M4A to expand and leverage existing partnerships creating additional opportunities for innovative and creative ways to serve M4A's service population and provide professional challenges, satisfaction, and growth to M4A employees.

For the last survey question, M4A received 48 responses. About 46% of the responses cited changes in Medicaid as the key threat. Related to this threat were other responses such as "loss of morale" and "fear" of what change entails such as changing the M4A business model, competing

with businesses, and the potential of losing one's job, and the necessity to upgrade professional skills, M4A IT, and operations.

Another 31% of responses expressed reduced funding or growth in M4A's service population as threats. Three responses expressed concern over the federal government making changes that would impact funding for services to the elderly and disabled.

Appendix D: Summary of Community Needs Assessment

M4A's 2017 Community Needs Assessment was developed and analyzed by Crystal Crim, Administrative Director, with the assistance of the M4A staff. The Community Needs Assessment ran from January 2017 through March 2017.

M4A Community Needs Assessment Results and Recommendations/Objectives

- To better understand the physical, social, economic, and environmental needs of those who are aging, disabled, and/or caregivers in M4A's five county region.
- To better understand how well current needs are being met.
- To better predict the types of needs those who are aging, disabled, and/or caregivers in M4A's five county region will face in the future.
- To better understand which services are known, utilized and needed in the community.
- To help M4A and other agencies develop services that will meet current and future needs.

Methods: The Community Needs Assessment was developed as a non-experimental, self-administered, cross-sectional assessment of service recipients in M4A's five county region. The assessment was primarily distributed to senior centers participants (homebound and congregate clients) located in M4A's region (Blount, Chilton, Shelby, St. Clair, and Walker counties), MWS clients, AL Cares clients, and Town Hall Meeting attendees. Staff also assisted by having friends and community members complete the assessment.

Results

A total of 243 individuals were surveyed between January 2017 and March 2017.

<u>Sociodemographic characteristics</u>

Age: Participants between the ages of 66 and 75 accounted for 33% of the group. Other represented ages were as followed: 20-34 at 1%, 35-44 at 4%, 45-55 at 6%, 56-65 at 17%, and 76 or older at 28%. 11% of the participants chose not to disclose their age.

Gender: The majority (66%) was female, 27% were male, 7% chose not to disclose.

Education: 8% of participants had less than high school education, 35% had a high school degree or GED, 7% attended some college, 7% had an associate's degree, 14% had a bachelor's degree, 7% had a graduate/master's degree, 1% had a doctoral or higher level degree and 21% chose not to disclose.

Income: 5% of participants had a total household monthly income of less than $750, 25% had between $751 and $1,499, 5% had between $1,500 and $1,999, 12% had between $2,000 and $2,999, 5% had between $3,000 and $3,999, 2% had between $4,000 and $4,999, 2% had between $5,000 and $5,999, 1% had $6,000 or more and 43% chose not to disclose.

Marital Status: 41% of participants reported being married, 12% reported being single or separated, 12% reported being divorced, 21% reported being widowed, and 14% chose not to disclose.

Caregiver Status

Of the participants assessed, 68% of participants reporting not being a caregiver, 14% chose not to answer, and 18% reported being a caregiver. Of those who reported being a caregiver, 31% reported caring for a parent or spouses parent(s), 38% reported caring for a spouse, 7% reported caring for a child under 18 years of age, 5% reported caring for an adult child, 3% reported caring for both a spouse and a grandchild, 5% reported caring for a sibling, 2% reported caring for a family member other than immediate family, 2% reported caring for a friend, and 7% chose not to disclose.

Needs

Top 5 Highest Overall Needs in M4A's 5 Counties: The assessment asked participants to identify 5 top needs they were aware of in their respective communities, such as needs they, their family members, friends, or community members may have.

- Transportation Assistance: 11%
- Meal Assistance: 9%
- Home Cleaning Service: 8.2%
- Help paying utility bills: 7.4%
- Home Repair Assistance: 7.4%

Highest Needs in Each County:

- Blount
    - Transportation Assistance: 11.4%
    - Meal Assistance: 10%
    - In-home care, Help paying utility bills, and Falls Prevention: 9%
- Chilton
    - Meal Assistance: 11%
    - Transportation Assistance: 9.5%
    - Home Cleaning Services: 9.3%
    - Help paying utility bills: 8%
    - In-home care: 6.4%
- Shelby
    - Transportation Assistance: 10%
    - Home Repair Assistance: 9.1%
    - Home Cleaning Services and Help paying utility bills: 7.4%
    - Meal Assistance: 7.2%
- St. Clair
    - Transportation Assistance: 12%
    - Meal Assistance: 8%
    - Home Repair Assistance and Falls Prevention: 7%
    - Home Cleaning Services, Help paying utility bills, and Social Activities: 6.5%
- Walker
    - Transportation Assistance: 15.5%
    - Home Cleaning Assistance: 11.5%
    - Meal Assistance: 11%

- o In-home care and Help paying utility bills: 7.4%

Recommendations

The assessment results identified similar needs among all five of M4A's counties. Future planning should account for these needs. Due to the low number of assessments, the Development and Marketing team should focus on increasing its outreach and promotional efforts in all five counties.

Current Efforts

FY 2016

- The Development and Marketing team developed and executed a 90-day Marketing plan. The results of the plan included an increase in calls to M4A. See Appendix A for the results of the Marketing plan.
- M4A began updating its website to be more user friendly.

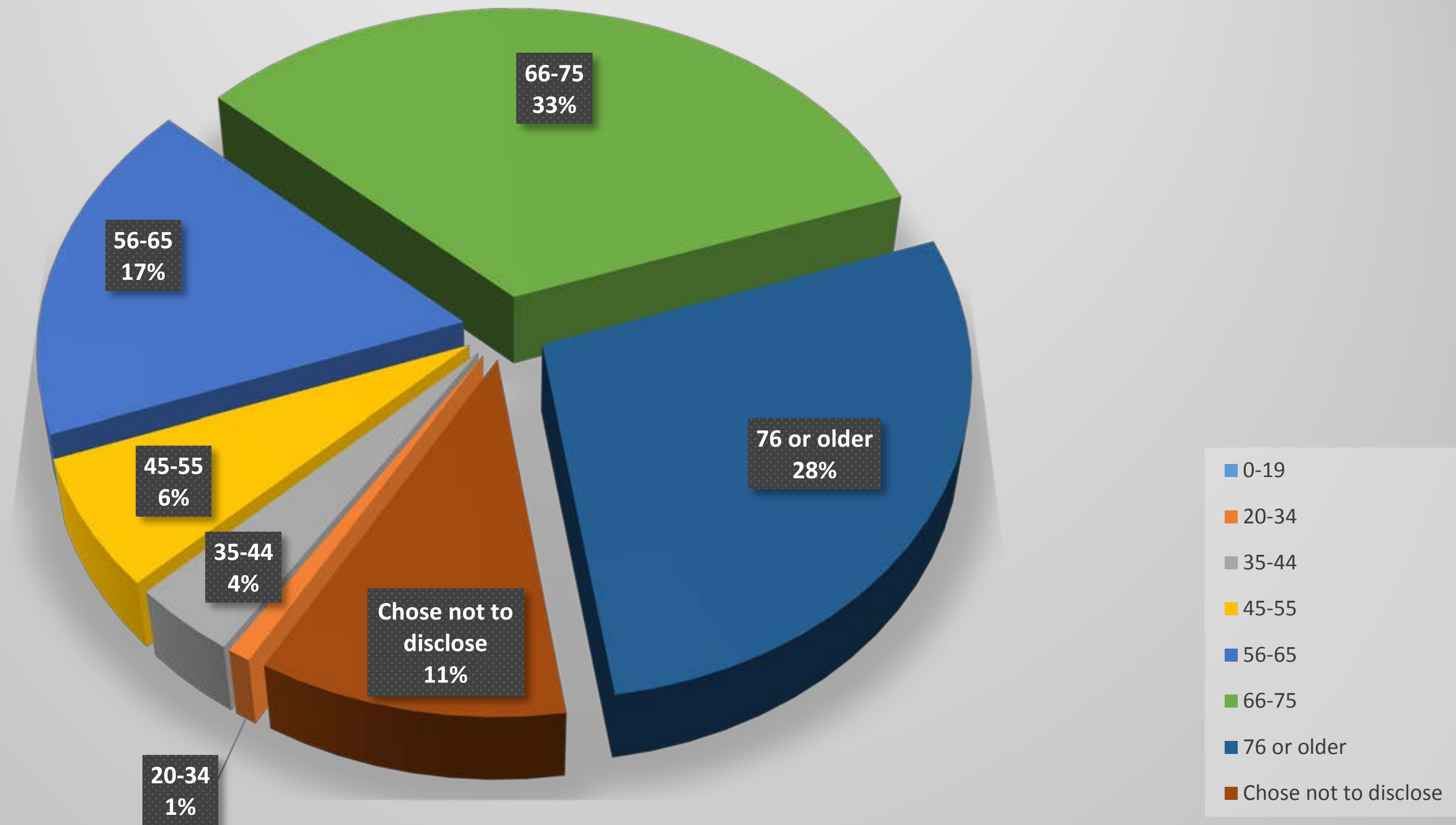
FY 2017

- The Development and Marketing team developed, and began distributing, "The Book." "The Book" is a resource guide that aims to educate M4A's service region about services and supports that M4A provides.
- The Nutrition and Transportation program increased its outreach efforts in FY 2017. M4A identified that St. Clair County clients account for the majority of clients on the Nutrition waiting list for M4A's 5 county service region. The Nutrition and Transportation Program is held its first annual "Senior Feeding Frenzy" in May 2017 in order to raise funds to assist St. Clair County clients on the nutrition waiting list. The event raised over $12,000. See Appendix B for the "Senior Feeding Frenzy" flyer and Appendix C for the WIAT News article by Jamie Ostroff.
- M4A met with county Advisory Council members in its service region and assessed their needs. Each county Advisory Council requested a listing of resources specific to their county and M4A began the development process. This process is set to complete in September 2017.

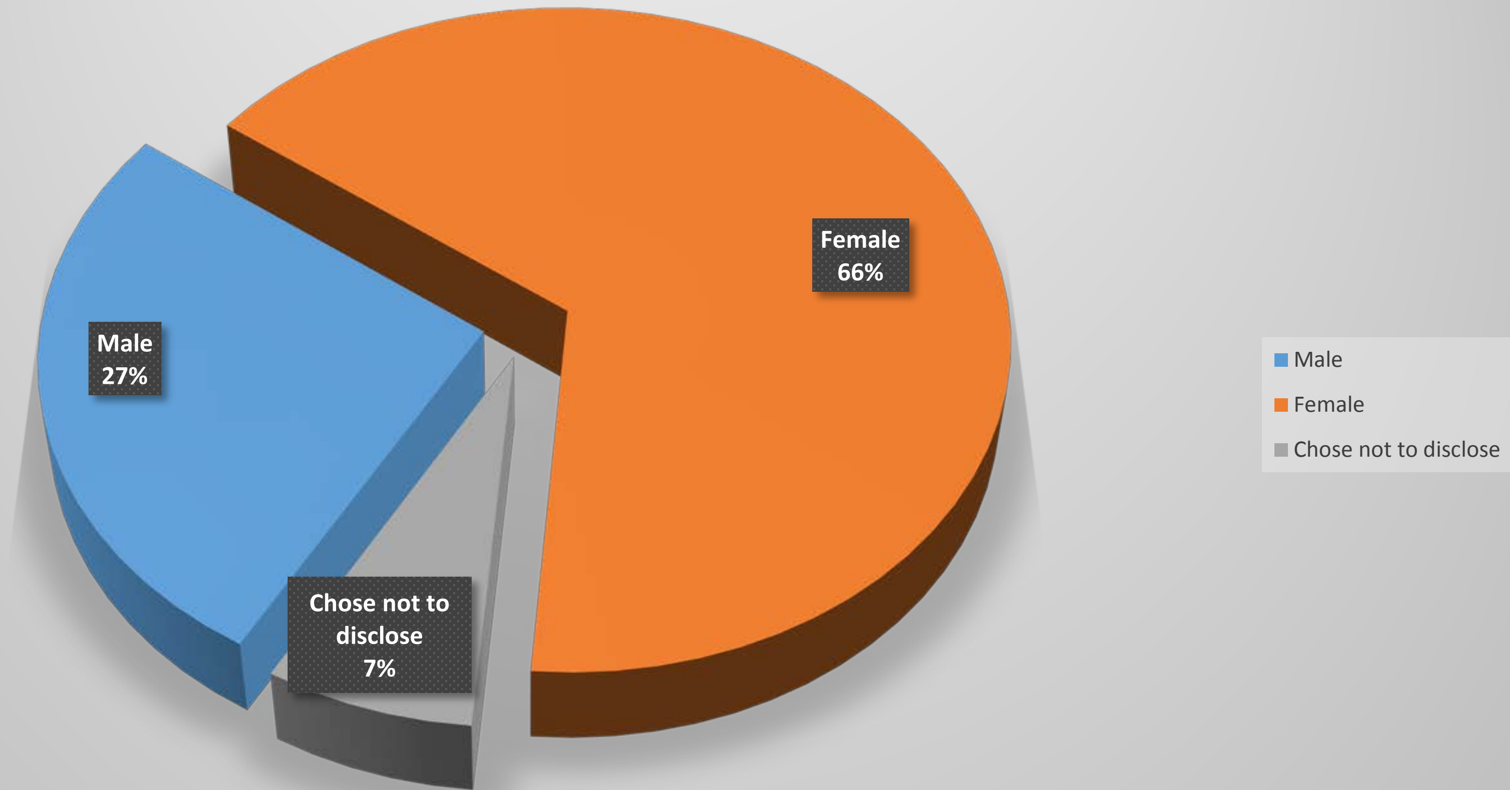
Other Recommendations

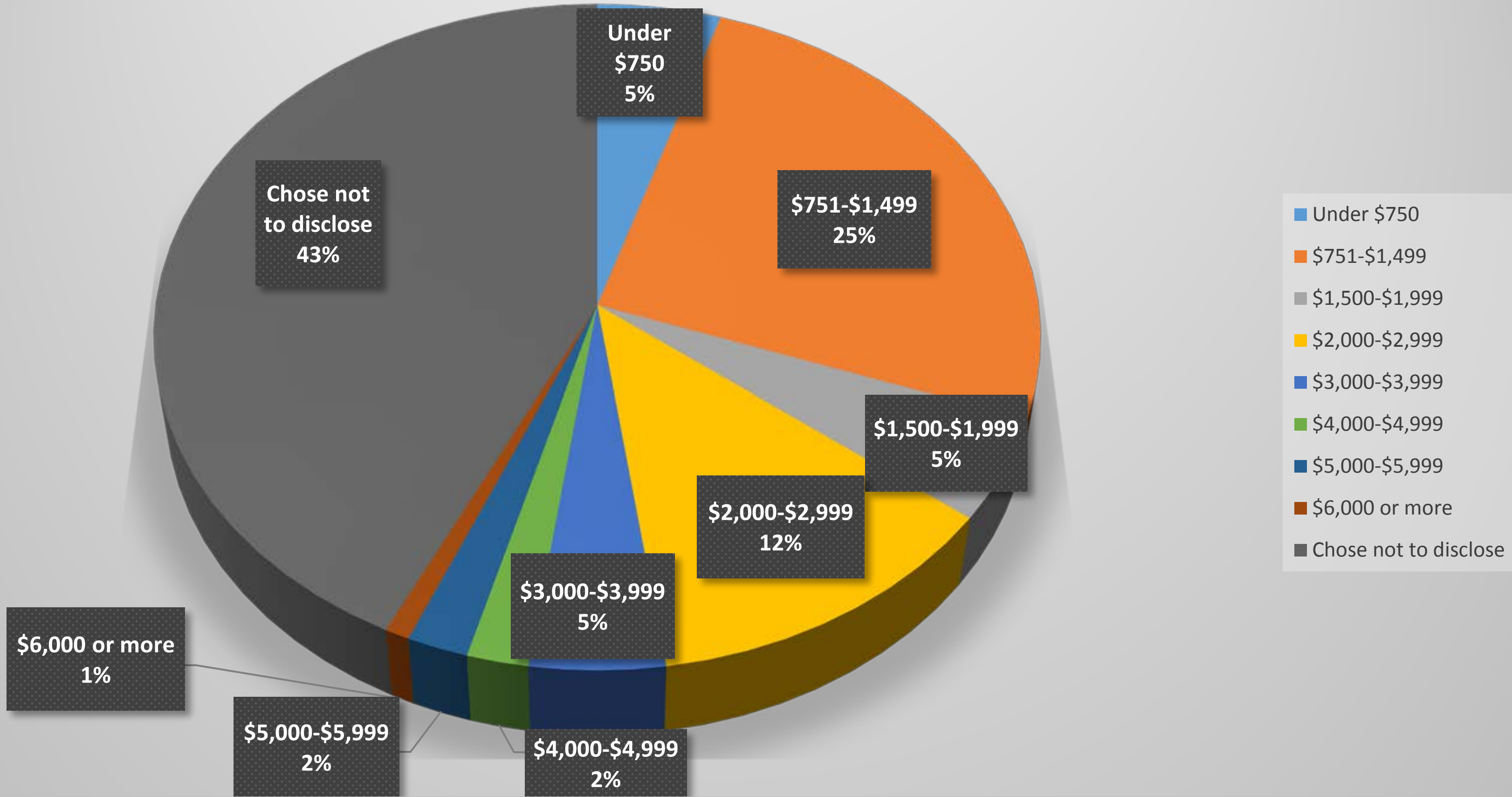
- Continue to conduct public awareness and service outreach to ensure older adults, persons with disabilities, and their caregivers are aware of the existing services, and know how to access these services.
- Continue to determine specific barriers to low participation in supportive services, especially for low-income individuals.
- Continue to seek new grants and revenue sources to support identified needs in each county.

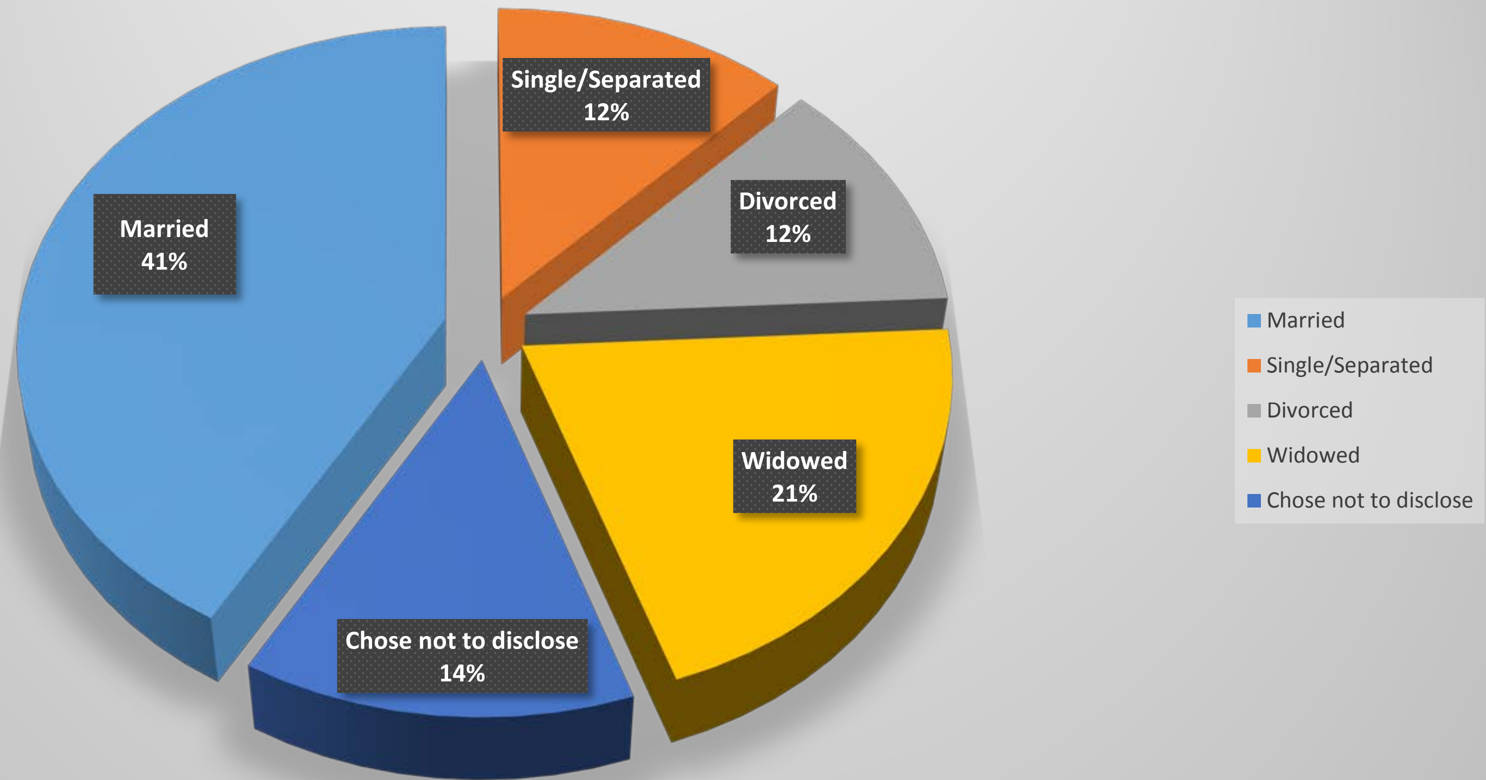
(See pages 193-199 for Community Needs Assessment Graphs.)

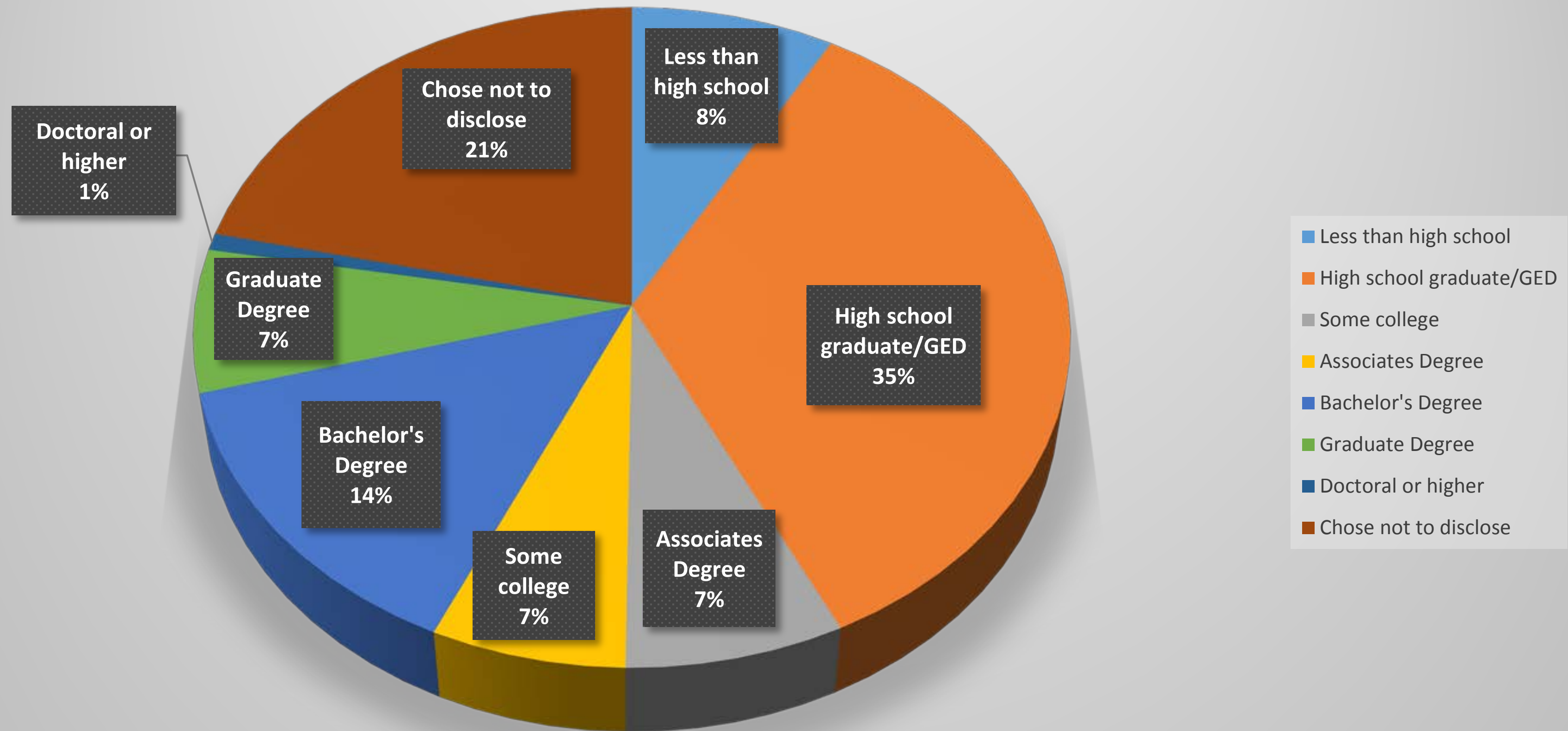


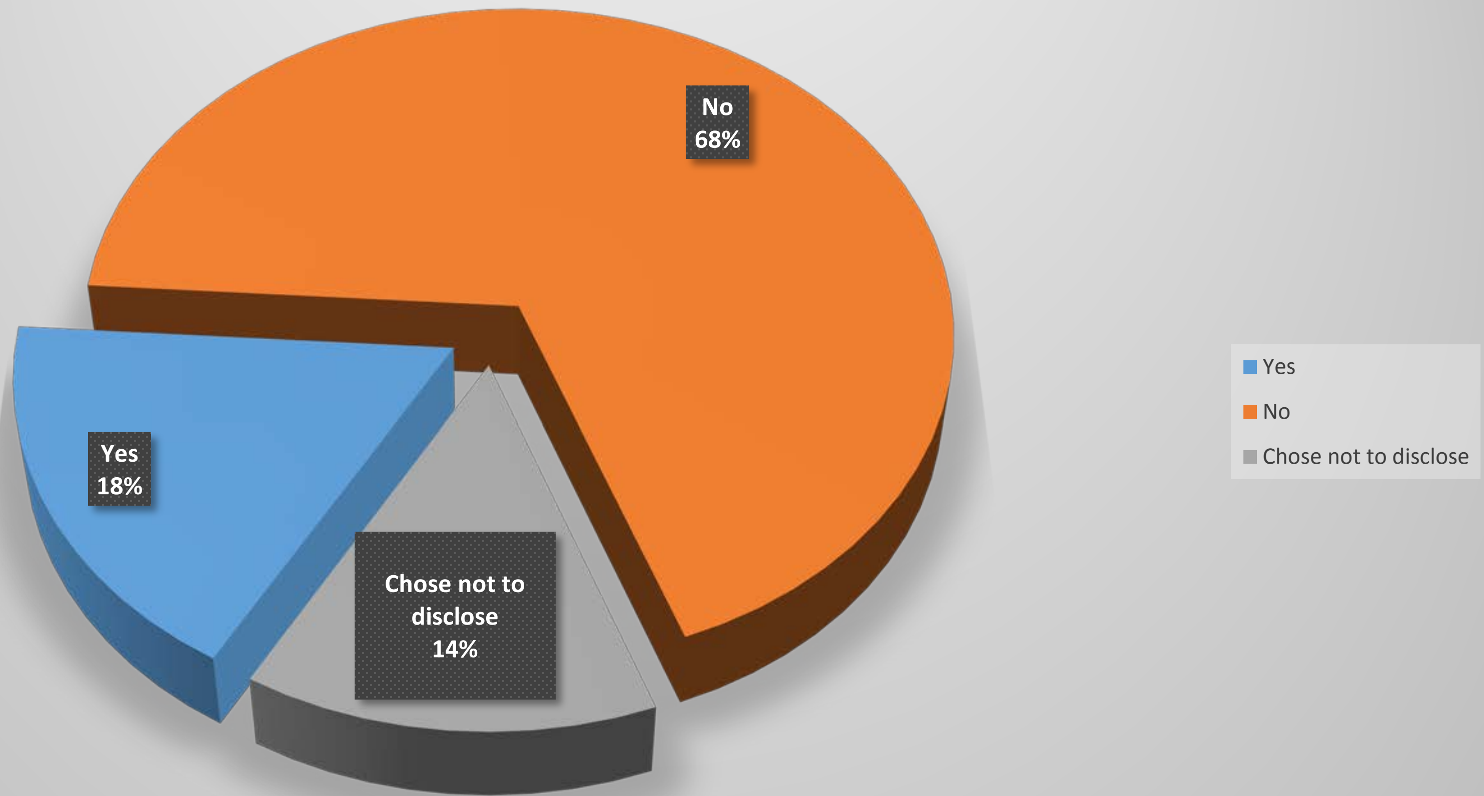
Age of each participant
66-75
33%
56-65
17%
76 or older
28%
45-55
6%
35-44
4%
Chose not to disclose
11%
20-34
1%
0-19
20-34
35-44
45-55
56-65
66-75
76 or older
Chose not to disclose

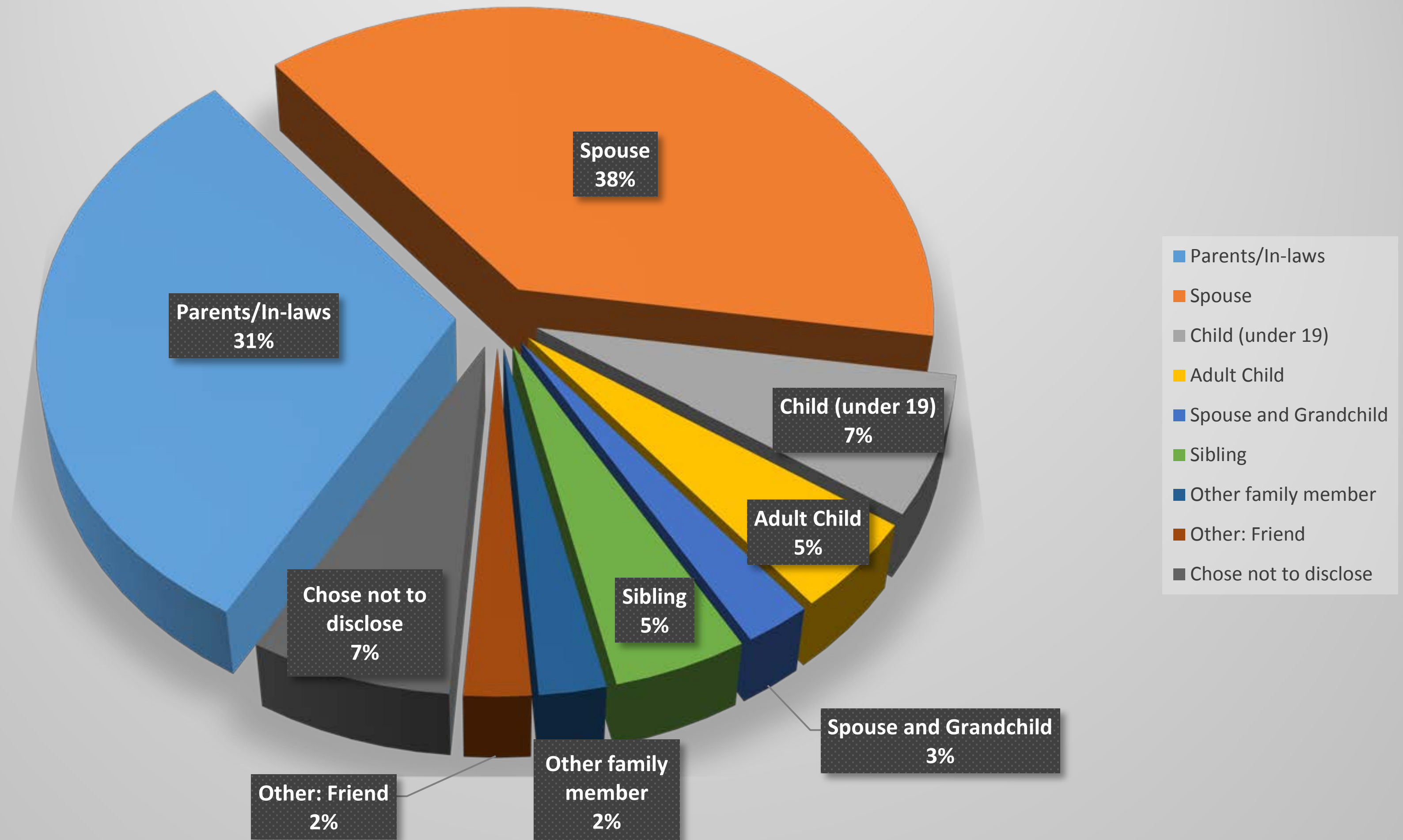

Gender of each participant
Female
66%
Male
27%
Chose not to
disclose
7%
Male
Female
Chose not to disclose


Average Monthly Income of each participant
Under $750 5%
$751-$1,499 25%
$1,500-$1,999 5%
$2,000-$2,999 12%
$3,000-$3,999 5%
$4,000-$4,999 2%
$5,000-$5,999 2%
$6,000 or more 1%
Chose not to disclose 43%
Under $750
$751-$1,499
$1,500-$1,999
$2,000-$2,999
$3,000-$3,999
$4,000-$4,999
$5,000-$5,999
$6,000 or more
Chose not to disclose


Marital of each participant
Single/Separated
12%
Divorced
12%
Married
41%
Widowed
21%
Chose not to disclose
14%
Married
Single/Separated
Divorced
Widowed
Chose not to disclose


Level of Education of each participant
Less than high school 8%
High school graduate/GED 35%
Associates Degree 7%
Some college 7%
Bachelor's Degree 14%
Graduate Degree 7%
Doctoral or higher 1%
Chose not to disclose 21%
Less than high school
High school graduate/GED
Some college
Associates Degree
Bachelor's Degree
Graduate Degree
Doctoral or higher
Chose not to disclose


Caregiver Status of each participant
No
68%
Yes
18%
Chose not to
disclose
14%
Yes
No
Chose not to disclose



Care recipient
Spouse
38%
Parents/In-laws
31%
Child (under 19)
7%
Adult Child
5%
Sibling
5%
Chose not to
disclose
7%
Spouse and Grandchild
3%
Other: Friend
2%
Other family
member
2%
Parents/In-laws
Spouse
Child (under 19)
Adult Child
Spouse and Grandchild
Sibling
Other family member
Other: Friend
Chose not to disclose

Appendix E: ADPH Health Status Indicators by County

Selected Health Status Indicators

Jointly produced to assist those seeking to improve health care in rural Alabama

By

The Office of Primary Care and Rural Health,
Alabama Department of Public Health
and
The Alabama Rural Health Association

Special thanks to the National Rural Health Association for funding assistance in the production of this publication.

April 2013

SELECTED HEALTH STATUS INDICATORS United States, Alabama, and Blount County						
Indicators	**United States**		**Alabama**		**Blount County**	
2011 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	311,591,917	100.0	4,802,740	100.0	57,677	100.0
African American (alone)	40,750,746	13.1	1,271,695	26.5	1,076	1.9
White (alone)	243,470,497	78.1	3,368,118	70.1	55,416	96.1
American Indian (alone)	3,814,772	1.2	33,298	0.7	359	0.6
Asian (alone)	15,578,383	5.0	57,155	1.2	124	0.2
Hispanic	52,045,277	16.7	193,868	4.0	4,936	8.6
Age 19 Years or Less	82,809,903	26.6	1,265,680	26.4	15,391	26.7
Age 65 Years or More	41,394,141	13.3	672,586	14.0	8,671	15.0
Age 85 Years or More	5,737,173	1.8	77,743	1.6	832	1.4
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2010	91,972,266 to 308,745,538	235.7	2,138,093 to 4,779,736	123.6	21,456 to 57,322	167.2
2010 – 2040 Projected	308,745,538 to 380,016,000	23.1	4,779,736 to 5,567,024	16.5	57,322 to 72,124	25.8
Age 65+: 2010 – 2040 Projected	40,267,984 to 79,719,000	98.0	657,792 to 1,199,853	82.4	8,439 to 16,680	97.7
Hispanic: 1990 – 2011	22,354,059 to 52,045,277	132.8	24,629 to 193,868	687.2	286 to 4,936	1,625.9
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2011	48,452,035	15.9%	896,117	19.1%	8,505	14.9%
Children Under 18 Below Poverty Level - 2011	16,386,500	22.5%	307,310	27.6%	3,094	22.2%
Population Under 200% Poverty Level (2006-2011)	97,686,522	32.7%	1,783,196	38.5%	20,716	36.5%
Per Capita Personal Income – 2011	N.A.	$41,560	N.A.	$34,880	N.A.	$27,220
Medicaid Eligible Population – 2011	N.A.	N.A.	1,070,781	22.3%	11,510	20.0%
Medicaid Eligible Children (Under 21) - 2011	N.A.	N.A.	618,137	46.9%	6,992	43.5%
Medicaid Births - 2011	N.A.	N.A.	31,498	53.1%	325	46.7%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Primary Care Physicians – 2012 (Per 10,000 Population)	208,807	6.8 (2010)	3,056	6.4	10	1.7
Dentists – 2013 (Per 10,000 Pop.)	155,700	5.0 (2010)	2,141	4.4	9	1.6
Psychiatrists – 2012 (Per 10,000 Pop.)	39,738	1.3	326	0.7	0	0.0
General Hospital Authorized Beds – 2013 (Per 10,000 Population)	N.A.	N.A.	16,475	34.3	40	6.9
Is there a hospital providing obstetrical service in the county?	N.A.	N.A.	YES in 31 counties NO in 36 counties		No	

2

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Blount County						
Indicators	**United States**		**Alabama**		**Blount County**	
Access to Health Care Indicators – continued	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Households With No Vehicle	10,397,000	9.1% (2010)	119,611	6.6% (2010)	775	3.7% (2008-2010)
Uninsured Population Under 65 Years of Age - 2010	46,556,803	17.7%	681,437	16.9%	9,351	19.3%
Dialysis Patients and Dialysis Patients per Dialysis Station – 2013	N.A	N.A.	7,584	3.2	25	2.1
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
All Causes	**7,418,471**	**800.9**	**143,493**	**1,000.6**	**1,692**	**981.4**
Septicemia	105,990	11.4	2,644	18.4	29	16.8
Cancer	**1,717,684**	**185.4**	**30,564**	**213.1**	**374**	**216.9**
Colon, Rectum, and Anus	157,259	17.0	2,694	18.8	29	16.8
Liver and Intrahepatic Bile Ducts	61,176	6.6	966	6.7	4	N.A.
Pancreas	109,887	11.9	1,813	12.6	23	13.3
Trachea, Bronchus, and Lung	473,090	51.1	9,644	67.2	135	78.3
Breast (female)	122,508	26.0	1,974	26.8	19	21.8
Prostate (male)	84,578	18.6	1,611	23.1	12	N.A.
Non-Hodgkin's Lymphoma	60,904	6.6	960	6.7	10	N.A.
Leukemia	68,157	7.4	1,148	8.0	10	N.A.
Diabetes Mellitus	211,058	22.8	3,840	26.8	23	13.3
Parkinson's Disease	65,704	7.1	1,075	7.5	9	N.A.
Alzheimer's Disease	247,188	26.7	4,498	31.4	25	14.5
Major Cardiovascular Diseases	**2,339,340**	**252.6**	**46,705**	**325.7**	**549**	**318.4**
Heart Diseases	**1,793,441**	**193.6**	**35,879**	**250.2**	**431**	**250.0**
Hypertensive Heart Disease	100,218	10.8	1,226	8.5	8	N.A.
Ischemic Heart Diseases	1,140,484	123.1	16,558	115.5	219	127.0
Acute Myocardial Infarction	367,267	39.7	7,593	52.9	108	62.6
Heart Failure	173,711	18.8	5,769	40.2	79	45.8
Cerebrovascular Diseases (Stroke)	387,249	41.8	7,786	54.3	99	57.4
Pneumonia	152,507	16.5	2,755	19.2	61	35.4
Chronic Lower Respiratory Diseases	418,815	45.2	8,498	59.3	130	75.4
Chronic Liver Disease and Cirrhosis	96,000	10.4	1,539	10.7	12	N.A.

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SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Blount County

Indicators	United States		Alabama		Blount County	
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
Nephritis, Nephrotic Syndrome, and Nephrosis	**145,142**	**15.7**	**3,410**	**23.8**	**35**	**20.3**
Renal Failure	131,884	14.2	3,183	22.2	34	19.7
Accidents	**361,657**	**39.0**	**7,307**	**51.0**	**97**	**56.3**
Motor Vehicle Accidents	106,225	11.5	2,723	19.0	34	19.7
Poisoning and Exposure to Noxious Substances	98,353	10.6	1,571	11.0	29	16.8
Intentional Self-Harm (suicide)	113,558	12.3	1,983	13.8	30	17.4
Assault (homicide)	49,011	5.3	1,181	8.2	10	N.A.

Causes of Death Groupings of Special Interest

Cause of Death Indicators	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.[1]
Firearm Deaths (intentional self-harm, assault, legal intervention, and undetermined intent)	95,182	10.3	2,387	16.6	26	15.1
Drug-Induced Deaths	119,779	12.9	1,812	12.6	30	17.4
Alcohol-Induced Deaths	76,466	8.3	748	5.2	7	N.A.

Cancer Incidence and Rates by Site and County

Indicators	United States		Alabama		Blount County	
Cancer Site	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.[1]**
All Sites	N.A.	N.A.	225,026	459.9	2,109	349.4
Lung	N.A.	N.A.	37,608	76.1	387	63.0
Colorectal	N.A.	N.A.	24,344	49.8	230	38.4
Oral	N.A.	N.A.	6,187	12.5	63	10.4
Melanoma	N.A.	N.A.	8,152	17.0	93	15.5
Prostate	N.A.	N.A.	33,711	155.8	277	98.5
Breast (Female, only)	N.A.	N.A.	31,171	117.3	275	84.9
Cervix	N.A.	N.A.	2,190	9.0	19	7.0

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SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Blount County

Indicators	United States		Alabama		Blount County	
Natality Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Infant Mortality 2009-2011 – (Per 1,000 Births)	74,908	6.2	1,516	8.3	11	5.2
Low Weight Births – 2011 (Percent of All Births)	325,563 (2010)	8.1 %	5,908	10.0 %	58	8.3%
Births to Teens (10-19) – 2011 (Percent of All Births)	372,175 (2010)	9.3 %	6,697	11.3 %	76	10.9%
Births With Less Than Adequate Prenatal Care – 2011 (Percent of All Births)	N.A.	N.A.	15,986	27.2 %	201	29.1%
Caesarian Births – 2011 (Percent of All Births)	1,309,182	32.8 %	20,980	35.4 %	241	34.6%
Tobacco Use During Pregnancy – 2011 (Percent of All Births)	N.A.	N.A.	6,289	10.6 %	116	16.7%
Births to Undereducated Women – 2011 (Percent of All Births)	N.A.	N.A.	9,295	15.7 %	126	18.2%
Births to Unmarried Women – 2011 (Percent of All Births)	1,633,471	40.8% (2010)	24,946	42.1%	198	28.5%
Preterm Births – 2009 - 2011 (Percent of All Births)	478,790	12.0% (2010)	29,096	16.0%	272	12.9%
Births for Which Diabetes was Reported as a Risk Factor – 2007-2011 (Per 1,000 Live Births)	201,218	50.5 (2010)	13,510	45.5	210	60.3
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 25+ With Less Than High School Education – 2007-2011	29,518,935	14.6 %	567,670	18.1 %	10,330	26.8%
Public School Graduation Rates - 2011	N.A.	78.0 % (2010)	45,221	71.8 %	581	81.5%
Receiving Medicare Disability – 2010 (Percent of Total Population)	7,735,377	2.5 %	203,252	4.3 %	1,870	3.3%
Adult Obesity – 2010 (Percent of Total Population Aged 20 Years or More)	56,369,496	25 %	1,153,068	33 %	13,347	32%
Adult Smoking - 2010 (Percent of Total Population Aged 18+ Years)	32,838,970	14 %	838,874	23 %	9,940	23%
Excessive Drinking - 2010 (Percent of Total Population Aged 18+ Years)	18,765,126	8 %	437,673	12 %	2,161	5%
Life Expectancy at Birth - 2011	78.7 years		75.7 years		75.6 years	
Sexually Transmitted Disease Cases Reported – January 2012 through March 2013 (Per 10,000 Pop.)	N.A.	N.A.	47,608	99.1	135	23.4

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SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Blount County						
Indicators	**United States**		**Alabama**		**Blount County**	
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
New HIV Cases – 2009 through 2011 (Per 100,000 Population) NOTE: Number of cases is not released in counties where this is less than five.	145,614	15.7	2,093	14.6	7	N.A.
Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation– October 2009 through September 2011 (Per 1,000 population Under Age 18)	N.A.	N.A.	39,581	17.5	428	15.2
Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 (Per 10,000 Adults Aged 18+ Years.	N.A.	N.A.	8,729	23.9	91	21.1

[1]Rates, percentages, etc based upon fewer than 16 events may not be statistically reliable for specific analyses. "N.A." is given for such indicators. Numbers of events, as well as measurements, are indicated using "N.A." for some indicators in accordance with the data owner's policy of not publishing smaller numbers of events.

Sources of Information and Special Notes

2011 Population Estimates: Alabama State Data Center, The University of Alabama, 2011 Population Estimates and Projections, http://cber.cba.ua.edu/edata/est_prj.html and, 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html

Population Change 1910-2010: U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2010 Summary File 1 (SF 1) 100-Percent Data for 2010 data.

Population Change 2000-2040: U.S. Census Bureau, National Population Projections, Interim Projections 2000-2050 based on Census 2000. http://www.census.gov/population/www/projections/natproj.html. Alabama State Data Center, Alabama County Population 2000-2010 and Projections 2015-2040. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2011: U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data and 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html.

Population Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Children Under 18 Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Population Under 200% Poverty Level (2006-2011): American Community Survey, 5-year data for 2007-2011, Table C17002.

2011 Per Capita Personal Income: U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/iTable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1

Medicaid Eligible Population - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Eligible Children (Under 21) - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Primary Care Physicians in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association's 2010 Physician Master File. National data was obtained from the Agency for Healthcare Research and Quality's on-line publication, Primary Care Workforce Facts and Stats #1, at http://www.ahrq.gov/research/pcwork1.htm. All data has been adjusted to exclude licensed retirees and include only those actively practicing primary care. (In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, gerontologists, and obstetricians and gynecologists.)

Dentists in 2013: Board of Dental Examiners of Alabama, Licensed dentists data base - 2013. National data is for 2010 and is obtained from the Bureau of Labor Statistics at http://www.bls.gov/emp/ep_table_102.htm.

Psychiatrists in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association, Physician Characteristics and Distribution in the US 2012, Table 1.2.

Hospital Beds in 2013: Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. March 21, 2013. http://www.adph.org/HEALTHCAREFACILITIES/Default.asp?id=5349.

Obstetrical Hospitals: Center for Health Statistics 2013 Birth Master File, special inquiry, February 28, 2013.

Households With No Vehicle in 2010: U.S. Census Bureau, American FactFinder, American Community Survey – 2010 or 2008-2010 or 2006-2010, Table B08210 – Household Size by Vehicles Available. Estimates are for 1-year, 3-years, or 5-years according to the population of each county.

Uninsured Persons Under Age 65 - 2010: U.S. Census Bureau, Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States. http://www.census.gov/did/www/sahie/index.html

Dialysis Patients and Dialysis Patients per Dialysis Station – 2013: Dialysis patients data by county was obtained by special request from Network 8, Inc. (http://www.esrdnetwork8.org) dated May 31, 2011. Dialysis stations by county was obtained from the *Healthcare Facilities Directory*, Alabama Department of Public Health (http://ph.state.al.us/facilitiesdirectory/(S(qc1vsw45hfl2iw45vbzbwini))/Default.aspx).

Cause of Death Indicators: Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2009, 2010, and 2011 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Detailed Mortality files for 2009 and 2010 (http://wonder.cdc.gov/). Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 2. (Cause of death data included in this publication is not age-adjusted)

Cancer Incidence and Rates by Site and County – Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry, Alabama Department of Public Health, Tables 3, 4, and 5. http://www.adph.org/ascr/assets/2011FactsFigures.pdf

Infant Mortality Rate - 2009-2011; Alabama Department of Public Health, Center for Health Statistics, http://www.adph.org/healthstats/assets/Total_Inf_Mort09_11.pdf. National Data: CDC WONDER Online Data Inquiry System, 2009 and 2010 Birth and Detailed Mortality data, http://wonder.cdc.gov/, National Vital Statistics Reports, Deaths: Preliminary Data for 2011, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf and Recent Trends in Births and Fertility Rates Through December 2011, http://www.cdc.gov/nchs/data/hestat/births_fertility_december_2011/births_fertility_december_2011.pdf.

Low Weight Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births. (Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Less Than Adequate Prenatal Care - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Caesarian Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Tobacco Use During Pregnancy - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Births to Undereducated Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Births to Unmarried Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Preterm Births – 2009 - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2009-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf Preterm births are those with a calculated gestation of less than 37 full weeks of pregnancy.

Births for Which Diabetes was Reported as a Risk Factor – 2007- 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2007-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Age 25+ With Less Than High School Education – 2007-2011: U.S. Census Bureau, American FactFinder, American Community Survey for 2007-2011, Table B15002.

Public School Graduation Rates – 2011: Alabama Kids Count Data Book – 2012, pp.31-98. http://www.alavoices.org/files/12_AKC-DataBook.pdf National data: National Center for Education Statistics.
The number of students who graduated from public high schools in Alabama in 2011 with regular, advanced, and credit-based diplomas expressed as a percentage of the total number of students who enrolled as first year freshmen four years earlier (or in 2007-2008). While the denominator used in computing the rate includes graduates, completers, students still enrolled, students withdrawn but still enrolled, students who enrolled but failed to attend, dropouts, and "others," it does not include students in the class of 2007-2008 who were retained from later classes. Data are adjusted for students who transferred into, and out of, the cohort over the four-year period. This method of measuring the graduation rate is referred to as the "four-year cohort graduation rate" and reflects efforts to conform to the National Governor's Association recommendation in 2005 that states implement a common measure of graduation beginning with the 2010-2011 academic year. However, the methodology used in computing the cohort graduation rate remains subject to variation from one state to another

Persons Receiving Medicare Disability - 2010: Centers for Medicare and Medicaid Services, Medicare Aged and Disabled by State and County as of July 1, 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Adult Obesity - Percent of Population Aged 20+ in 2010: County Health Rankings & Roadmaps. The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2. Estimates of obesity prevalence by county were calculated by the CDC's National

Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Adult Smoking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Excessive Drinking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Life Expectancy at Birth - 2011: Alabama Department of Public Health, Center for Health Statistics, special request and Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 6.

Sexually Transmitted Disease Cases – January 2011 through March 2012: Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, 2011 and 2012. http://www.adph.org/STD/Default.asp?id=1080

New HIV Cases – 2009 through 2011: Alabama Department of Public Health (ADPH), HIV Surveillance Branch. Any analyses, interpretation or conclusions reached from this data are those of the user and not the HIV Surveillance Branch. National data: HIV Surveillance Report, Diagnosis of HIV Infection in the United States and Dependent Areas, 2011, Vol.23, Table 1a. Note that national data is estimated to account for reporting delays and missing transmission.

Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation – October 2009 through September 2011: Alabama Department of Human Resources, Child Protective Services, special request for FY 2010 and FY 2011. Please note that it is possible for there to be more than one report on the same family and the number of reports does not correspond with the number of children since reports can involve more than one child in a family.

Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 : Alabama Department of Human Resources, Adult Protective Services, special request for FY 2011 and FY 2012. Please note that it is possible for there to be more than one report on the same adult.

This and other county reports are available online at www. Arhaonline.org or www.adph.org/ruralhealth/

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For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 546-3502.

Selected Health Status Indicators

CHILTON COUNTY

Jointly produced to assist those seeking to improve health care in rural Alabama

By

The Office of Primary Care and Rural Health,
Alabama Department of Public Health
and
The Alabama Rural Health Association

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April 2013

SELECTED HEALTH STATUS INDICATORS
United States, Alabama, and Chilton County

Indicators	United States		Alabama		Chilton County	
2011 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	311,591,917	100.0	4,802,740	100.0	43,895	100.0
African American (alone)	40,750,746	13.1	1,271,695	26.5	4,527	10.3
White (alone)	243,470,497	78.1	3,368,118	70.1	38,479	87.7
American Indian (alone)	3,814,772	1.2	33,298	0.7	226	0.5
Asian (alone)	15,578,383	5.0	57,155	1.2	152	0.3
Hispanic	52,045,277	16.7	193,868	4.0	3,411	7.8
Age 19 Years or Less	82,809,903	26.6	1,265,680	26.4	11,923	27.2
Age 65 Years or More	41,394,141	13.3	672,586	14.0	6,186	14.1
Age 85 Years or More	5,737,173	1.8	77,743	1.6	639	1.5
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2010	91,972,266 to 308,745,538	235.7	2,138,093 to 4,779,736	123.6	23,187 to 43,643	88.2
2010 – 2040 Projected	308,745,538 to 380,016,000	23.1	4,779,736 to 5,567,024	16.5	43,643 to 54,720	25.4
Age 65+: 2010 – 2040 Projected	40,267,984 to 79,719,000	98.0	657,792 to 1,199,853	82.4	5,921 to 10,760	81.7
Hispanic: 1990 – 2011	22,354,059 to 52,045,277	132.8	24,629 to 193,868	687.2	116 to 3,411	2,840.5
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2011	48,452,035	15.9%	896,117	19.1%	7,940	18.3%
Children Under 18 Below Poverty Level - 2011	16,386,500	22.5%	307,310	27.6%	3,048	28.4%
Population Under 200% Poverty Level (2006-2011)	97,686,522	32.7%	1,783,196	38.5%	17,726	41.2%
Per Capita Personal Income – 2011	N.A.	$41,560	N.A.	$34,880	N.A.	$28,844
Medicaid Eligible Population – 2011	N.A.	N.A.	1,070,781	22.3%	10,967	25.0%
Medicaid Eligible Children (Under 21) - 2011	N.A.	N.A.	618,137	46.9%	6,617	53.2%
Medicaid Births - 2011	N.A.	N.A.	31,498	53.1%	320	57.3%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Primary Care Physicians – 2012 (Per 10,000 Population)	208,807	6.8 (2010)	3,056	6.4	13	3.0
Dentists – 2013 (Per 10,000 Pop.)	155,700	5.0 (2010)	2,141	4.4	7	1.6
Psychiatrists – 2012 (Per 10,000 Pop.)	39,738	1.3	326	0.7	0	0.0
General Hospital Authorized Beds – 2013 (Per 10,000 Population)	N.A.	N.A.	16,475	34.3	0	0.0
Is there a hospital providing obstetrical service in the county?	N.A.	N.A.	YES in 31 counties NO in 36 counties		No	

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Chilton County						
Indicators	**United States**		**Alabama**		**Chilton County**	
Access to Health Care Indicators – continued	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Households With No Vehicle	10,397,000	9.1% (2010)	119,611	6.6% (2010)	603	3.7% (2008-2010)
Uninsured Population Under 65 Years of Age - 2010	46,556,803	17.7%	681,437	16.9%	7,481	20.0%
Dialysis Patients and Dialysis Patients per Dialysis Station – 2013	N.A	N.A.	7,584	3.2	36	3.0
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
All Causes	**7,418,471**	**800.9**	**143,493**	**1,000.6**	**1,388**	**1,060.0**
Septicemia	105,990	11.4	2,644	18.4	27	20.6
Cancer	**1,717,684**	**185.4**	**30,564**	**213.1**	**289**	**220.7**
Colon, Rectum, and Anus	157,259	17.0	2,694	18.8	22	16.8
Liver and Intrahepatic Bile Ducts	61,176	6.6	966	6.7	10	N.A.
Pancreas	109,887	11.9	1,813	12.6	15	N.A.
Trachea, Bronchus, and Lung	473,090	51.1	9,644	67.2	103	78.7
Breast (female)	122,508	26.0	1,974	26.8	12	N.A.
Prostate (male)	84,578	18.6	1,611	23.1	12	N.A.
Non-Hodgkin's Lymphoma	60,904	6.6	960	6.7	17	13.0
Leukemia	68,157	7.4	1,148	8.0	11	N.A.
Diabetes Mellitus	211,058	22.8	3,840	26.8	20	15.3
Parkinson's Disease	65,704	7.1	1,075	7.5	14	N.A.
Alzheimer's Disease	247,188	26.7	4,498	31.4	35	26.7
Major Cardiovascular Diseases	**2,339,340**	**252.6**	**46,705**	**325.7**	**445**	**339.8**
Heart Diseases	**1,793,441**	**193.6**	**35,879**	**250.2**	**363**	**277.2**
Hypertensive Heart Disease	100,218	10.8	1,226	8.5	8	N.A.
Ischemic Heart Diseases	1,140,484	123.1	16,558	115.5	194	148.2
Acute Myocardial Infarction	367,267	39.7	7,593	52.9	124	94.7
Heart Failure	173,711	18.8	5,769	40.2	56	42.8
Cerebrovascular Diseases (Stroke)	387,249	41.8	7,786	54.3	66	50.4
Pneumonia	152,507	16.5	2,755	19.2	47	35.9
Chronic Lower Respiratory Diseases	418,815	45.2	8,498	59.3	108	82.5
Chronic Liver Disease and Cirrhosis	96,000	10.4	1,539	10.7	9	N.A.

SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Chilton County

Indicators	United States		Alabama		Chilton County	
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
Nephritis, Nephrotic Syndrome, and Nephrosis	**145,142**	**15.7**	**3,410**	**23.8**	**27**	**20.6**
Renal Failure	131,884	14.2	3,183	22.2	24	18.3
Accidents	**361,657**	**39.0**	**7,307**	**51.0**	**74**	**56.5**
Motor Vehicle Accidents	106,225	11.5	2,723	19.0	26	19.9
Poisoning and Exposure to Noxious Substances	98,353	10.6	1,571	11.0	25	19.1
Intentional Self-Harm (suicide)	113,558	12.3	1,983	13.8	26	19.9
Assault (homicide)	49,011	5.3	1,181	8.2	8	N.A.

Causes of Death Groupings of Special Interest

Cause of Death Indicators	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.[1]
Firearm Deaths (intentional self-harm, assault, legal intervention, and undetermined intent)	95,182	10.3	2,387	16.6	25	19.1
Drug-Induced Deaths	119,779	12.9	1,812	12.6	25	19.1
Alcohol-Induced Deaths	76,466	8.3	748	5.2	7	N.A.

Cancer Incidence and Rates by Site and County

Indicators	United States		Alabama		Chilton County	
Cancer Site	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.[1]**
All Sites	N.A.	N.A.	225,026	459.9	1,808	409.3
Lung	N.A.	N.A.	37,608	76.1	359	80.1
Colorectal	N.A.	N.A.	24,344	49.8	178	40.7
Oral	N.A.	N.A.	6,187	12.5	52	11.5
Melanoma	N.A.	N.A.	8,152	17.0	72	16.4
Prostate	N.A.	N.A.	33,711	155.8	241	117.9
Breast (Female, only)	N.A.	N.A.	31,171	117.3	237	101.4
Cervix	N.A.	N.A.	2,190	9.0	19	9.2

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Chilton County						
Indicators	**United States**		**Alabama**		**Chilton County**	
Natality Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Infant Mortality 2009-2011 – (Per 1,000 Births)	74,908	6.2	1,516	8.3	16	9.3
Low Weight Births – 2011 (Percent of All Births)	325,563 (2010)	8.1 %	5,908	10.0 %	60	10.7%
Births to Teens (10-19) – 2011 (Percent of All Births)	372,175 (2010)	9.3 %	6,697	11.3 %	78	14.0%
Births With Less Than Adequate Prenatal Care – 2011 (Percent of All Births)	N.A.	N.A.	15,986	27.2 %	224	40.1%
Caesarian Births – 2011 (Percent of All Births)	1,309,182	32.8 %	20,980	35.4 %	178	31.8%
Tobacco Use During Pregnancy – 2011 (Percent of All Births)	N.A.	N.A.	6,289	10.6 %	100	17.9%
Births to Undereducated Women – 2011 (Percent of All Births)	N.A.	N.A.	9,295	15.7 %	114	20.4%
Births to Unmarried Women – 2011 (Percent of All Births)	1,633,471	40.8% (2010)	24,946	42.1%	161	28.8%
Preterm Births – 2009 - 2011 (Percent of All Births)	478,790	12.0% (2010)	29,096	16.0%	254	14.7%
Births for Which Diabetes was Reported as a Risk Factor – 2007-2011 (Per 1,000 Live Births)	201,218	50.5 (2010)	13,510	45.5	140	50.1
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 25+ With Less Than High School Education – 2007-2011	29,518,935	14.6 %	567,670	18.1 %	7,270	25.2%
Public School Graduation Rates - 2011	N.A.	78.0 % (2010)	45,221	71.8 %	454	73.1%
Receiving Medicare Disability – 2010 (Percent of Total Population)	7,735,377	2.5 %	203,252	4.3 %	1,793	4.1%
Adult Obesity – 2010 (Percent of Total Population Aged 20 Years or More)	56,369,496	25 %	1,153,068	33 %	11,057	35%
Adult Smoking - 2010 (Percent of Total Population Aged 18+ Years)	32,838,970	14 %	838,874	23 %	7,517	23%
Excessive Drinking - 2010 (Percent of Total Population Aged 18+ Years)	18,765,126	8 %	437,673	12 %	3,268	10%
Life Expectancy at Birth - 2011	78.7 years		75.7 years		74.5 years	
Sexually Transmitted Disease Cases Reported – January 2012 through March 2013 (Per 10,000 Pop.)	N.A.	N.A.	47,608	99.1	197	44.9

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Chilton County						
Indicators	**United States**		**Alabama**		**Chilton County**	
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
New HIV Cases – 2009 through 2011 (Per 100,000 Population) NOTE: Number of cases is not released in counties where this is less than five.	145,614	15.7	2,093	14.6	7	N.A.
Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation– October 2009 through September 2011 (Per 1,000 population Under Age 18)	N.A.	N.A.	39,581	17.5	262	12.0
Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 (Per 10,000 Adults Aged 18+ Years.	N.A.	N.A.	8,729	23.9	71	21.7

[1]Rates, percentages, etc based upon fewer than 16 events may not be statistically reliable for specific analyses. "N.A." is given for such indicators. Numbers of events, as well as measurements, are indicated using "N.A." for some indicators in accordance with the data owner's policy of not publishing smaller numbers of events.

Sources of Information and Special Notes

2011 Population Estimates: Alabama State Data Center, The University of Alabama, 2011 Population Estimates and Projections, http://cber.cba.ua.edu/edata/est_prj.html and, 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html

Population Change 1910-2010: U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2010 Summary File 1 (SF 1) 100-Percent Data for 2010 data.

Population Change 2000-2040: U.S. Census Bureau, National Population Projections, Interim Projections 2000-2050 based on Census 2000. http://www.census.gov/population/www/projections/natproj.html. Alabama State Data Center, Alabama County Population 2000-2010 and Projections 2015-2040. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2011: U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data and 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html.

Population Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Children Under 18 Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Population Under 200% Poverty Level (2006-2011): American Community Survey, 5-year data for 2007-2011, Table C17002.

2011 Per Capita Personal Income: U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/iTable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1

Medicaid Eligible Population - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Eligible Children (Under 21) - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Primary Care Physicians in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association's 2010 Physician Master File. National data was obtained from the Agency for Healthcare Research and Quality's on-line publication, Primary Care Workforce Facts and Stats #1, at http://www.ahrq.gov/research/pcwork1.htm. All data has been adjusted to exclude licensed retirees and include only those actively practicing primary care. (In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, gerontologists, and obstetricians and gynecologists.)

Dentists in 2013: Board of Dental Examiners of Alabama, Licensed dentists data base - 2013. National data is for 2010 and is obtained from the Bureau of Labor Statistics at http://www.bls.gov/emp/ep_table_102.htm.

Psychiatrists in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association, Physician Characteristics and Distribution in the US 2012, Table 1.2.

Hospital Beds in 2013: Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. March 21, 2013. http://www.adph.org/HEALTHCAREFACILITIES/Default.asp?id=5349.

Obstetrical Hospitals: Center for Health Statistics 2013 Birth Master File, special inquiry, February 28, 2013.

Households With No Vehicle in 2010: U.S. Census Bureau, American FactFinder, American Community Survey – 2010 or 2008-2010 or 2006-2010, Table B08210 – Household Size by Vehicles Available. Estimates are for 1-year, 3-years, or 5-years according to the population of each county.

Uninsured Persons Under Age 65 - 2010: U.S. Census Bureau, Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States. http://www.census.gov/did/www/sahie/index.html

Dialysis Patients and Dialysis Patients per Dialysis Station – 2013: Dialysis patients data by county was obtained by special request from Network 8, Inc. (http://www.esrdnetwork8.org) dated May 31, 2011. Dialysis stations by county was obtained from the *Healthcare Facilities Directory*, Alabama Department of Public Health (http://ph.state.al.us/facilitiesdirectory/(S(qc1vsw45hfl2iw45vbzbwini))/Default.aspx).

Cause of Death Indicators: Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2009, 2010, and 2011 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Detailed Mortality files for 2009 and 2010 (http://wonder.cdc.gov/). Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 2. (Cause of death data included in this publication is not age-adjusted)

Cancer Incidence and Rates by Site and County – Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry, Alabama Department of Public Health, Tables 3, 4, and 5. http://www.adph.org/ascr/assets/2011FactsFigures.pdf

Infant Mortality Rate - 2009-2011; Alabama Department of Public Health, Center for Health Statistics, http://www.adph.org/healthstats/assets/Total_Inf_Mort09_11.pdf. National Data: CDC WONDER Online Data Inquiry System, 2009 and 2010 Birth and Detailed Mortality data, http://wonder.cdc.gov/, National Vital Statistics Reports, Deaths: Preliminary Data for 2011, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf and Recent Trends in Births and Fertility Rates Through December 2011, http://www.cdc.gov/nchs/data/hestat/births_fertility_december_2011/births_fertility_december_2011.pdf.

Low Weight Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births. (Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Less Than Adequate Prenatal Care - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Caesarian Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Tobacco Use During Pregnancy - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Births to Undereducated Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.
(Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Births to Unmarried Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Preterm Births – 2009 - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2009-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf
Preterm births are those with a calculated gestation of less than 37 full weeks of pregnancy.

Births for Which Diabetes was Reported as a Risk Factor – 2007- 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2007-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Age 25+ With Less Than High School Education – 2007-2011: U.S. Census Bureau, American FactFinder, American Community Survey for 2007-2011, Table B15002.

Public School Graduation Rates – 2011: Alabama Kids Count Data Book – 2012, pp.31-98. http://www.alavoices.org/files/12_AKC-DataBook.pdf National data: National Center for Education Statistics.
The number of students who graduated from public high schools in Alabama in 2011 with regular, advanced, and credit-based diplomas expressed as a percentage of the total number of students who enrolled as first year freshmen four years earlier (or in 2007-2008). While the denominator used in computing the rate includes graduates, completers, students still enrolled, students withdrawn but still enrolled, students who enrolled but failed to attend, dropouts, and "others," it does not include students in the class of 2007-2008 who were retained from later classes. Data are adjusted for students who transferred into, and out of, the cohort over the four-year period. This method of measuring the graduation rate is referred to as the "four-year cohort graduation rate" and reflects efforts to conform to the National Governor's Association recommendation in 2005 that states implement a common measure of graduation beginning with the 2010-2011 academic year. However, the methodology used in computing the cohort graduation rate remains subject to variation from one state to another

Persons Receiving Medicare Disability - 2010: Centers for Medicare and Medicaid Services, Medicare Aged and Disabled by State and County as of July 1, 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Adult Obesity - Percent of Population Aged 20+ in 2010: County Health Rankings & Roadmaps. The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2. Estimates of obesity prevalence by county were calculated by the CDC's National

Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Adult Smoking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Excessive Drinking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Life Expectancy at Birth - 2011: Alabama Department of Public Health, Center for Health Statistics, special request and Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 6.

Sexually Transmitted Disease Cases – January 2011 through March 2012: Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, 2011 and 2012. http://www.adph.org/STD/Default.asp?id=1080

New HIV Cases – 2009 through 2011: Alabama Department of Public Health (ADPH), HIV Surveillance Branch. Any analyses, interpretation or conclusions reached from this data are those of the user and not the HIV Surveillance Branch. National data: HIV Surveillance Report, Diagnosis of HIV Infection in the United States and Dependent Areas, 2011, Vol.23, Table 1a. Note that national data is estimated to account for reporting delays and missing transmission.

Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation – October 2009 through September 2011: Alabama Department of Human Resources, Child Protective Services, special request for FY 2010 and FY 2011. Please note that it is possible for there to be more than one report on the same family and the number of reports does not correspond with the number of children since reports can involve more than one child in a family.

Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 : Alabama Department of Human Resources, Adult Protective Services, special request for FY 2011 and FY 2012. Please note that it is possible for there to be more than one report on the same adult.

This and other county reports are available online at www. Arhaonline.org or www.adph.org/ruralhealth/

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For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 546-3502.

Selected Health Status Indicators

SHELBY COUNTY

Jointly produced to assist those seeking to improve health care in rural Alabama

By

The Office of Primary Care and Rural Health,
Alabama Department of Public Health
and
The Alabama Rural Health Association

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April 2013

SELECTED HEALTH STATUS INDICATORS United States, Alabama, and Shelby County						
Indicators	**United States**		**Alabama**		**Shelby County**	
2011 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	311,591,917	100.0	4,802,740	100.0	197,936	100.0
African American (alone)	40,750,746	13.1	1,271,695	26.5	22,565	11.4
White (alone)	243,470,497	78.1	3,368,118	70.1	168,186	85.0
American Indian (alone)	3,814,772	1.2	33,298	0.7	734	0.4
Asian (alone)	15,578,383	5.0	57,155	1.2	3,963	2.0
Hispanic	52,045,277	16.7	193,868	4.0	11,785	6.0
Age 19 Years or Less	82,809,903	26.6	1,265,680	26.4	54,359	27.5
Age 65 Years or More	41,394,141	13.3	672,586	14.0	21,940	11.1
Age 85 Years or More	5,737,173	1.8	77,743	1.6	2,080	1.1
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2010	91,972,266 to 308,745,538	235.7	2,138,093 to 4,779,736	123.6	26,949 to 195,085	623.9
2010 – 2040 Projected	308,745,538 to 380,016,000	23.1	4,779,736 to 5,567,024	16.5	195,085 to 317,209	62.6
Age 65+: 2010 – 2040 Projected	40,267,984 to 79,719,000	98.0	657,792 to 1,199,853	82.4	20,627 to 71,941	248.8
Hispanic: 1990 – 2011	22,354,059 to 52,045,277	132.8	24,629 to 193,868	687.2	525 to 11,785	2,144.8
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2011	48,452,035	15.9%	896,117	19.1%	15,743	8.1%
Children Under 18 Below Poverty Level - 2011	16,386,500	22.5%	307,310	27.6%	5,728	11.5%
Population Under 200% Poverty Level (2006-2011)	97,686,522	32.7%	1,783,196	38.5%	38,637	20.4%
Per Capita Personal Income – 2011	N.A.	$41,560	N.A.	$34,880	N.A.	$44,734
Medicaid Eligible Population – 2011	N.A.	N.A.	1,070,781	22.3%	15,364	7.8%
Medicaid Eligible Children (Under 21) - 2011	N.A.	N.A.	618,137	46.9%	9,183	21.6%
Medicaid Births - 2011	N.A.	N.A.	31,498	53.1%	631	26.0%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Primary Care Physicians – 2012 (Per 10,000 Population)	208,807	6.8 (2010)	3,056	6.4	96	4.9
Dentists – 2013 (Per 10,000 Pop.)	155,700	5.0 (2010)	2,141	4.4	74	3.7
Psychiatrists – 2012 (Per 10,000 Pop.)	39,738	1.3	326	0.7	13	0.7
General Hospital Authorized Beds – 2013 (Per 10,000 Population)	N.A.	N.A.	16,475	34.3	212	10.7
Is there a hospital providing obstetrical service in the county?	N.A.	N.A.	YES in 31 counties NO in 36 counties		Yes	

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Shelby County						
Indicators	**United States**		**Alabama**		**Shelby County**	
Access to Health Care Indicators – continued	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Households With No Vehicle	10,397,000	9.1% (2010)	119,611	6.6% (2010)	1,801	2.5% (2010)
Uninsured Population Under 65 Years of Age - 2010	46,556,803	17.7%	681,437	16.9%	20,999	12.3%
Dialysis Patients and Dialysis Patients per Dialysis Station – 2013	N.A	N.A.	7,584	3.2	120	2.6
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
All Causes	**7,418,471**	**800.9**	**143,493**	**1,000.6**	**3,584**	**611.7**
Septicemia	105,990	11.4	2,644	18.4	61	10.4
Cancer	**1,717,684**	**185.4**	**30,564**	**213.1**	**824**	**140.6**
Colon, Rectum, and Anus	157,259	17.0	2,694	18.8	64	10.9
Liver and Intrahepatic Bile Ducts	61,176	6.6	966	6.7	31	5.3
Pancreas	109,887	11.9	1,813	12.6	46	7.9
Trachea, Bronchus, and Lung	473,090	51.1	9,644	67.2	276	47.1
Breast (female)	122,508	26.0	1,974	26.8	59	19.7
Prostate (male)	84,578	18.6	1,611	23.1	32	11.2
Non-Hodgkin's Lymphoma	60,904	6.6	960	6.7	18	3.1
Leukemia	68,157	7.4	1,148	8.0	29	4.9
Diabetes Mellitus	211,058	22.8	3,840	26.8	48	8.2
Parkinson's Disease	65,704	7.1	1,075	7.5	40	6.8
Alzheimer's Disease	247,188	26.7	4,498	31.4	78	13.3
Major Cardiovascular Diseases	**2,339,340**	**252.6**	**46,705**	**325.7**	**1,098**	**187.4**
Heart Diseases	**1,793,441**	**193.6**	**35,879**	**250.2**	**873**	**149.0**
Hypertensive Heart Disease	100,218	10.8	1,226	8.5	131	22.4
Ischemic Heart Diseases	1,140,484	123.1	16,558	115.5	299	51.0
Acute Myocardial Infarction	367,267	39.7	7,593	52.9	126	21.5
Heart Failure	173,711	18.8	5,769	40.2	116	19.8
Cerebrovascular Diseases (Stroke)	387,249	41.8	7,786	54.3	177	30.2
Pneumonia	152,507	16.5	2,755	19.2	52	8.9
Chronic Lower Respiratory Diseases	418,815	45.2	8,498	59.3	204	34.8
Chronic Liver Disease and Cirrhosis	96,000	10.4	1,539	10.7	40	6.8

SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Shelby County

Indicators	United States		Alabama		Shelby County	
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
Nephritis, Nephrotic Syndrome, and Nephrosis	**145,142**	**15.7**	**3,410**	**23.8**	**89**	**15.2**
Renal Failure	131,884	14.2	3,183	22.2	82	14.0
Accidents	**361,657**	**39.0**	**7,307**	**51.0**	**239**	**40.8**
Motor Vehicle Accidents	106,225	11.5	2,723	19.0	80	13.7
Poisoning and Exposure to Noxious Substances	98,353	10.6	1,571	11.0	70	11.9
Intentional Self-Harm (suicide)	113,558	12.3	1,983	13.8	81	13.8
Assault (homicide)	49,011	5.3	1,181	8.2	25	4.3

Causes of Death Groupings of Special Interest

Cause of Death Indicators	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.[1]
Firearm Deaths (intentional self-harm, assault, legal intervention, and undetermined intent)	95,182	10.3	2,387	16.6	69	11.8
Drug-Induced Deaths	119,779	12.9	1,812	12.6	84	14.3
Alcohol-Induced Deaths	76,466	8.3	748	5.2	13	N.A.

Cancer Incidence and Rates by Site and County

Indicators	United States		Alabama		Shelby County	
Cancer Site	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.[1]**
All Sites	N.A.	N.A.	225,026	459.9	5,788	398.7
Lung	N.A.	N.A.	37,608	76.1	931	68.6
Colorectal	N.A.	N.A.	24,344	49.8	549	39.4
Oral	N.A.	N.A.	6,187	12.5	162	10.8
Melanoma	N.A.	N.A.	8,152	17.0	264	17.2
Prostate	N.A.	N.A.	33,711	155.8	920	140.4
Breast (Female, only)	N.A.	N.A.	31,171	117.3	861	103.7
Cervix	N.A.	N.A.	2,190	9.0	42	4.7

SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Shelby County

Indicators	United States		Alabama		Shelby County	
Natality Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**[1]
Infant Mortality 2009-2011 – (Per 1,000 Births)	74,908	6.2	1,516	8.3	42	5.7
Low Weight Births – 2011 (Percent of All Births)	325,563 (2010)	8.1 %	5,908	10.0 %	197	8.1%
Births to Teens (10-19) – 2011 (Percent of All Births)	372,175 (2010)	9.3 %	6,697	11.3 %	124	5.1%
Births With Less Than Adequate Prenatal Care – 2011 (Percent of All Births)	N.A.	N.A.	15,986	27.2 %	596	24.7%
Caesarian Births – 2011 (Percent of All Births)	1,309,182	32.8 %	20,980	35.4 %	864	35.6%
Tobacco Use During Pregnancy – 2011 (Percent of All Births)	N.A.	N.A.	6,289	10.6 %	128	5.3%
Births to Undereducated Women – 2011 (Percent of All Births)	N.A.	N.A.	9,295	15.7 %	212	8.7%
Births to Unmarried Women – 2011 (Percent of All Births)	1,633,471	40.8% (2010)	24,946	42.1%	430	17.7%
Preterm Births – 2009 - 2011 (Percent of All Births)	478,790	12.0% (2010)	29,096	16.0%	1,030	13.9%
Births for Which Diabetes was Reported as a Risk Factor – 2007-2011 (Per 1,000 Live Births)	201,218	50.5 (2010)	13,510	45.5	655	54.0
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 25+ With Less Than High School Education – 2007-2011	29,518,935	14.6 %	567,670	18.1 %	11,010	8.6%
Public School Graduation Rates - 2011	N.A.	78.0 % (2010)	45,221	71.8 %	1,637	86.4%
Receiving Medicare Disability – 2010 (Percent of Total Population)	7,735,377	2.5 %	203,252	4.3 %	3,615	1.9%
Adult Obesity – 2010 (Percent of Total Population Aged 20 Years or More)	56,369,496	25 %	1,153,068	33 %	39,393	28%
Adult Smoking - 2010 (Percent of Total Population Aged 18+ Years)	32,838,970	14 %	838,874	23 %	29,025	20%
Excessive Drinking - 2010 (Percent of Total Population Aged 18+ Years)	18,765,126	8 %	437,673	12 %	18,866	13%
Life Expectancy at Birth - 2011	78.7 years		75.7 years		79.0 years	
Sexually Transmitted Disease Cases Reported – January 2012 through March 2013 (Per 10,000 Pop.)	N.A.	N.A.	47,608	99.1	609	30.8

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Shelby County						
Indicators	**United States**		**Alabama**		**Shelby County**	
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
New HIV Cases – 2009 through 2011 (Per 100,000 Population) NOTE: Number of cases is not released in counties where this is less than five.	145,614	15.7	2,093	14.6	18	3.1
Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation– October 2009 through September 2011 (Per 1,000 population Under Age 18)	N.A.	N.A.	39,581	17.5	1,358	13.6
Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 (Per 10,000 Adults Aged 18+ Years.	N.A.	N.A.	8,729	23.9	128	8.8

[1]Rates, percentages, etc based upon fewer than 16 events may not be statistically reliable for specific analyses. "N.A." is given for such indicators. Numbers of events, as well as measurements, are indicated using "N.A." for some indicators in accordance with the data owner's policy of not publishing smaller numbers of events.

Sources of Information and Special Notes

2011 Population Estimates: Alabama State Data Center, The University of Alabama, 2011 Population Estimates and Projections, http://cber.cba.ua.edu/edata/est_prj.html and, 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html

Population Change 1910-2010: U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2010 Summary File 1 (SF 1) 100-Percent Data for 2010 data.

Population Change 2000-2040: U.S. Census Bureau, National Population Projections, Interim Projections 2000-2050 based on Census 2000. http://www.census.gov/population/www/projections/natproj.html. Alabama State Data Center, Alabama County Population 2000-2010 and Projections 2015-2040. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2011: U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data and 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html.

Population Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Children Under 18 Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Population Under 200% Poverty Level (2006-2011): American Community Survey, 5-year data for 2007-2011, Table C17002.

2011 Per Capita Personal Income: U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/iTable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1

Medicaid Eligible Population - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Eligible Children (Under 21) - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Primary Care Physicians in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association's 2010 Physician Master File. National data was obtained from the Agency for Healthcare Research and Quality's on-line publication, Primary Care Workforce Facts and Stats #1, at http://www.ahrq.gov/research/pcwork1.htm. All data has been adjusted to exclude licensed retirees and include only those actively practicing primary care. (In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, gerontologists, and obstetricians and gynecologists.)

Dentists in 2013: Board of Dental Examiners of Alabama, Licensed dentists data base - 2013. National data is for 2010 and is obtained from the Bureau of Labor Statistics at http://www.bls.gov/emp/ep_table_102.htm.

Psychiatrists in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association, Physician Characteristics and Distribution in the US 2012, Table 1.2.

Hospital Beds in 2013: Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. March 21, 2013. http://www.adph.org/HEALTHCAREFACILITIES/Default.asp?id=5349.

Obstetrical Hospitals: Center for Health Statistics 2013 Birth Master File, special inquiry, February 28, 2013.

Households With No Vehicle in 2010: U.S. Census Bureau, American FactFinder, American Community Survey – 2010 or 2008-2010 or 2006-2010, Table B08210 – Household Size by Vehicles Available. Estimates are for 1-year, 3-years, or 5-years according to the population of each county.

Uninsured Persons Under Age 65 - 2010: U.S. Census Bureau, Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States. http://www.census.gov/did/www/sahie/index.html

Dialysis Patients and Dialysis Patients per Dialysis Station – 2013: Dialysis patients data by county was obtained by special request from Network 8, Inc. (http://www.esrdnetwork8.org) dated May 31, 2011. Dialysis stations by county was obtained from the *Healthcare Facilities Directory*, Alabama Department of Public Health (http://ph.state.al.us/facilitiesdirectory/(S(qc1vsw45hfl2iw45vbzbwini))/Default.aspx).

Cause of Death Indicators: Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2009, 2010, and 2011 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Detailed Mortality files for 2009 and 2010 (http://wonder.cdc.gov/). Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 2. (Cause of death data included in this publication is not age-adjusted)

Cancer Incidence and Rates by Site and County – Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry, Alabama Department of Public Health, Tables 3, 4, and 5. http://www.adph.org/ascr/assets/2011FactsFigures.pdf

Infant Mortality Rate - 2009-2011; Alabama Department of Public Health, Center for Health Statistics, http://www.adph.org/healthstats/assets/Total_Inf_Mort09_11.pdf. National Data: CDC WONDER Online Data Inquiry System, 2009 and 2010 Birth and Detailed Mortality data, http://wonder.cdc.gov/, National Vital Statistics Reports, Deaths: Preliminary Data for 2011, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf and Recent Trends in Births and Fertility Rates Through December 2011, http://www.cdc.gov/nchs/data/hestat/births_fertility_december_2011/births_fertility_december_2011.pdf.

Low Weight Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births. (Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Less Than Adequate Prenatal Care - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Caesarian Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Tobacco Use During Pregnancy - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Births to Undereducated Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Births to Unmarried Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Preterm Births – 2009 - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2009-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf Preterm births are those with a calculated gestation of less than 37 full weeks of pregnancy.

Births for Which Diabetes was Reported as a Risk Factor – 2007- 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2007-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Age 25+ With Less Than High School Education – 2007-2011: U.S. Census Bureau, American FactFinder, American Community Survey for 2007-2011, Table B15002.

Public School Graduation Rates – 2011: Alabama Kids Count Data Book – 2012, pp.31-98. http://www.alavoices.org/files/12_AKC-DataBook.pdf National data: National Center for Education Statistics.
The number of students who graduated from public high schools in Alabama in 2011 with regular, advanced, and credit-based diplomas expressed as a percentage of the total number of students who enrolled as first year freshmen four years earlier (or in 2007-2008). While the denominator used in computing the rate includes graduates, completers, students still enrolled, students withdrawn but still enrolled, students who enrolled but failed to attend, dropouts, and "others," it does not include students in the class of 2007-2008 who were retained from later classes. Data are adjusted for students who transferred into, and out of, the cohort over the four-year period. This method of measuring the graduation rate is referred to as the "four-year cohort graduation rate" and reflects efforts to conform to the National Governor's Association recommendation in 2005 that states implement a common measure of graduation beginning with the 2010-2011 academic year. However, the methodology used in computing the cohort graduation rate remains subject to variation from one state to another

Persons Receiving Medicare Disability - 2010: Centers for Medicare and Medicaid Services, Medicare Aged and Disabled by State and County as of July 1, 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Adult Obesity - Percent of Population Aged 20+ in 2010: County Health Rankings & Roadmaps. The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2. Estimates of obesity prevalence by county were calculated by the CDC's National

Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Adult Smoking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Excessive Drinking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Life Expectancy at Birth - 2011: Alabama Department of Public Health, Center for Health Statistics, special request and Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 6.

Sexually Transmitted Disease Cases – January 2011 through March 2012: Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, 2011 and 2012. http://www.adph.org/STD/Default.asp?id=1080

New HIV Cases – 2009 through 2011: Alabama Department of Public Health (ADPH), HIV Surveillance Branch. Any analyses, interpretation or conclusions reached from this data are those of the user and not the HIV Surveillance Branch. National data: HIV Surveillance Report, Diagnosis of HIV Infection in the United States and Dependent Areas, 2011, Vol.23, Table 1a. Note that national data is estimated to account for reporting delays and missing transmission.

Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation – October 2009 through September 2011: Alabama Department of Human Resources, Child Protective Services, special request for FY 2010 and FY 2011. Please note that it is possible for there to be more than one report on the same family and the number of reports does not correspond with the number of children since reports can involve more than one child in a family.

Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 : Alabama Department of Human Resources, Adult Protective Services, special request for FY 2011 and FY 2012. Please note that it is possible for there to be more than one report on the same adult.

This and other county reports are available online at www. Arhaonline.org or www.adph.org/ruralhealth/

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For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 546-3502.

Selected Health Status Indicators

ST. CLAIR COUNTY

Jointly produced to assist those seeking to improve health care in rural Alabama

By

The Office of Primary Care and Rural Health,
Alabama Department of Public Health
and
The Alabama Rural Health Association

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April 2013

SELECTED HEALTH STATUS INDICATORS United States, Alabama, and St. Clair County						
Indicators	**United States**		**Alabama**		**St. Clair County**	
2011 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	311,591,917	100.0	4,802,740	100.0	84,398	100.0
African American (alone)	40,750,746	13.1	1,271,695	26.5	7,642	9.1
White (alone)	243,470,497	78.1	3,368,118	70.1	74,784	88.6
American Indian (alone)	3,814,772	1.2	33,298	0.7	311	0.4
Asian (alone)	15,578,383	5.0	57,155	1.2	561	0.7
Hispanic	52,045,277	16.7	193,868	4.0	1,869	2.2
Age 19 Years or Less	82,809,903	26.6	1,265,680	26.4	21,760	25.8
Age 65 Years or More	41,394,141	13.3	672,586	14.0	11,500	13.6
Age 85 Years or More	5,737,173	1.8	77,743	1.6	983	1.2
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2010	91,972,266 to 308,745,538	235.7	2,138,093 to 4,779,736	123.6	20,715 to 83,593	303.5
2010 – 2040 Projected	308,745,538 to 380,016,000	23.1	4,779,736 to 5,567,024	16.5	83,593 to 131,566	57.4
Age 65+: 2010 – 2040 Projected	40,267,984 to 79,719,000	98.0	657,792 to 1,199,853	82.4	10,909 to 28,680	162.9
Hispanic: 1990 – 2011	22,354,059 to 52,045,277	132.8	24,629 to 193,868	687.2	209 to 1,869	794.3
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2011	48,452,035	15.9%	896,117	19.1%	14,249	17.3%
Children Under 18 Below Poverty Level - 2011	16,386,500	22.5%	307,310	27.6%	4,963	25.2%
Population Under 200% Poverty Level (2006-2011)	97,686,522	32.7%	1,783,196	38.5%	27,025	33.8%
Per Capita Personal Income – 2011	N.A.	$41,560	N.A.	$34,880	N.A.	$32,240
Medicaid Eligible Population – 2011	N.A.	N.A.	1,070,781	22.3%	19,137	22.7%
Medicaid Eligible Children (Under 21) - 2011	N.A.	N.A.	618,137	46.9%	12,236	40.6%
Medicaid Births - 2011	N.A.	N.A.	31,498	53.1%	428	41.4%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Primary Care Physicians – 2012 (Per 10,000 Population)	208,807	6.8 (2010)	3,056	6.4	24	2.8
Dentists – 2013 (Per 10,000 Pop.)	155,700	5.0 (2010)	2,141	4.4	11	1.3
Psychiatrists – 2012 (Per 10,000 Pop.)	39,738	1.3	326	0.7	0	0.0
General Hospital Authorized Beds – 2013 (Per 10,000 Population)	N.A.	N.A.	16,475	34.3	40	4.7
Is there a hospital providing obstetrical service in the county?	N.A.	N.A.	YES in 31 counties NO in 36 counties		No	

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and St. Clair County						
Indicators	**United States**		**Alabama**		**St. Clair County**	
Access to Health Care Indicators – continued	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Households With No Vehicle	10,397,000	9.1% (2010)	119,611	6.6% (2010)	767	2.4% (2010)
Uninsured Population Under 65 Years of Age - 2010	46,556,803	17.7%	681,437	16.9%	10,777	15.2%
Dialysis Patients and Dialysis Patients per Dialysis Station – 2013	N.A	N.A.	7,584	3.2	94	2.0
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
All Causes	**7,418,471**	**800.9**	**143,493**	**1,000.6**	**2,331**	**928.9**
Septicemia	105,990	11.4	2,644	18.4	38	15.1
Cancer	**1,717,684**	**185.4**	**30,564**	**213.1**	**503**	**200.4**
Colon, Rectum, and Anus	157,259	17.0	2,694	18.8	40	15.9
Liver and Intrahepatic Bile Ducts	61,176	6.6	966	6.7	14	N.A.
Pancreas	109,887	11.9	1,813	12.6	32	12.8
Trachea, Bronchus, and Lung	473,090	51.1	9,644	67.2	195	77.7
Breast (female)	122,508	26.0	1,974	26.8	17	13.6
Prostate (male)	84,578	18.6	1,611	23.1	21	16.7
Non-Hodgkin's Lymphoma	60,904	6.6	960	6.7	19	7.6
Leukemia	68,157	7.4	1,148	8.0	18	7.2
Diabetes Mellitus	211,058	22.8	3,840	26.8	35	13.9
Parkinson's Disease	65,704	7.1	1,075	7.5	11	N.A.
Alzheimer's Disease	247,188	26.7	4,498	31.4	63	25.1
Major Cardiovascular Diseases	**2,339,340**	**252.6**	**46,705**	**325.7**	**721**	**287.3**
Heart Diseases	**1,793,441**	**193.6**	**35,879**	**250.2**	**585**	**233.1**
Hypertensive Heart Disease	100,218	10.8	1,226	8.5	2	N.A.
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Acute Myocardial Infarction	367,267	39.7	7,593	52.9	102	40.6
Heart Failure	173,711	18.8	5,769	40.2	105	41.8
Cerebrovascular Diseases (Stroke)	387,249	41.8	7,786	54.3	118	47.0
Pneumonia	152,507	16.5	2,755	19.2	53	21.1
Chronic Lower Respiratory Diseases	418,815	45.2	8,498	59.3	161	64.2
Chronic Liver Disease and Cirrhosis	96,000	10.4	1,539	10.7	29	11.6

SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and St. Clair County

Indicators	United States		Alabama		St. Clair County	
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
Nephritis, Nephrotic Syndrome, and Nephrosis	**145,142**	**15.7**	**3,410**	**23.8**	**51**	**20.3**
Renal Failure	131,884	14.2	3,183	22.2	51	20.3
Accidents	**361,657**	**39.0**	**7,307**	**51.0**	**161**	**64.2**
Motor Vehicle Accidents	106,225	11.5	2,723	19.0	64	25.5
Poisoning and Exposure to Noxious Substances	98,353	10.6	1,571	11.0	41	16.3
Intentional Self-Harm (suicide)	113,558	12.3	1,983	13.8	46	18.3
Assault (homicide)	49,011	5.3	1,181	8.2	15	N.A.

Causes of Death Groupings of Special Interest

Cause of Death Indicators	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.[1]
Firearm Deaths (intentional self-harm, assault, legal intervention, and undetermined intent)	95,182	10.3	2,387	16.6	49	19.5
Drug-Induced Deaths	119,779	12.9	1,812	12.6	44	17.5
Alcohol-Induced Deaths	76,466	8.3	748	5.2	14	N.A.

Cancer Incidence and Rates by Site and County

Indicators	United States		Alabama		St. Clair County	
Cancer Site	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.[1]**
All Sites	N.A.	N.A.	225,026	459.9	3,225	422.6
Lung	N.A.	N.A.	37,608	76.1	643	83.5
Colorectal	N.A.	N.A.	24,344	49.8	299	39.7
Oral	N.A.	N.A.	6,187	12.5	94	12.0
Melanoma	N.A.	N.A.	8,152	17.0	125	16.9
Prostate	N.A.	N.A.	33,711	155.8	412	116.4
Breast (Female, only)	N.A.	N.A.	31,171	117.3	377	92.6
Cervix	N.A.	N.A.	2,190	9.0	27	7.2

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and St. Clair County						
Indicators	**United States**		**Alabama**		**St. Clair County**	
Natality Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Infant Mortality 2009-2011 – (Per 1,000 Births)	74,908	6.2	1,516	8.3	28	8.5
Low Weight Births – 2011 (Percent of All Births)	325,563 (2010)	8.1 %	5,908	10.0 %	103	10.0%
Births to Teens (10-19) – 2011 (Percent of All Births)	372,175 (2010)	9.3 %	6,697	11.3 %	92	8.9%
Births With Less Than Adequate Prenatal Care – 2011 (Percent of All Births)	N.A.	N.A.	15,986	27.2 %	260	25.3%
Caesarian Births – 2011 (Percent of All Births)	1,309,182	32.8 %	20,980	35.4 %	399	38.6%
Tobacco Use During Pregnancy – 2011 (Percent of All Births)	N.A.	N.A.	6,289	10.6 %	154	14.9%
Births to Undereducated Women – 2011 (Percent of All Births)	N.A.	N.A.	9,295	15.7 %	128	12.4%
Births to Unmarried Women – 2011 (Percent of All Births)	1,633,471	40.8% (2010)	24,946	42.1%	315	30.4%
Preterm Births – 2009 - 2011 (Percent of All Births)	478,790	12.0% (2010)	29,096	16.0%	425	13.0%
Births for Which Diabetes was Reported as a Risk Factor – 2007-2011 (Per 1,000 Live Births)	201,218	50.5 (2010)	13,510	45.5	300	58.0
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 25+ With Less Than High School Education – 2007-2011	29,518,935	14.6 %	567,670	18.1 %	11,256	20.1%
Public School Graduation Rates - 2011	N.A.	78.0 % (2010)	45,221	71.8 %	755	76.6%
Receiving Medicare Disability – 2010 (Percent of Total Population)	7,735,377	2.5 %	203,252	4.3 %	3,000	3.6%
Adult Obesity – 2010 (Percent of Total Population Aged 20 Years or More)	56,369,496	25 %	1,153,068	33 %	22,234	36%
Adult Smoking - 2010 (Percent of Total Population Aged 18+ Years)	32,838,970	14 %	838,874	23 %	17,217	27%
Excessive Drinking - 2010 (Percent of Total Population Aged 18+ Years)	18,765,126	8 %	437,673	12 %	7,014	11%
Life Expectancy at Birth - 2011	78.7 years		75.7 years		75.2 years	
Sexually Transmitted Disease Cases Reported – January 2012 through March 2013 (Per 10,000 Pop.)	N.A.	N.A.	47,608	99.1	226	26.8

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and St. Clair County						
Indicators	**United States**		**Alabama**		**St. Clair County**	
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**[1]
New HIV Cases – 2009 through 2011 (Per 100,000 Population) NOTE: Number of cases is not released in counties where this is less than five.	145,614	15.7	2,093	14.6	13	N.A.
Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation– October 2009 through September 2011 (Per 1,000 population Under Age 18)	N.A.	N.A.	39,581	17.5	847	21.4
Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 (Per 10,000 Adults Aged 18+ Years.	N.A.	N.A.	8,729	23.9	112	17.6

[1]Rates, percentages, etc based upon fewer than 16 events may not be statistically reliable for specific analyses. "N.A." is given for such indicators. Numbers of events, as well as measurements, are indicated using "N.A." for some indicators in accordance with the data owner's policy of not publishing smaller numbers of events.

Sources of Information and Special Notes

2011 Population Estimates: Alabama State Data Center, The University of Alabama, 2011 Population Estimates and Projections, http://cber.cba.ua.edu/edata/est_prj.html and, 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html

Population Change 1910-2010: U.S. Census Bureau, County Population Census Counts 1900-90, http://www.census.gov/population/cencounts/al190090.txt for 1910 data; U.S. Census Bureau, American FactFinder, Census 2010 Summary File 1 (SF 1) 100-Percent Data for 2010 data.

Population Change 2000-2040: U.S. Census Bureau, National Population Projections, Interim Projections 2000-2050 based on Census 2000. http://www.census.gov/population/www/projections/natproj.html. Alabama State Data Center, Alabama County Population 2000-2010 and Projections 2015-2040. http://cber.cba.ua.edu/edata/est_prj.html

Hispanic Population Change 1990-2011: U.S. Census Bureau, American FactFinder, Census 1990 Summary File 1 (STF 1) 100-Percent Data for 1990 data and 2011 Population Estimates Data, http://www.census.gov/popest/data/index.html.

Population Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Children Under 18 Below Poverty Level - 2011: U.S. Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/data/statecounty/data/2011.html

Population Under 200% Poverty Level (2006-2011): American Community Survey, 5-year data for 2007-2011, Table C17002.

2011 Per Capita Personal Income: U.S. Bureau of Economic Analysis, Interactive Tables: Local Area Personal Income, Table CA1-3. http://www.bea.gov/iTable/iTable.cfm?ReqID=70&step=1#reqid=70&step=1&isuri=1

Medicaid Eligible Population - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Eligible Children (Under 21) - 2011: Alabama Medicaid Agency, 2011 Statistics by County. http://medicaid.alabama.gov/CONTENT/2.0_Newsroom/2.6_Statistics.aspx

Medicaid Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Primary Care Physicians in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association's 2010 Physician Master File. National data was obtained from the Agency for Healthcare Research and Quality's on-line publication, Primary Care Workforce Facts and Stats #1, at http://www.ahrq.gov/research/pcwork1.htm. All data has been adjusted to exclude licensed retirees and include only those actively practicing primary care. (In this publication, primary care physicians include family practitioners, internal medicine specialists, pediatricians, gerontologists, and obstetricians and gynecologists.)

Dentists in 2013: Board of Dental Examiners of Alabama, Licensed dentists data base - 2013. National data is for 2010 and is obtained from the Bureau of Labor Statistics at http://www.bls.gov/emp/ep_table_102.htm.

Psychiatrists in 2012: Medical Licensure Commission, Licensed Physician Data Base – 2012. National data is for 2010 and is obtained from the American Medical Association, Physician Characteristics and Distribution in the US 2012, Table 1.2.

Hospital Beds in 2013: Alabama Department of Public Health, Division of Provider Services, Healthcare Facilities Directory – Hospital Section. March 21, 2013. http://www.adph.org/HEALTHCAREFACILITIES/Default.asp?id=5349.

Obstetrical Hospitals: Center for Health Statistics 2013 Birth Master File, special inquiry, February 28, 2013.

Households With No Vehicle in 2010: U.S. Census Bureau, American FactFinder, American Community Survey – 2010 or 2008-2010 or 2006-2010, Table B08210 – Household Size by Vehicles Available. Estimates are for 1-year, 3-years, or 5-years according to the population of each county.

Uninsured Persons Under Age 65 - 2010: U.S. Census Bureau, Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States. http://www.census.gov/did/www/sahie/index.html

Dialysis Patients and Dialysis Patients per Dialysis Station – 2013: Dialysis patients data by county was obtained by special request from Network 8, Inc. (http://www.esrdnetwork8.org) dated May 31, 2011. Dialysis stations by county was obtained from the *Healthcare Facilities Directory*, Alabama Department of Public Health (http://ph.state.al.us/facilitiesdirectory/(S(qc1vsw45hfl2iw45vbzbwini))/Default.aspx).

Cause of Death Indicators: Alabama Department of Public Health, Center for Health Statistics, Special queries of the 2009, 2010, and 2011 Mortality Statistics Files for Alabama data. Centers for Disease Control and Prevention, CDC Wonder Interactive Program, Detailed Mortality files for 2009 and 2010 (http://wonder.cdc.gov/). Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 2. (Cause of death data included in this publication is not age-adjusted)

Cancer Incidence and Rates by Site and County – Alabama Cancer Facts & Figures 2011, Alabama Statewide Cancer Registry, Alabama Department of Public Health, Tables 3, 4, and 5. http://www.adph.org/ascr/assets/2011FactsFigures.pdf

Infant Mortality Rate - 2009-2011; Alabama Department of Public Health, Center for Health Statistics, http://www.adph.org/healthstats/assets/Total_Inf_Mort09_11.pdf. National Data: CDC WONDER Online Data Inquiry System, 2009 and 2010 Birth and Detailed Mortality data, http://wonder.cdc.gov/, National Vital Statistics Reports, Deaths: Preliminary Data for 2011, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf and Recent Trends in Births and Fertility Rates Through December 2011, http://www.cdc.gov/nchs/data/hestat/births_fertility_december_2011/births_fertility_december_2011.pdf.

Low Weight Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births. (Births weighing less than 2,500 grams or 5 pounds and 8 ounces are defined as being of low weight.)

Births to Teenagers (Age 10-19) - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Less Than Adequate Prenatal Care - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (The Kotelchuck Index is used in determining adequacy of prenatal care. This index primarily considers the date when prenatal care was begun and the number of visits in determining adequacy.)

Caesarian Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

Births With Tobacco Use During Pregnancy - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File.

Births to Undereducated Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. (Women are considered to be "undereducated" when their years of education is at least two years less than what would be expected for someone of their age.)

Births to Unmarried Women - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Preterm Births – 2009 - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2009-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf Preterm births are those with a calculated gestation of less than 37 full weeks of pregnancy.

Births for Which Diabetes was Reported as a Risk Factor – 2007- 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2007-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

Age 25+ With Less Than High School Education – 2007-2011: U.S. Census Bureau, American FactFinder, American Community Survey for 2007-2011, Table B15002.

Public School Graduation Rates – 2011: Alabama Kids Count Data Book – 2012, pp.31-98. http://www.alavoices.org/files/12_AKC-DataBook.pdf National data: National Center for Education Statistics.
The number of students who graduated from public high schools in Alabama in 2011 with regular, advanced, and credit-based diplomas expressed as a percentage of the total number of students who enrolled as first year freshmen four years earlier (or in 2007-2008). While the denominator used in computing the rate includes graduates, completers, students still enrolled, students withdrawn but still enrolled, students who enrolled but failed to attend, dropouts, and "others," it does not include students in the class of 2007-2008 who were retained from later classes. Data are adjusted for students who transferred into, and out of, the cohort over the four-year period. This method of measuring the graduation rate is referred to as the "four-year cohort graduation rate" and reflects efforts to conform to the National Governor's Association recommendation in 2005 that states implement a common measure of graduation beginning with the 2010-2011 academic year. However, the methodology used in computing the cohort graduation rate remains subject to variation from one state to another

Persons Receiving Medicare Disability - 2010: Centers for Medicare and Medicaid Services, Medicare Aged and Disabled by State and County as of July 1, 2010. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2010.pdf

Adult Obesity - Percent of Population Aged 20+ in 2010: County Health Rankings & Roadmaps. The adult obesity measure represents the percent of the adult population (age 20 and older) that has a body mass index (BMI) greater than or equal to 30 kg/m2. Estimates of obesity prevalence by county were calculated by the CDC's National

Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, using multiple years of Behavioral Risk Factor Surveillance System (BRFSS) data. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone.

Adult Smoking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Excessive Drinking - Percent of Population Aged 18+ in 2010: County Health Rankings & Roadmaps. This measure was calculated by the National Center for Health Statistics using data from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial survey. BRFSS data are representative of the total non-institutionalized U.S. population over 18 years of age living in households with a land-line telephone. The estimates are based on seven years of data.

Life Expectancy at Birth - 2011: Alabama Department of Public Health, Center for Health Statistics, special request and Deaths – Preliminary Data for 2011, Vol. 61, Number 6, October 10, 2012, Table 6.

Sexually Transmitted Disease Cases – January 2011 through March 2012: Alabama Department of Public Health, Division of STD Prevention and Control, Statistics, 2011 and 2012. http://www.adph.org/STD/Default.asp?id=1080

New HIV Cases – 2009 through 2011: Alabama Department of Public Health (ADPH), HIV Surveillance Branch. Any analyses, interpretation or conclusions reached from this data are those of the user and not the HIV Surveillance Branch. National data: HIV Surveillance Report, Diagnosis of HIV Infection in the United States and Dependent Areas, 2011, Vol.23, Table 1a. Note that national data is estimated to account for reporting delays and missing transmission.

Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation – October 2009 through September 2011: Alabama Department of Human Resources, Child Protective Services, special request for FY 2010 and FY 2011. Please note that it is possible for there to be more than one report on the same family and the number of reports does not correspond with the number of children since reports can involve more than one child in a family.

Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 : Alabama Department of Human Resources, Adult Protective Services, special request for FY 2011 and FY 2012. Please note that it is possible for there to be more than one report on the same adult.

This and other county reports are available online at www. Arhaonline.org or www.adph.org/ruralhealth/

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For additional information please contact the Office of Primary Care and Rural Health Development at (334) 206-5396 or the Alabama Rural Health Association at (334) 546-3502.

Selected Health Status Indicators

WALKER COUNTY

Jointly produced to assist those seeking to improve health care in rural Alabama

By

The Office of Primary Care and Rural Health,
Alabama Department of Public Health
and
The Alabama Rural Health Association

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April 2013

SELECTED HEALTH STATUS INDICATORS United States, Alabama, and Walker County						
Indicators	**United States**		**Alabama**		**Walker County**	
2011 Population	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**	**Number**	**Pct. of Total**
Total	311,591,917	100.0	4,802,740	100.0	66,661	100.0
African American (alone)	40,750,746	13.1	1,271,695	26.5	4,097	6.1
White (alone)	243,470,497	78.1	3,368,118	70.1	61,192	91.8
American Indian (alone)	3,814,772	1.2	33,298	0.7	292	0.4
Asian (alone)	15,578,383	5.0	57,155	1.2	225	0.3
Hispanic	52,045,277	16.7	193,868	4.0	1,381	2.1
Age 19 Years or Less	82,809,903	26.6	1,265,680	26.4	16,432	24.7
Age 65 Years or More	41,394,141	13.3	672,586	14.0	11,117	16.7
Age 85 Years or More	5,737,173	1.8	77,743	1.6	1,112	1.7
Population Change	**Number**	**Pct. Change**	**Number**	**Pct. Change**	**Number**	**Pct. Change**
1910 – 2010	91,972,266 to 308,745,538	235.7	2,138,093 to 4,779,736	123.6	37,013 to 67,023	81.1
2010 – 2040 Projected	308,745,538 to 380,016,000	23.1	4,779,736 to 5,567,024	16.5	67,023 to 57,614	-14.0
Age 65+: 2010 – 2040 Projected	40,267,984 to 79,719,000	98.0	657,792 to 1,199,853	82.4	10,894 to 13,586	24.7
Hispanic: 1990 – 2011	22,354,059 to 52,045,277	132.8	24,629 to 193,868	687.2	224 to 1,381	516.5
Income Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Population Below Poverty Level – 2011	48,452,035	15.9%	896,117	19.1%	14,511	22.1%
Children Under 18 Below Poverty Level - 2011	16,386,500	22.5%	307,310	27.6%	4,354	29.7%
Population Under 200% Poverty Level (2006-2011)	97,686,522	32.7%	1,783,196	38.5%	28,289	42.8%
Per Capita Personal Income – 2011	N.A.	$41,560	N.A.	$34,880	N.A.	$33,167
Medicaid Eligible Population – 2011	N.A.	N.A.	1,070,781	22.3%	17,712	26.6%
Medicaid Eligible Children (Under 21) - 2011	N.A.	N.A.	618,137	46.9%	9,307	54.3%
Medicaid Births - 2011	N.A.	N.A.	31,498	53.1%	491	59.4%
Access to Health Care Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Primary Care Physicians – 2012 (Per 10,000 Population)	208,807	6.8 (2010)	3,056	6.4	35	5.3
Dentists – 2013 (Per 10,000 Pop.)	155,700	5.0 (2010)	2,141	4.4	28	4.2
Psychiatrists – 2012 (Per 10,000 Pop.)	39,738	1.3	326	0.7	2	0.3
General Hospital Authorized Beds – 2013 (Per 10,000 Population)	N.A.	N.A.	16,475	34.3	267	40.1
Is there a hospital providing obstetrical service in the county?	N.A.	N.A.	YES in 31 counties NO in 36 counties		Yes	

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Walker County						
Indicators	**United States**		**Alabama**		**Walker County**	
Access to Health Care Indicators – continued	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Households With No Vehicle	10,397,000	9.1% (2010)	119,611	6.6% (2010)	1,358	5.7% (2010)
Uninsured Population Under 65 Years of Age - 2010	46,556,803	17.7%	681,437	16.9%	9,249	16.7%
Dialysis Patients and Dialysis Patients per Dialysis Station – 2013	N.A	N.A.	7,584	3.2	93	2.7
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
All Causes	**7,418,471**	**800.9**	**143,493**	**1,000.6**	**2,816**	**1,400.8**
Septicemia	105,990	11.4	2,644	18.4	53	26.4
Cancer	**1,717,684**	**185.4**	**30,564**	**213.1**	**596**	**296.5**
Colon, Rectum, and Anus	157,259	17.0	2,694	18.8	42	20.9
Liver and Intrahepatic Bile Ducts	61,176	6.6	966	6.7	15	N.A.
Pancreas	109,887	11.9	1,813	12.6	33	16.4
Trachea, Bronchus, and Lung	473,090	51.1	9,644	67.2	211	105.0
Breast (female)	122,508	26.0	1,974	26.8	28	27.2
Prostate (male)	84,578	18.6	1,611	23.1	29	29.6
Non-Hodgkin's Lymphoma	60,904	6.6	960	6.7	19	9.5
Leukemia	68,157	7.4	1,148	8.0	28	13.9
Diabetes Mellitus	211,058	22.8	3,840	26.8	72	35.8
Parkinson's Disease	65,704	7.1	1,075	7.5	15	N.A.
Alzheimer's Disease	247,188	26.7	4,498	31.4	73	36.3
Major Cardiovascular Diseases	**2,339,340**	**252.6**	**46,705**	**325.7**	**816**	**405.9**
Heart Diseases	**1,793,441**	**193.6**	**35,879**	**250.2**	**675**	**335.8**
Hypertensive Heart Disease	100,218	10.8	1,226	8.5	6	N.A.
Ischemic Heart Diseases	1,140,484	123.1	16,558	115.5	221	109.9
Acute Myocardial Infarction	367,267	39.7	7,593	52.9	95	47.3
Heart Failure	173,711	18.8	5,769	40.2	104	51.7
Cerebrovascular Diseases (Stroke)	387,249	41.8	7,786	54.3	106	52.7
Pneumonia	152,507	16.5	2,755	19.2	39	19.4
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Chronic Liver Disease and Cirrhosis	96,000	10.4	1,539	10.7	34	16.9

SELECTED HEALTH STATUS INDICATORS - continued
United States, Alabama, and Walker County

Indicators	United States		Alabama		Walker County	
Cause of Death Indicators (Includes all causes with 950 or more deaths statewide.)	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.**	**Number in 2009 - 2011**	**Rate per 100,000 Pop.[1]**
Nephritis, Nephrotic Syndrome, and Nephrosis	**145,142**	**15.7**	**3,410**	**23.8**	**62**	**30.8**
Renal Failure	131,884	14.2	3,183	22.2	61	30.3
Accidents	**361,657**	**39.0**	**7,307**	**51.0**	**231**	**114.9**
Motor Vehicle Accidents	106,225	11.5	2,723	19.0	73	36.3
Poisoning and Exposure to Noxious Substances	98,353	10.6	1,571	11.0	98	48.7
Intentional Self-Harm (suicide)	113,558	12.3	1,983	13.8	40	19.9
Assault (homicide)	49,011	5.3	1,181	8.2	13	N.A.

Causes of Death Groupings of Special Interest

Cause of Death Indicators	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.	Number in 2009 - 2011	Rate per 100,000 Pop.[1]
Firearm Deaths (intentional self-harm, assault, legal intervention, and undetermined intent)	95,182	10.3	2,387	16.6	7	N.A.
Drug-Induced Deaths	119,779	12.9	1,812	12.6	100	49.7
Alcohol-Induced Deaths	76,466	8.3	748	5.2	14	N.A.

Cancer Incidence and Rates by Site and County

Indicators	United States		Alabama		Walker County	
Cancer Site	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.**	**Number in 2000 - 2009**	**Rate per 100,000 Pop.[1]**
All Sites	N.A.	N.A.	225,026	459.9	4,341	516.1
Lung	N.A.	N.A.	37,608	76.1	889	102.1
Colorectal	N.A.	N.A.	24,344	49.8	431	51.0
Oral	N.A.	N.A.	6,187	12.5	122	14.4
Melanoma	N.A.	N.A.	8,152	17.0	130	16.3
Prostate	N.A.	N.A.	33,711	155.8	497	132.5
Breast (Female, only)	N.A.	N.A.	31,171	117.3	528	116.7
Cervix	N.A.	N.A.	2,190	9.0	46	12.4

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Walker County						
Indicators	**United States**		**Alabama**		**Walker County**	
Natality Related Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
Infant Mortality 2009-2011 – (Per 1,000 Births)	74,908	6.2	1,516	8.3	23	9.2
Low Weight Births – 2011 (Percent of All Births)	325,563 (2010)	8.1 %	5,908	10.0 %	85	10.3%
Births to Teens (10-19) – 2011 (Percent of All Births)	372,175 (2010)	9.3 %	6,697	11.3 %	110	13.3%
Births With Less Than Adequate Prenatal Care – 2011 (Percent of All Births)	N.A.	N.A.	15,986	27.2 %	136	16.5%
Caesarian Births – 2011 (Percent of All Births)	1,309,182	32.8 %	20,980	35.4 %	258	31.2%
Tobacco Use During Pregnancy – 2011 (Percent of All Births)	N.A.	N.A.	6,289	10.6 %	170	20.6%
Births to Undereducated Women – 2011 (Percent of All Births)	N.A.	N.A.	9,295	15.7 %	159	19.3%
Births to Unmarried Women – 2011 (Percent of All Births)	1,633,471	40.8% (2010)	24,946	42.1%	244	29.5%
Preterm Births – 2009 - 2011 (Percent of All Births)	478,790	12.0% (2010)	29,096	16.0%	388	15.5%
Births for Which Diabetes was Reported as a Risk Factor – 2007-2011 (Per 1,000 Live Births)	201,218	50.5 (2010)	13,510	45.5	260	62.9
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure**
Age 25+ With Less Than High School Education – 2007-2011	29,518,935	14.6 %	567,670	18.1 %	11,204	24.0%
Public School Graduation Rates - 2011	N.A.	78.0 % (2010)	45,221	71.8 %	604	76.6%
Receiving Medicare Disability – 2010 (Percent of Total Population)	7,735,377	2.5 %	203,252	4.3 %	5,111	7.6%
Adult Obesity – 2010 (Percent of Total Population Aged 20 Years or More)	56,369,496	25 %	1,153,068	33 %	17,588	35%
Adult Smoking - 2010 (Percent of Total Population Aged 18+ Years)	32,838,970	14 %	838,874	23 %	14,536	28%
Excessive Drinking - 2010 (Percent of Total Population Aged 18+ Years)	18,765,126	8 %	437,673	12 %	3,634	7%
Life Expectancy at Birth - 2011	78.7 years		75.7 years		70.1 years	
Sexually Transmitted Disease Cases Reported – January 2012 through March 2013 (Per 10,000 Pop.)	N.A.	N.A.	47,608	99.1	384	57.6

SELECTED HEALTH STATUS INDICATORS - continued United States, Alabama, and Walker County						
Indicators	**United States**		**Alabama**		**Walker County**	
Other Indicators	**Number**	**Measure**	**Number**	**Measure**	**Number**	**Measure[1]**
New HIV Cases – 2009 through 2011 (Per 100,000 Population) NOTE: Number of cases is not released in counties where this is less than five.	145,614	15.7	2,093	14.6	8	N.A.
Child Abuse and Neglect Cases Reported to Child Protective Services for Investigation– October 2009 through September 2011 (Per 1,000 population Under Age 18)	N.A.	N.A.	39,581	17.5	673	22.3
Adults Involved in Reported Abuse and Neglect Cases – October 2010 through September 2012 (Per 10,000 Adults Aged 18+ Years.	N.A.	N.A.	8,729	23.9	138	26.6

[1]Rates, percentages, etc based upon fewer than 16 events may not be statistically reliable for specific analyses. "N.A." is given for such indicators. Numbers of events, as well as measurements, are indicated using "N.A." for some indicators in accordance with the data owner's policy of not publishing smaller numbers of events.

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Caesarian Births - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2011 Birth Statistics File and CDC WONDER Online Data Inquiry System, 2010 Births.

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Preterm Births – 2009 - 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2009-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf Preterm births are those with a calculated gestation of less than 37 full weeks of pregnancy.

Births for Which Diabetes was Reported as a Risk Factor – 2007- 2011: Alabama Department of Public Health, Center for Health Statistics, Special query of the 2007-2011 Birth Statistics Files. National data: National Vital Statistics Reports, Vol. 61, No. 1, August 28, 2012, Final Data for 2010, Supplemental Tables, http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01_tables/pdf

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Appendix F: EngAge Report

EngAge: A Report to the Community on Senior Adults in the Greater Birmingham Area

Results from the AdvantAge Initiative Survey

COMMUNITY FOUNDATION OF GREATER BIRMINGHAM

EngAge

A Report to the Community on Senior Adults in the Greater Birmingham Area

INTRODUCTION

Dear Community Leader:

The Community Foundation of Greater Birmingham is proud to present EngAge, a report on the state of our community's senior adults. This report benchmarks our community's effectiveness in meeting the needs of our senior population with regard to aging in place. The majority of older adults wish to remain in their homes, rooted in their communities, anchored in their established networks and among their familiar support structures. This study assesses how "age friendly" our six-county region is in meeting these challenges.

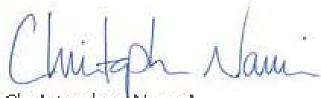
The Community Foundation has a long history of supporting agencies whose mission's serve our senior population. In fact, the very first grant made by the Foundation in the early 1960's was to Fairhaven Methodist Retirement Home. As Baby Boomers reach retirement age, it is well documented that their needs, as well as the resources required by those who care for them will increase dramatically. This "silver tsunami" results in over 8,000 individuals turning 65 every day in the US. Remarkably, those aged 85 and older are the fastest growing segment of our population.

As resources become more limited, we recognize the need to be more strategic. This comprehensive survey provides the starting point. Our interest in undertaking this analysis is twofold: 1) to guide the Community Foundation in channeling resources to the greatest needs and, 2) to help providers deploy their precious resources in a more deliberate way to maximize impact.

To help us achieve these goals, the Foundation utilized the AdvantAge Initiative, a national leader in surveys concerning the needs of older adults. Nearly 1,800 intensive interviews were conducted with local seniors, resulting in statistically valid and reliable data. Because the AdvantAge survey has been administered in over 60 communities nationally, our data can be compared to other sites providing us a perspective in areas where we are succeeding as well as those where work needs to be done. Importantly, the data can also be broken down by specific demographics such as geography, race, income and health so that targeted interventions can be developed to meet the highest need.

The accompanying report provides a thoughtful analysis of Birmingham's metropolitan region. The Community Foundation intends to use this data to create a roadmap for community action by engaging stakeholders in finding innovative solutions to our most significant needs. We hope this report will be a useful tool to encourage a collective sense of urgency to create an elder-friendly environment. Thank you to everyone who assisted the Community Foundation in this year-long effort, in particular the Canterbury Beeson Committee for funding support. A list of our stakeholders can be found on the Acknowledgements page. This work would not have been possible without their vision and support.

Sincerely,

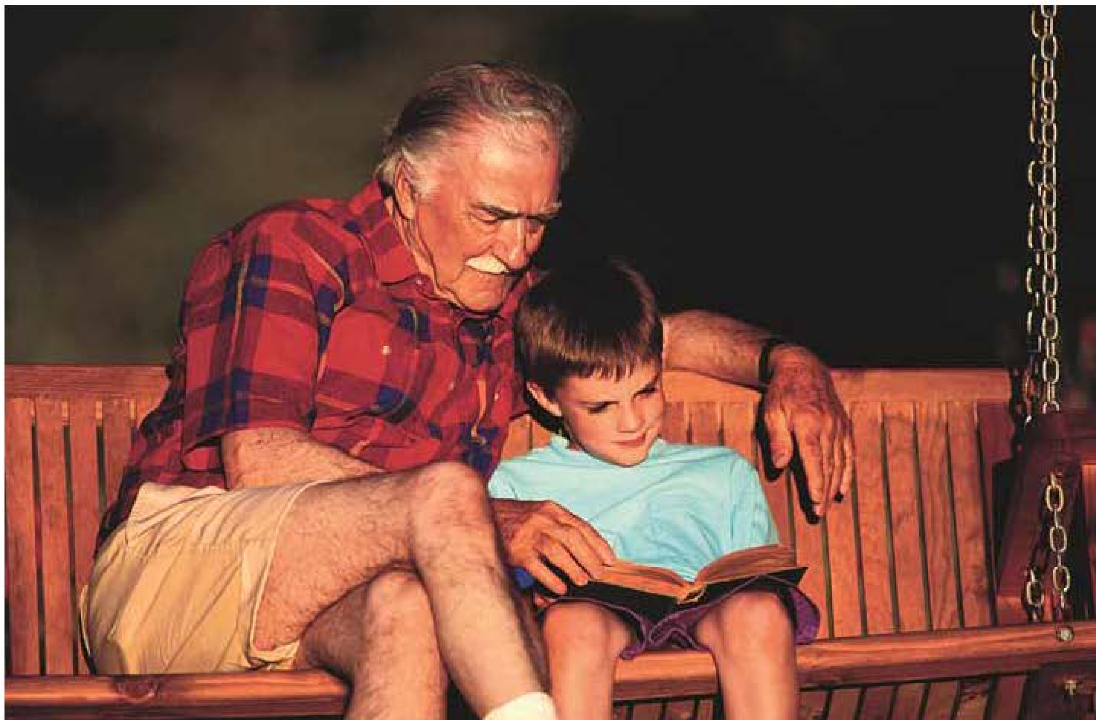


Christopher Nanni
President and CEO
Community Foundation of Greater Birmingham

Background: The AdvantAge Initiative

The AdvantAge Initiative is a project of the Center for Home Care Policy and Research (CHCPR) of the Visiting Nurse Service of New York (VNSNY) that began in 1999 with support from the Archstone Foundation, Atlantic Philanthropies, the Hartford Foundation, the Robert Wood Johnson Foundation, the Retirement Research Foundation and the Fan Fox and Leslie R. Samuels Foundation.

The purpose of the Initiative is to help organizations measure the "aging-friendliness" of their communities, develop plans and implement action steps to make their communities better places to live for older adults and their families. The components of the AdvantAge Initiative include: a framework with four domains of an aging-friendly community, pictured on page four; a set of indicators that help measure community aging-friendliness within each of those domains; a consumer survey questionnaire relating to the indicators; a stakeholder engagement process; and technical assistance to help organizations conduct the Initiative in their communities. The centerpiece of the AdvantAge Initiative is a consumer survey designed not only to gather basic information about older adults, but also to elicit their perceptions of, and experiences in, their communities. This information helps stakeholders identify community assets and opportunities for action, set priorities and develop responses to identified aging issues. To date, the AdvantAge Initiative survey has been conducted in 60 communities nationwide.



The AdvantAge Initiative Framework: Four Domains of an Aging-Friendly Community

Survey Overview

In 2014, the Community Foundation of Greater Birmingham commissioned the AdvantAge Initiative team at the CHCPR to conduct the AdvantAge telephone survey with random samples of adults aged 60+ in six Alabama counties: Blount, Chilton, Jefferson, St. Clair, Shelby, and Walker. Jefferson County was divided into five areas: Area 1 (Rural); Area 2 (West); Area 3 (Central); Area 4 (East); and Area 5 (South).

The AdvantAge team contracted with SSRS, a professional survey research company in Media, PA, which has conducted the majority of AdvantAge Initiative telephone surveys to date. The team conferred with Community Foundation of Greater Birmingham staff members and with staff at SSRS to customize the basic AdvantAge survey questionnaire to include questions on a variety of topics of interest to the Foundation. Once the survey questionnaire was finalized, SSRS conducted interviewer trainings and test calls, then put the survey into the field. Adults aged 60+ living in the geographic areas shown on the map on page six were eligible to take the survey.[1]

The survey was in the field from November 8, 2014 to January 19, 2015, and the average length of the survey interviews was 36 minutes. The survey questionnaire included an option for respondents to enter a drawing to win five $100 gift cards. When the survey was finished, SSRS used a program to randomly select the five winners from the pool of respondents who entered the drawing, and these names and their contact information were sent to the Foundation. Please see Appendix A, Zip Codes (page 42) for additional information about the survey methodology. Seniors in the six counties who responded to the survey had different reasons for doing so: one in five (20%) said they took the survey because they wanted to make a contribution to their community; 32% said that they were curious to hear the survey questions; and others said they responded for other reasons, such as wanting to enter the raffle. In total, 1,759 survey interviews were completed.

The survey findings summarized in this report follow the AdvantAge Initiative framework—the four domains of an aging-friendly community and the 21 indicators Appendix A, Indicators (page 43) within the domains. The findings are reported as percentages of the whole 60+ population in the six-county area and, where warranted, comparisons are made between findings for the whole population and findings for individual geographic areas, such as individual counties or areas within Jefferson County. Sometimes, there are very few differences between findings for the whole 60+ population and those of the 60+ population in individual geographic areas. In other cases, the differences are of interest and are reported as well. For example, in the following, the percentage of the whole 60+ population ("7% of older adults overall") is contrasted with two areas within Jefferson County, where the percentages were the highest among all the geographic areas: "Sixteen percent (16%) of older adults in Central Jefferson County (A3) and 13% of those in East Jefferson County (A4) got emergency food from a food pantry in the past 12 months, compared to 7% of older adults overall" Similar types of comparisons can be found throughout this report.

1. 29% of the respondents in the survey sample were between the ages of 60 and 64, and 71% were aged 65+

ADVANTAGE REGIONAL SURVEY AREAS

JEFFERSON COUNTY

AREA 1 - RURAL
AREA 2 - WEST
AREA 3 - CENTRAL
AREA 4 - EAST
AREA 5 - SOUTH
WALKER
ST. CLAIR
SHELBY
CHILTON
BLOUNT

COMMUNITY FOUNDATION OF GREATER BIRMINGHAM

BLOUNT COUNTY
WALKER COUNTY
ST. CLAIR COUNTY
JEFFERSON COUNTY
1
2
3
4
5
5
SHELBY COUNTY
CHILTON COUNTY

RPCGB

0 5 10 20 Miles

Demographic Characteristics

The percentage of adults aged 65+ in the U.S. population is 14.1%, and the 65+ population in the state of Alabama is slightly higher, 14.9%. The percentage of adults aged 65+ living in the six surveyed counties varies from county to county. Four of the counties (Blount, Chilton, St. Clair, and Walker) have a higher proportion of adults aged 65+ in their population than does the U.S. as a whole, and two counties (Jefferson and Shelby) have a lower proportion. Chilton County has the same percentage of people 65+ as the state of Alabama (14.9%), and Walker County is the "oldest" compared to the U.S., Alabama, and the other five counties.[2] Looking to the future, it is projected that by 2030 Alabama's 60+ population will increase by more than 40%. This growth will be significantly faster than the growth of other segments of the population and will have a profound effect on state and local organizations and communities. In this study, we chose to include adults age 60 to 64 to help us fully understand the effects of this growth. Following are the demographic characteristics of adults 60+ in the study area.

CHARACTERISTICS	PERCENTAGE
Gender	
Male	44%
Female	56%
Age	
60-64	29%
65-74	42%
75-84	23%
85+	6%
Race	
White	78%
Black	20%
Other	2%
Educational level	
Less than high school	7%
High school or GED	26%
Some college	31%
College graduate	17%
Some graduate study/graduate degree	19%
Marital Status	
Single	7%
Married/Partnered	62%
Widowed	21%
Divorced/Separated	10%

2. State and County QuickFacts from the U.S. Census Bureau, 2014 Estimated Population.

CHARACTERISTICS	PERCENTAGE
Living Arrangement	
Lives alone	25%
Lives with others	75%
Living Children	
No children	10%
One child	15%
Two children	35%
Three or more children	40%
Self-rated Health Status	
Excellent	15%
Very Good	37%
Good	30%
Fair	14%
Poor	4%
Employment Status	
Retired	72%
Working full-time	14%
Working part-time	6%
Not working but seeking employment	1%
Not working and not seeking employment	6%
Income	
Less than $35,000 per year	42%
$35,000 - $60,000	26%
$60,000 or more	32%
Number of Years in the Community	
Less than 10 years	9%
10-19 years	11%
20-29 years	11%
30-39 years	10%
40-49 years	9%
50 years or more	49%

Older Adults: A Vital Community Asset

The AdvantAge Initiative survey is not merely a needs assessment. It also provides a window into the contributions of older adults in the geographic areas that were surveyed. For example:

Older adults in the six-county area contribute to neighborhood stability

- **79%** of older adults have lived in their communities for 20 or more years
- **93%** said that they would like to stay in their current residences for as long as possible
- **95%** said that they are satisfied with their neighborhoods as places to live

They are civic minded

- **92%** voted in local elections
- **40%** contacted their local officials
- **29%** notified the police or other government agency about a problem in their community
- **92%** made a donation of money or goods to charity

They volunteer their time for a variety of organizations and causes

- **40%** do volunteer work in the community, assisting civic and social organizations, tutoring or mentoring youth, and helping other seniors
- In Jefferson County South (A5), fully **50%** of older adults volunteer, and the percentages of volunteers in Chilton County (**46%**) and Shelby County (**40%**) are not far behind

They are caregivers to family members and friends

- About one in three (**31%**) older adults report being a caregiver, providing help or care, or arranging for help or care, to a relative or friend because that person is unable to do some things for him or herself
- Half of these caregivers have been caring for the person for more than 3 years, and the amount of time they spend caregiving ranges from 1 hour to 10 hours per week
- **82%** of older adults in the six-county area have grandchildren or great-grandchildren, and of these over one-third (**37%**) are involved in providing care or babysitting for them

"Older Alabamians are engaged in making life better for their families and communities. They are volunteers, they are caregivers, and they are community activists. Their wisdom and energy is a valuable resource to all."
Candi Williams, AARP Alabama

Priorities for Community Action

In addition to identifying the contributions that older adults provide to their families and communities, some of the survey findings show that there is room to improve community responsiveness to the needs of older adults. Working groups of community stakeholders were convened around each of the four domains of an elder-friendly community. These groups were asked to review the findings of the survey and identify priorities for improvement based not only on the data collected, but also on their expertise and experience in working with seniors in our community.

Each stakeholder group determined "priorities for action" within its domain – areas where local government, the business sector, philanthropic organizations, community-based organizations, medical and social services providers, volunteers and others could intervene to address the unmet needs of older adults and improve the aging- friendliness of their communities.

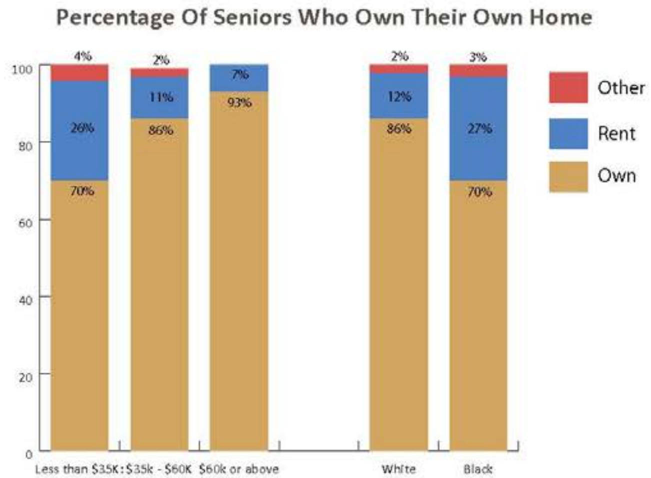
These findings are discussed one domain at a time.

Domain I: Basic Needs

Overview

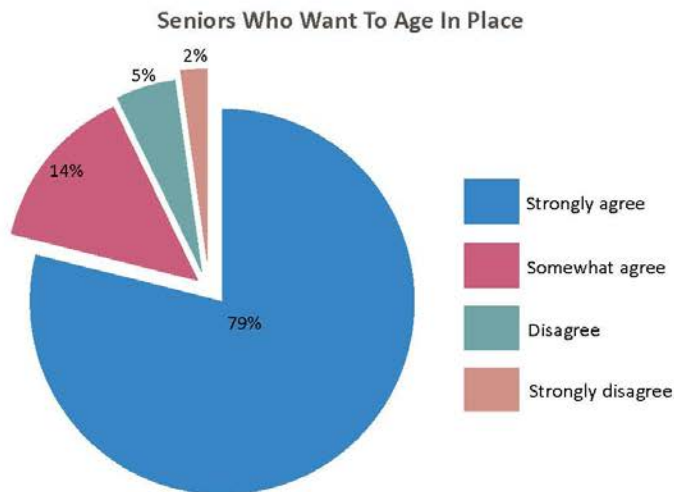
In the "Basic Needs" domain, we include four broad topics that are essential to older adults' ability to stay in their homes and communities for as long as they would like, which is popularly known as "aging in place." Included in this domain are indicators related to housing, safety, financial security, access to healthy food and access to information.

Housing Needs



Overall, in the six-county area, the vast majority of older adults (83%) own their homes, slightly higher than the rate of homeownership nationally (81%). However, within geographic areas, homeownership rates vary widely. For example, homeownership is lowest in Central Jefferson County (A3), where 60% of older adults own their own homes, and highest in Chilton County (93%). The survey shows that income disparities play a part in rates of home ownership. The median income in 2013 for 65+ households in the U.S. was $35,611. Within the six-county area, Central and East Jefferson County (A3 and A4) have the greatest proportion of lower income older adults – 66% in Central Jefferson County (A3) and 58% in East Jefferson County (A4) have annual incomes under $35,000. Lower income adults, as well as African Americans, are much more likely to rent than own their homes.

In the survey, older adults were asked whether they agree or disagree with the statement, "What I'd really like to do is stay in my current residence for as long as possible." Overall, 93% said they agree or strongly agree with that statement, while only 7% said they disagree or strongly disagree with it. However, older adults in East Jefferson County (A4) are twice as likely (14%) to say that they disagree or strongly disagree with the statement.



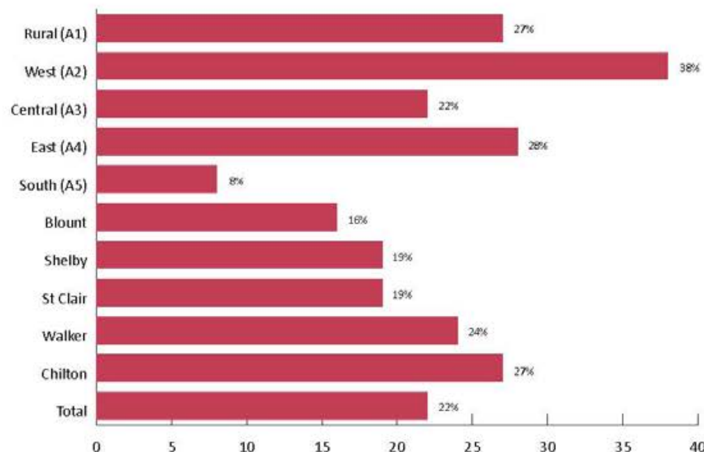
Affordable and appropriate housing is available to older community residents

The Federal government considers spending more than 30% of one's income on housing as "housing cost burden." In the six-county area, the vast majority of older adults (96%) are confident that they will be able to afford to stay in their current residences as they grow older. Overall, only 4% said that they were not confident, but that percentage was higher (9%) among older adults in East Jefferson County (A4) and 7% in West Jefferson County (A2) (See Appendix B, Figure 1 for comparisons across geographic areas).

Some older adults report that in the past 12 months there was a time when they didn't have enough money to pay their rent, mortgage, real estate taxes, and utility bills (See Appendix B, Figures 2 and 3 for comparisons across geographic areas).

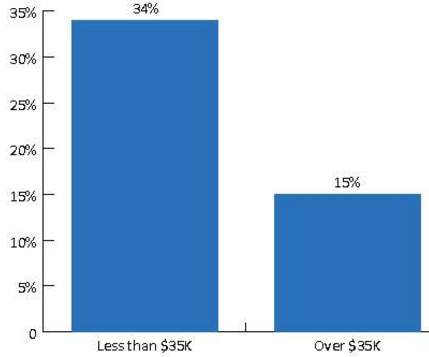
Housing is modified to accommodate mobility and safety

Overall, 22% of older adults' homes in the six-county area need modifications or repairs to improve their ability to live there in the next five years. The top three areas where older adults report home modification needs include: 1) West Jefferson County (A2), with 38% reporting home modification needs; 2) East Jefferson County (A4), where 28% have such needs; and 3) Chilton County, where 27% have home modification needs. When these survey areas are broken down further into zip codes, the need for home modification is even greater in some areas. For example, in West Jefferson County zip codes 35228 (63%) and 35020 (64%) report having home modification needs. Similarly, in East Jefferson County zip code 35212 reports 54% of older adults need home modifications.

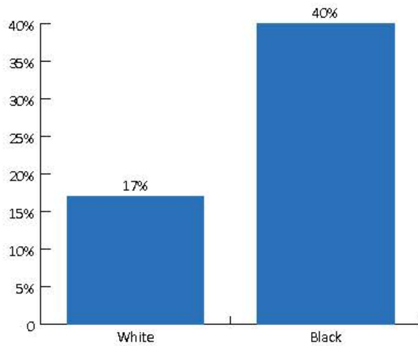


There are also wide disparities in the need for major repairs by race, income and health status:

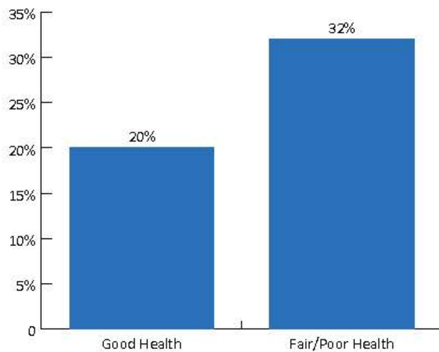
Need Home Repairs Or Modifications By Income



Need Home Repairs Or Modifications By Race



Need Home Repairs Or Modifications By Health Status



The top home modifications that older adults need include:

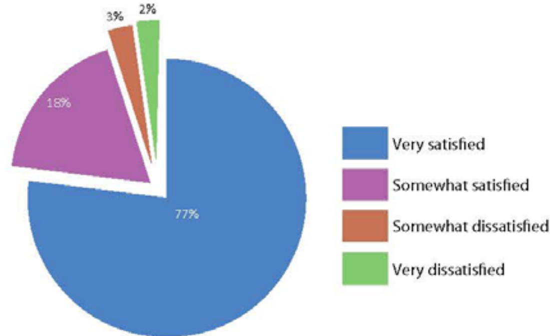
- **68%** need minor repairs such as painting and floor refinishing
- **48%** need bathroom modification, such as installation of grab bars, handrails, elevated toilets or non-slip floors
- **44%** need major repairs, such as a new roof or plumbing
- **28%** need better heating in the winter
- **27%** need accommodations to get in or out of the home, such as ramps
- **22%** need help dealing with insects or rodents
- **18%** need an emergency response system installed

"Sometimes simple additions like a handrail on outside steps, a grab bar in a bathroom or repairing exterior siding can help older adults continue to live independently in their homes." Adam Guthrie, Avondale Samaritan Place

The neighborhood is livable and safe

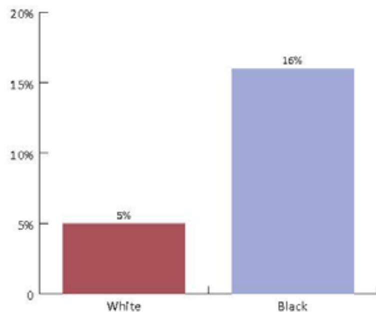
Despite identifying multiple neighborhood problems, the vast majority of older adults (95%) are satisfied with their neighborhoods as places to live. However, 11% in Central Jefferson County (A3) and 10% in East Jefferson County (A4) say that they are somewhat or very dissatisfied with their neighborhoods.

Percentage Who Are Satisfied With The Neighborhood As A Place To Live

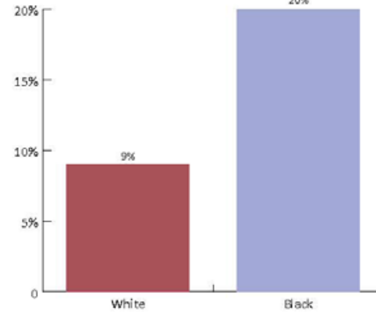


In our survey area, disparities rise to the surface when people are asked about safety and security in their neighborhoods. For example, in the following charts we see the differences in perceptions about neighborhood safety between racial groups.

Personal Safety Is Fair Or Poor



Crime Is A Big Problem

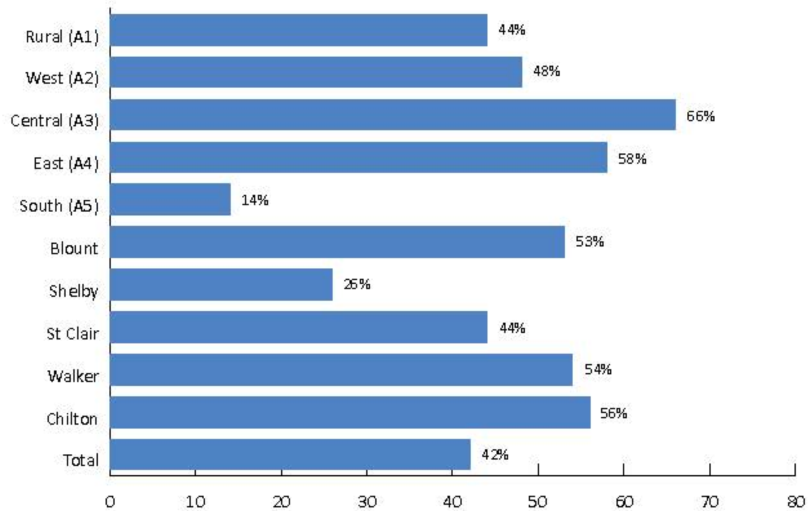


The percentage of older adults who feel that safety in their neighborhood is fair or poor ranges from 1% to 18% across the six-county area (See Appendix B, Figure 4 for comparisons). Residents of West, Central, and East Jefferson County (A2, 3, and 4) are more likely than others to say that safety is fair or poor in their neighborhoods, as are African Americans.

Overall, the top five neighborhood problems cited by older adults in the six-county area include: 1) Streets and sidewalks need repair or don't exist (21%); 2) People don't get involved in efforts to improve the community (20%); 3) Heavy traffic (14%); 4) Not enough affordable housing (13%); and 5) Crime (11%) (See Appendix B, Figures 5-9 for comparisons across the 6-county area).

Financial security

As shown in the demographic table in on pages 7 and 8, 42% of older adults in the six-county area have annual incomes under $35,000. The percentage of lower income individuals is considerably higher in Central Jefferson County (A3) and East Jefferson County (A4), as well as Blount, Walker, and Chilton Counties. Older adults in these areas had more difficulties affording housing-related costs than those in other areas (See previously referenced charts, Appendix B, Figures 2 and 3).



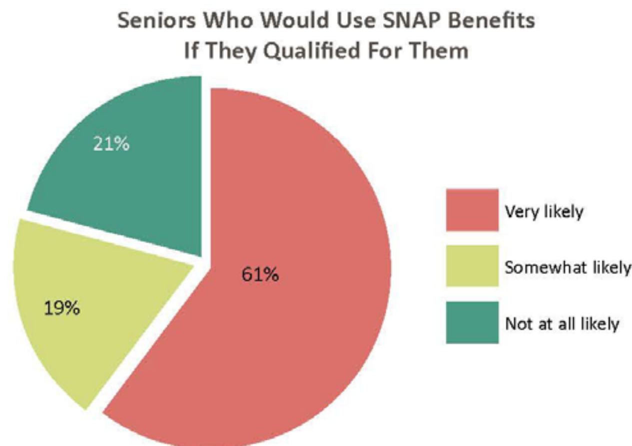
People have access to healthy food

Seven percent (7%) of adults aged 60+ in the six-county area have cut the size of, or skipped meals, in the past year because they didn't have enough money for food. This is slightly less than the 9% of older adults nationally who are "food insecure," meaning that they did not have access at all times to enough food for an active, healthy life for all household members.[3] In the six-county area, however, the percentages were higher in some regions (See Appendix B, Figure 10).

Additionally, among seniors with incomes below $35k almost one in five (17%) report skipping meals. More than a quarter of these low-income adults report that food pantries don't exist or they are not aware if they exist in their neighborhood. Overall, 7% of seniors report that they have utilized a food pantry in the past 12 months, although this percentage is higher in some areas. For example, 16% in Central Jefferson County (A3) and 13% in East Jefferson County (A4) got emergency food supplies from a food pantry in the past 12 months.

According to the AARP Public Policy Institute, 18% of older adults in the U.S. receive SNAP benefits (better known as "food stamps"). In the six-county area surveyed, only 6% of older adults overall take advantage of this benefit. Although in some areas this percentage is higher (for example, 26% of older adults in Central Jefferson County (A3) and 12% in East Jefferson County (A4)), many more seniors in the 6-county area likely qualify for this benefit but are not currently using it. In Rural Jefferson County (A1) only 2% of seniors utilize SNAP benefits, while in both Shelby and St. Clair Counties, only 3% of seniors receive SNAP. Survey results show that the majority of older adults in the six-county area who do not currently receive SNAP benefits would use these benefits if they qualified for them: 61% would be "very likely" to use them and 19% would be "somewhat likely" to use them. Only one in five (21%) are "not at all likely" to use SNAP benefits even if they qualified for them.

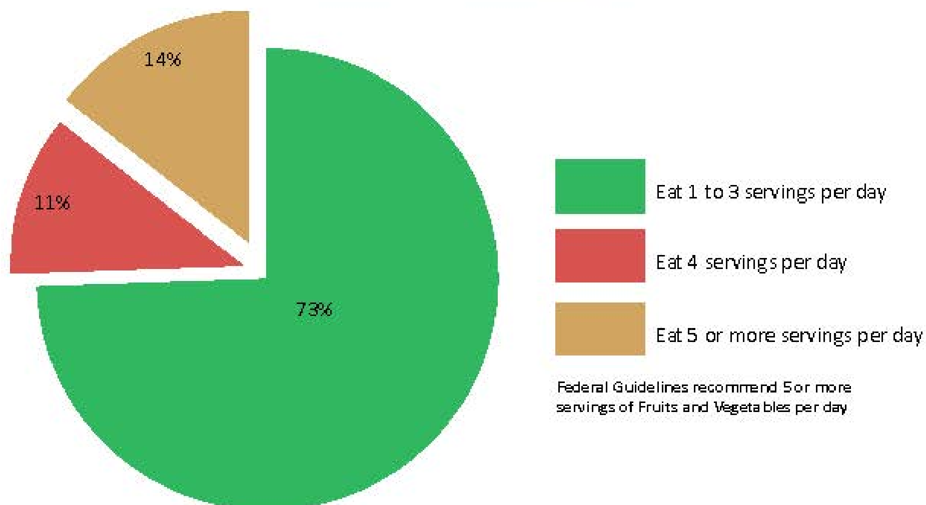
Seniors Who Would Use SNAP Benefits If They Qualified For Them



3. Retrieved from: http://www.feedingamerica.org/hunger-in-america/impact-of-hunger/senior-hunger/senior-hunger-fact-sheet.html

Finally, the quality of the food that people eat is as important as the quantity. Federal dietary guidelines include the recommendation that people should consume five or more servings of fruits and vegetables per day.[4] The vast majority of older adults (73%) in the six-county area eat only 1 to 3 servings of fruits and vegetables on a typical day; 11% have 4 servings; and 14% have the recommended 5 or more servings (See Appendix B, Figures 11-13 for comparisons across geographic areas). Additionally, one in five (20%) report that there aren't convenient places in their neighborhoods to buy fresh fruits and vegetables. In Central Jefferson County (A3), that figure is 31%. Overall, 7% report that fresh fruits and vegetables are not affordable in their area, and surprisingly, 15% in rural Jefferson County say that fruits and vegetables are unaffordable.

Seniors Who Consume Daily Recommended Number Of Fruits & Vegetables



4. A serving is one piece of fruit; or ½ cup of vegetables; or 1 full cup of greens, such as lettuce or spinach.

People have access to information

Nowadays it is common for people of all ages to access information via the Internet, and seniors in the six-county area are no different. Overall, 68% of older adults in the six-county area use computers. A full 88% of those with access to computers use them to send and receive email; 87% use search engines to find information; 62% find information about community events and do online shopping; 51% do online banking; and 50% use a social networking site such as Facebook or Twitter. Still, there is evidence of a digital divide in the six-county area. Nearly half (49%) of seniors in Central Jefferson County (A3) do not use computers nor do 42% of seniors in West Jefferson County (A2), 41% in Walker County and 41% in Chilton County.

Area Agencies on Aging are normally a source of information about area resources for seniors, but this was not the case in most areas surveyed. Two-thirds (67%) of older adults in the six-county area are not familiar with the Middle Alabama Area Agency on Aging (M4A) or the Jefferson County Office of Senior Citizen Services. Percentages of older adults unfamiliar with these agencies are even higher in Blount (74%); Shelby (77%); Walker (77%); and St. Clair (84%) Counties. Overall, 82% of older residents have never attended one of the programs these agencies provide, and 72% have never contacted them for information. When reporting the best source of information about services in their communities, only 6% of older adults mention the M4A or the Jefferson County Office of Senior Citizen Services.

67% of Senior Adults in the six-county survey area are not familiar with the Middle Alabama Area Agency on Aging (M4A) or the Jefferson County Office of Senior Citizen Services.

Priorities for Action: Basic Needs

Housing

- Develop more affordable senior housing options, especially utilizing new models of community-based, continuing care communities
- Increase availability of home modification services, focusing on accessibility issues
- Increase availability of in-home services that help seniors age in place (e.g. homemaker services, medication management, meal preparation)
- Conduct safety assessments and deploy technological advances in the home that facilitate aging in place

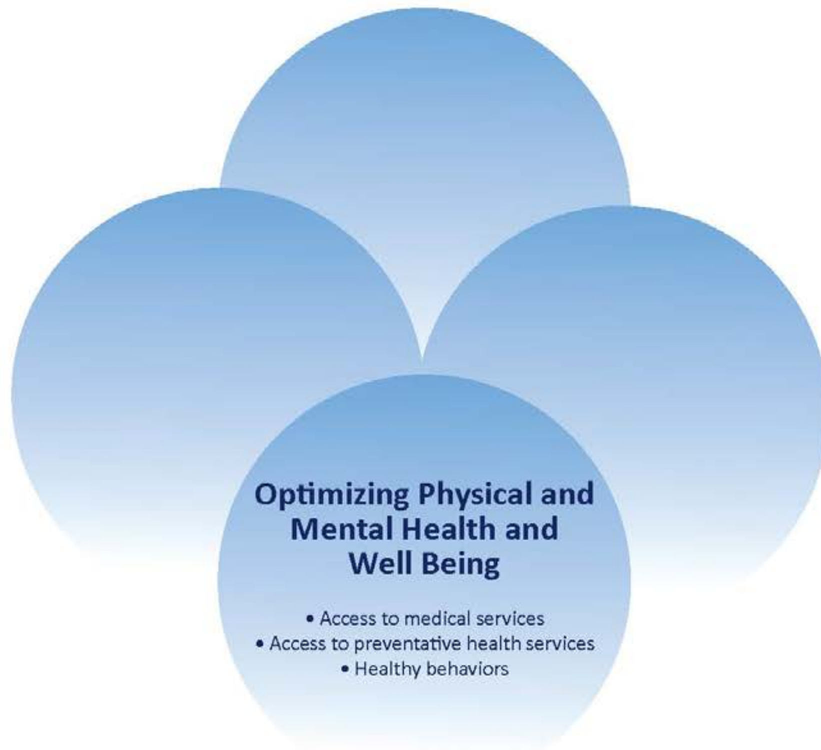
"We are exploring a variety of options, including education about SNAP benefits, to help get affordable, healthy food to senior adults in our area."
Gus Heard- Hughes,
Community Foundation

Access to Healthy Food

- Identify food deserts; increase the quality of food, with a focus on fruit, vegetables, and protein; and develop innovative partnerships to connect seniors with healthy prepared foods
- Conduct a campaign around the availability of SNAP benefits for seniors, prioritizing outreach to outlying counties

Access to Information

- Develop an easily accessible hub for information about services for seniors
- Institute a "no wrong door" approach to information and referral
- Use a common intake process, sharing information among social service agencies to better connect seniors with community services



Domain II: Optimizing Physical and Mental Health and Well-Being

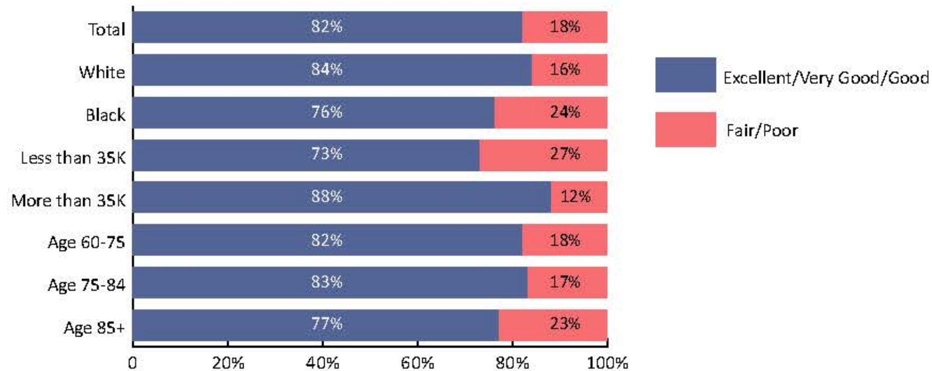
Overview

The key indicators in this domain relate to healthy behaviors, access to preventative and needed medical care, and health risks. Following are selected survey findings that measure different aspects of older adults' health status and needs.

Physical and mental health status

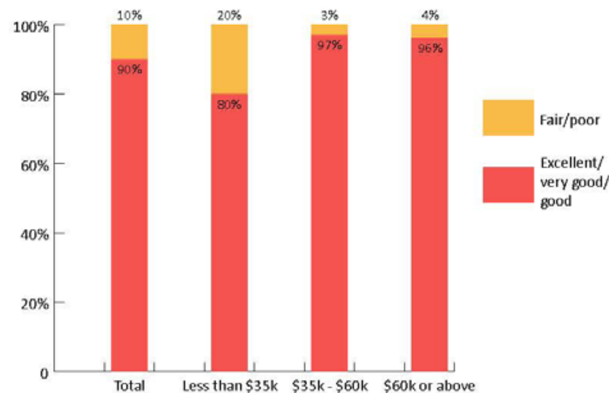
Research has shown that individuals' rating of their own health is a good measure of their actual health status. Overall, 82% of older adults in the six-county area rate their health as good, very good, or excellent, compared to 76% of older adults in the entire U.S.[5] Only 18% rated their health as fair or poor, compared to 23% nationally.[6] Older adults in the six-county area seem to be doing better than older adults nationally, but as shown in Appendix C, Figure 14, the percentage of older adults reporting fair or poor health is noticeably higher than 18% in some areas. Additionally, there are marked demographic differences in the percentage of seniors who say their health is fair or poor.

Health Status By Demographics

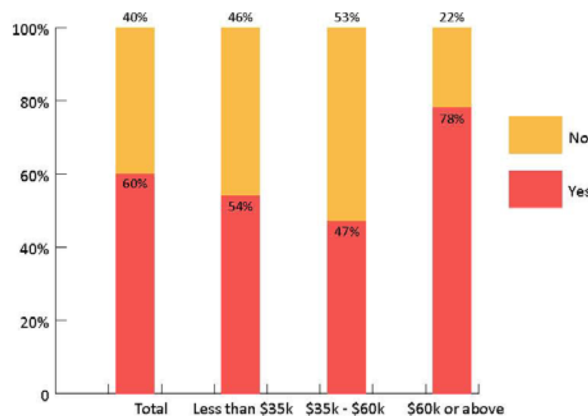


5 Federal Interagency Forum on Aging-Related Statistics. (June 2012.) Older Americans 2012: Key Indicators of Well-Being. Federal Interagency Forum on Aging-Related Statistics. Washington, DC: U.S. Government Printing Office.
6 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (May, 2014). Health, United States, 2014.

In the area of mental health, our 6-county area has much room for improvement. Nationally, according to the Centers for Disease Control and Prevention (CDC), rates of depression among older adults range from 1% to 5%, with the highest rates found among older adults who have other illnesses, such as heart disease or cancer, or who have functional limitations. In the six-county survey area, 10% of older adults rate their mental health status as fair or poor, but the percentage of people reporting fair or poor mental health status was much higher than 10% in three of the geographic areas (See Appendix C, Figure 15). Additionally, 13% of older adults say that there was a time in the past year when they thought they needed the help of a health professional because they felt depressed or anxious, and of these, two of five (40%) did not get the professional help they thought they needed (See Appendix C, Figure 16 for comparisons across geographic areas).

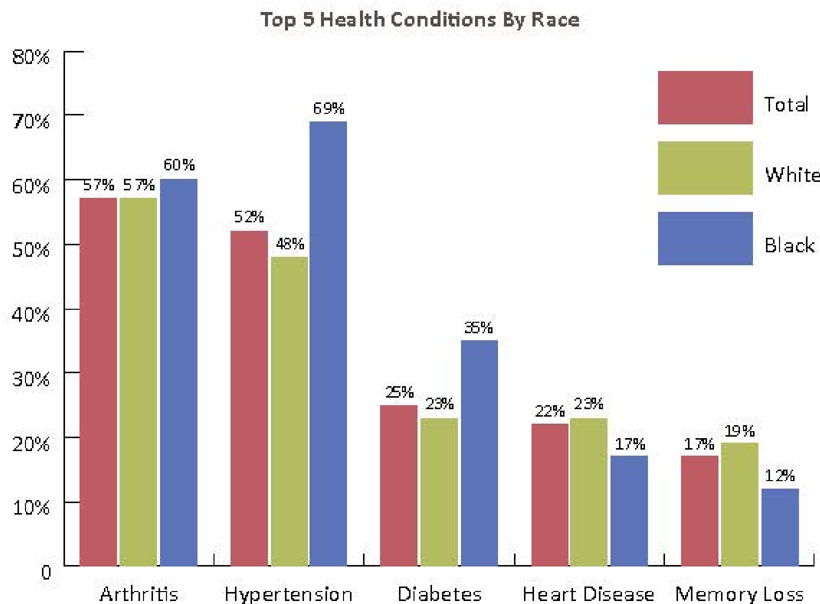


Seniors with lower incomes (less than $35,000) were more likely to rate their mental health as fair or poor and were less likely to report receiving care for depression or anxiety. Interestingly, those with moderate income levels ($35,000 to $60,000) are the least likely to report getting the help they needed.



Health conditions

The top 5 chronic health conditions among older adults in the six-county area are: 1) arthritis (57%); 2) hypertension or high blood pressure (53%); 3) diabetes (25%); 4) heart disease (22%); and 5) memory loss (17%). Nationally, 56% of people 65 and older have hypertension; 30% have heart disease; and 21% have diabetes.[7]



Access to Care

There is good news with respect to access to medical services. Virtually all older adults in the six-county area have some form of health insurance, including Medicare (75%), employer or union-provided insurance (44%), private insurance (30%), one of the health insurance plans offered by the state of Alabama (23%), veterans' insurance (14%), and Medicaid (8%). Many seniors report having more than one medical insurance provider. Additionally, virtually all have a usual source of health care. Most (82%) get their primary care at a private doctor's office, while others (10%) get their care at a clinic or health center. Receiving care at a clinic is higher in four of the five areas in Jefferson County: Rural (A1) (14%); West (A2) (16%); Central (A3) (18%), and East (A4) (12%). Only 1% of older adults do not have a regular place to go for their medical care.

7 Older Americans 2012: Key Indicators of Well-Being, op cit.

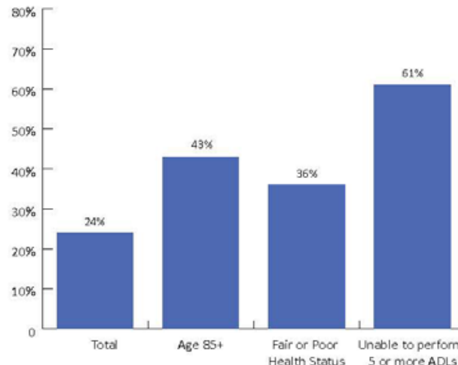
Medication management

Taking medications exactly as prescribed is very important for older patients, particularly for those who take multiple medications. In the six-county area, 91% of older adults take medications every day. Of those 82% have an up-to-date list of their medications, while 18% do not. Many (46%) keep the list in their wallets or purses, on their computers (14%), or "somewhere else" (48%). Twenty-seven percent (27%) report that they sometimes forget to take their medications.

Falls

> *"About half of all falls happen at home. A home safety check can help identify potential fall hazards that need to be removed or changed, such as tripping hazards, clutter, and poor lighting."*
> *– Center for Disease Control and Prevention*

According to the Centers for Disease Control and Prevention, one in three older adults falls each year. Among older adults, falls are the leading cause of both fatal and nonfatal injuries.[8] While seniors in our region report fewer falls than the national average, nearly a quarter of senior adults in the six-county area (24%) say that they fell to the ground in the past year and over half of these report falling more than once. The falls happened indoors (47%), outdoors (32%), and both indoors and outdoors (21%). The highest rates of falls are found in Walker County (36%); Blount County (31%); and Chilton County (31%). As expected, those seniors over the age of 85, those in fair or poor health and those with limited activity report a higher incidence of falls.



Dental care

Overall, 44% of older adults in the six-county area have all their own teeth and 56% do not. Fifty-two percent (52%) do not have dental insurance, but 69% visit their dentist at least once per year, although there is variation across geographic areas (See Appendix C, Figure 17). The top three reasons older adults do not see their dentist once a year are: 1) "Dentist visits are too expensive" (30%); 2) "I wear dentures/I don't have my own teeth" (24%); and 3) "I don't think I need to see

8 Centers for Disease Control and Prevention, Falls Among Older Adults: An Overview, Retrieved from http://www.cdc.gov/homeandrecreationalstudy/Falls/adultfalls.html

a dentist" (23%). Appendix C, Figures 18-20 show the reasons for not seeing a dentist at least annually, across geographic areas. Among those who currently have dental needs, 42% say they need a routine cleaning and 12% say they need dentures.

Preventative health measures

Overall, older adults in the six-county area did well in accessing some of the recommended health screenings in the past 12 months. For example, 97% had their blood pressure checked by a health professional; 91% were screened for cholesterol levels; 83% had a colonoscopy in the past 10 years; 80% had a test for high blood sugar; and 72% had an eye exam. The lowest rate of screening is seen in hearing tests. Only 26% of seniors in the six-county area report having a hearing test in the past 12 months. This low rate is remarkably consistent across geographic areas and demographic characteristics.[9]

There is, however, room for improvement. For example, 18% of older adults in Walker County, 16% in Chilton County, and 13% in St. Clair County have never had a colonoscopy. Overall, 42% of seniors did not get a flu shot in the past year. In Blount County half (50%) did not get a flu shot. Thirty-seven percent (37%) overall; 43% in Shelby County; and 42% in Central Jefferson County (A3) have never had a pneumonia shot. These are all preventative measures that can provide substantial health benefits for older adults.

Seniors Who Have Not Accessed The Following Health Measures In The Past Year

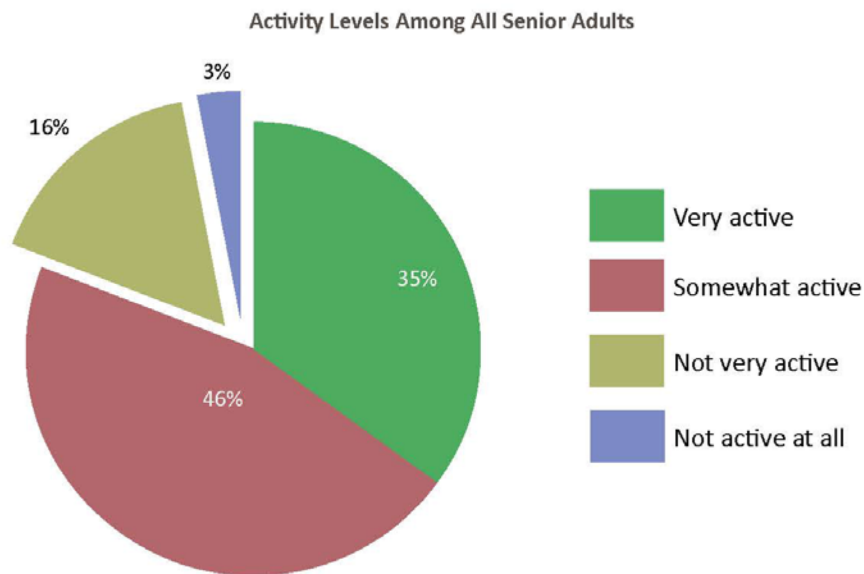
Area	Complete Physical	Eye Exam	Flu Shot	Pneumonia Shot
Area 1 (Rural)	14%	32%	44%	35%
Area 2 (West)	18%	25%	44%	33%
Area 3 (Central)	11%	26%	47%	42%
Area 4 (East)	20%	33%	47%	34%
Area 5 (South)	11%	17%	28%	35%
Blount	20%	26%	50%	33%
Shelby	15%	31%	45%	43%
St. Clair	27%	32%	43%	36%
Walker	26%	34%	43%	38%
Chilton	32%	27%	45%	41%
Total	**17%**	**28%**	**42%**	**37%**

9 Interestingly, in every survey the AdvantAge Initiative team has conducted, the rates for hearing tests are always the lowest. It is not clear why exactly this is so, but some possible explanations include: 1) primary care physicians do not routinely refer older adults for hearing tests; 2) people don't get hearing tests unless they feel there is a problem with their hearing; 3) insurance doesn't cover it; 4) people think that hearing loss is a natural part of aging; and 5) people avoid the test because if hearing loss is found, it is possible that the only remedy is a hearing aid and hearing aids are prohibitively expensive.

Physical activity

A little more than one in three (35%) seniors in the six-county area rate themselves as "very physically active;" 46% report being "somewhat active," and 20% as "not very active" or "not active at all" (See Appendix C, Figures 21-23 for older adults' activity levels across geographic areas).

The Centers for Disease Control and Prevention recommend getting at least 150 minutes of moderate-intensity aerobic activity (such as brisk walking or fast bicycling) every week and muscle strengthening activities two or more days a week. In the U.S. as a whole, only 11% of people age 65+ report participating in activities that meet these guidelines. Older adults in our survey area report that they far exceed national trends. Thirty percent (30%) of older adults in the six-county area do vigorous activities for at least 20 minutes three or more times per week, and some (29%) do moderate or light activities for at least 30 minutes five times per week. But there is always room for improvement. Of the seniors surveyed, 44% never do vigorous activities; 18% never do moderate or light activities; and 54% never do muscle strengthening exercises, such as pushups or lifting weights.



Paying for health care

Of all older adults in the six-county area, only 6% say that they had problems paying for medical care over the past 12 months. But in some geographic areas, higher percentages of older adults had difficulties paying not only for medical care but for prescription drugs, dental care, and eyeglasses (See Appendix C, Figures 24-26 for comparative findings across geographic areas).

Priorities for Action: Optimizing Physical and Mental Health and Well-Being

Supportive Communities

- Use faith and community-based networks to train community members and other volunteers (e.g. community health workers, parish nurses) to provide health education and support to older adults, with a special emphasis on homebound seniors
- Look for new and innovative evidence-based models for community support
- Develop new strategies for mental health interventions in the older population, such as the use of telemedicine in areas with limited mental health providers
- Develop quality assurance measures to ensure that support is available and appropriate

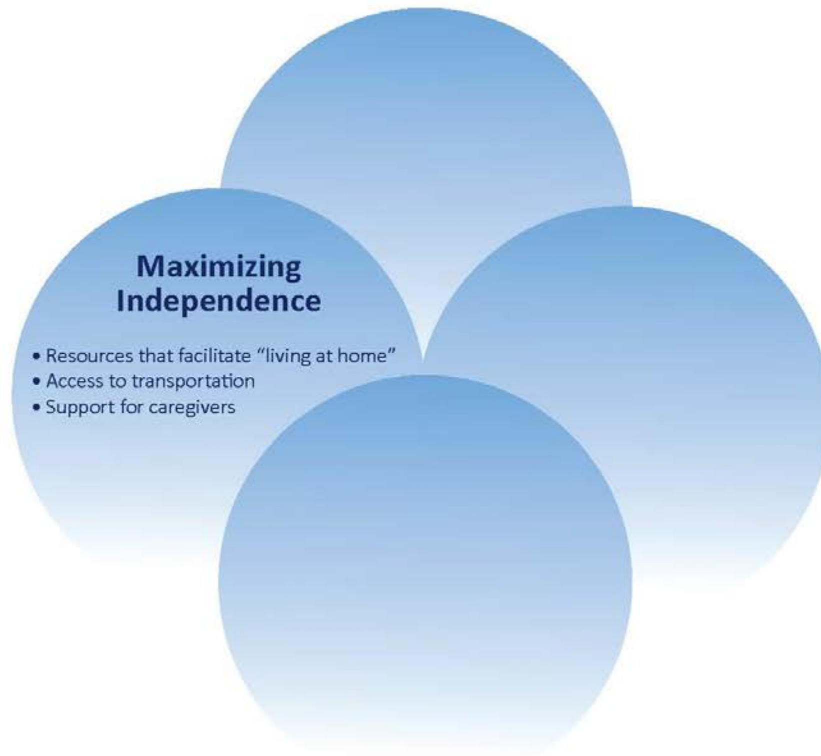
Access to Information

- Strengthen both faith and community-based information and referral networks, with special consideration given to isolated and rural areas
- Ensure that information is high quality, but presented at a relatively low literacy level and available throughout the community (e.g. through churches, libraries, clinics, drugstores)
- Place emphasis on falls prevention

Care Coordination

- Link patient-centered medical homes with community-based support and services with special consideration given to the most prevalent chronic diseases (i.e. arthritis, hypertension, and diabetes)
- Explore the use of telemedicine for areas with limited providers of care
- Partner with institutions that do annual community needs assessments, gain access to the data, and look for emerging areas of concern.

"Churches and other faith-based institutions are often already equipped with programs to meet the basic needs and concerns of their own congregants and members, especially older adults. Within their organizational structure, they meet such needs as education, elder care, pastoral care, counseling, social activities, and benevolence." - Rev. Carolyn Foster, Greater Birmingham Ministries



Domain III: Maximizing Independence for the Frail and Disabled

Overview

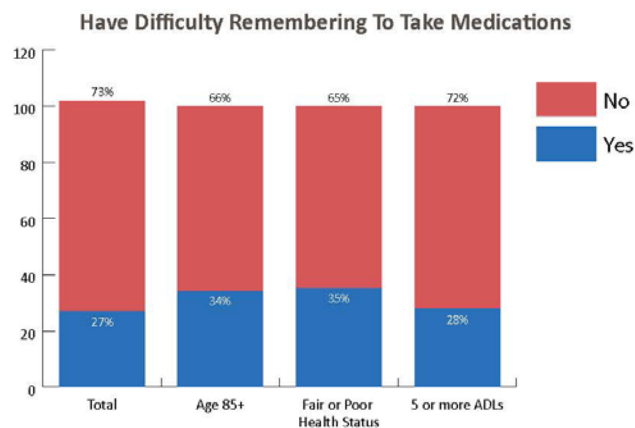
This domain focuses on the factors that enable high-need older adults to stay in their homes and communities for as long as they would like—sometimes called "aging in place" or "aging in community"—and includes such topics as having access to information and resources for living at home; mobility and transportation options; and caregiving. Key objectives of this domain are to find out what needs older adults have and whether those needs are being met; how aware they are about the availability of services in their communities; and whether they use these community-based services.

The community service system enables people to live comfortably and safely at home

Services for older adults, such as Meals on Wheels and home health aide services, are typically found in communities around the country, including in the six-county area. But utilization of these services by older adults is quite low in the survey area. Overall, only 5% have used home health aide services, and only 2% have used Meals on Wheels. Senior centers are the most frequently used service, with 10% of older adults attending senior center activities. A total of 83% have not used any of these services. As with other survey findings, there is some variation in these percentages across geographic areas (See Appendix D, Figures 27-32). These low percentages are in line with those of other AdvantAge Initiative surveys conducted in different parts of the country.[10]

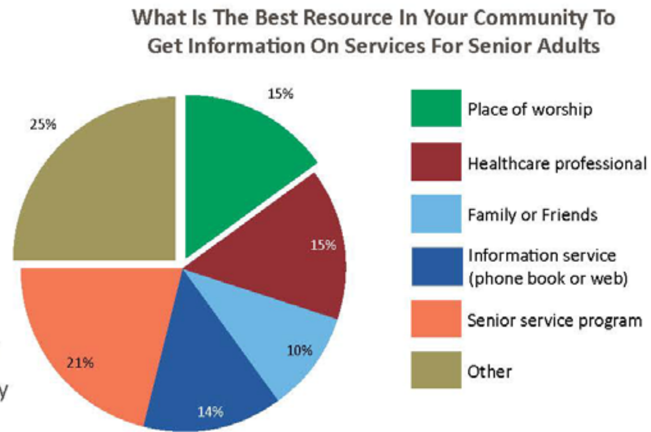
A small minority of seniors, ranging from 1% to 4% overall, report needing assistance with personal care—the activities of daily life (ADL) such as taking a bath or shower, dressing, or eating. Others, ranging from 2% to 5% overall, say they need assistance with the instrumental activities of daily living (IADL), such as driving a car, keeping track of money or bills, and taking the right amount of medications.

As reported in Domain II (page 24), medication management is a concern among seniors, and this issue is more pronounced among our most frail seniors. Among seniors who take medication every day, 27% overall report sometimes forgetting to take their medication. This percentage is noticeably higher for seniors aged 85 and older and seniors who report fair or poor health status. Additionally, while 6% of seniors report times in the past year when they did not have enough money to fill a prescription, this percentage doubles for seniors in poor health and for those reporting 5 or more ADL/IADLs.



10. Service utilization rates have been low in virtually all the AdvantAge surveys. There are several possible reasons for this, including 1) the survey did not reach sufficient numbers of disabled or homebound seniors who would typically use such services; 2) respondents don't need the services at this point in time; 3) respondents don't know about the services or don't know how to access them; and 4) the services are unavailable in their community.

Residents know how to access services



Even if people are not currently using available services to help them live at home, it's still beneficial to know whom to call in case the need for these services arises. Overall, 15% of older adults in the six-county area turn to their churches when they need information about available community services; 15% contact their doctor or other health professional; and some turn to the senior center (15%), the Internet (12%), and family and/or friends (10%). But 33% do not know whom to call (See Appendix D, Figure 33 for variations across geographic areas).

Transportation is accessible and affordable

In the US, the automobile is the primary mode of transportation and the same holds true in our six-county area. Although the vast majority of seniors report that they are always able to get transportation to places they need to go, the percentage of those who say that they are sometimes or never able to get needed transportation varies significantly across both geographic areas and demographics.

Regarding the accessibility of transportation, 93% of older adults in the six-county area are always able to get transportation to the places they need to go, but 5% are only able to get it sometimes. The vast majority (85%) of older adults drive a car or ride as a passenger in a car (12%) for their usual trips around the community. Seemingly, the only people who use public transportation are 10% of older adults who live in Central Jefferson County (A3).

In Jefferson County, where public transportation is more readily available than in outlying counties, the need appears to be greater. For example, in Central Jefferson County (A3), 19% of seniors say that they are only sometimes or never able to get transportation. Among both low-income seniors and those reporting fair or poor health status, 16% find it more difficult to access transportation.

The experts in our working groups agree that while transportation is not always identified by seniors as a critical need, the need for available, convenient, flexible and affordable public transportation will continue to grow, especially among our most vulnerable seniors. In our six-county area, because public transportation does not often meet these requirements, many seniors have learned how to "get by" using friends and families.

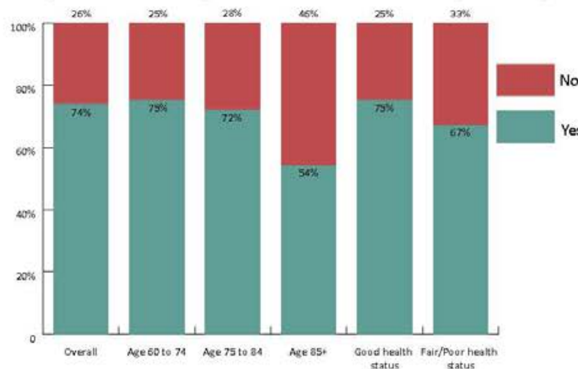
Interestingly, when asked, "Are there any programs or services that seniors need that are not available in your county?" 11% of seniors overall answer "better transportation." In Blount County, 13% say better transportation; in St. Clair County it is 14%, and in South Jefferson County (A5) it is 17%.

Informal caregivers complement the formal service system

About 31% of seniors in the six-county area report being a caregiver, providing help or care or arranging for help or care for a relative or friend because that person is unable to do some things for her or himself (See Appendix D, Figure 34 for variations across geographic areas). Half of the caregivers (50%) have been caring for the person for more than 3 years, and the amount of time they spend caregiving ranges from 1 to 3 hours per week (43%) to over 10 hours per week (34%). More than a quarter of caregivers (26%) do not get time off, or respite, from their caregiving duties (See Appendix D, Figure 35 for variations across geographic areas).

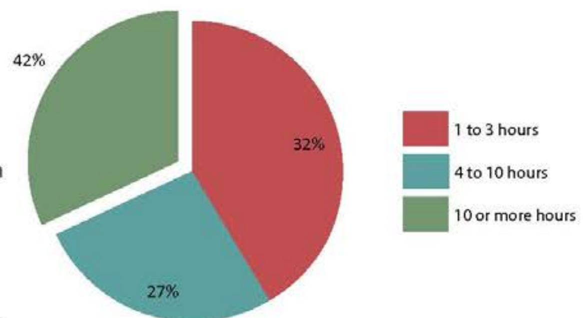
In this survey, the oldest seniors (age 85+) report the lowest incidence of respite from caregiving, as do those reporting fair or poor health statuses.

Do you sometimes get relief or time off from providing care



Eighty-two percent (82%) of older adults in the six-county area have grandchildren or great-grandchildren, and of these 37% are involved in providing care or babysitting for them. Most (42%) spend from 1 to 3 hours a week caring or babysitting for the children; others (27%) spend 4-10 hour s; and 32% spend more than 10 hours each week. Demographic differences can be seen in these rates as well, especially for those who provide the highest amount of care. Almost half (42%) of both low income seniors and African Americans report babysitting more than 10 hours each week.

Number Of Hours A Week Spent Caring For Grandchildren Or Great-grandchildren

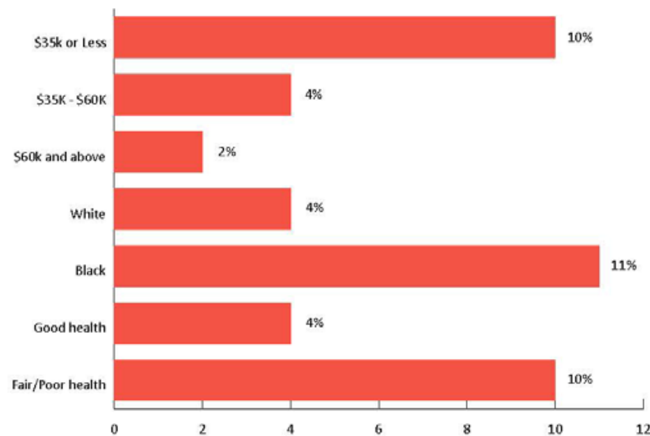


Frail and disabled older adults are free from exploitation

While the percentages are relatively small, some seniors in the six-county area have experienced some form of abuse. According to the Centers for Disease Control and Prevention, one in ten older adults nationally have experienced some form of maltreatment (e.g. physical, emotional, or financial abuse), but the numbers may be higher because many victims do not report the abuse. Older adults who are frail or disabled may be more at risk of being taken advantage of or exploited. While few older adults in the area(4%) have difficulty managing their finances, fourteen percent (14%) in Central Jefferson County (A3) and 11% in Walker County think they have been taken advantage of financially by someone they trusted with their money. Additionally, 10% of seniors overall report that someone has taken something of theirs without asking permission; 3% have signed documents that they either did not understand or did not want to sign; and one percent (1%) report that someone at home has hurt them or touched them without consent.

Payday Loans

A growing area of concern in our region is related to predatory loans, either payday or auto title loans. With interest rates of up to 456% APR for payday loans and 300% APR for auto title loans, these loan products can be devastating to the financial health of seniors, especially those on a fixed monthly income. While only 5% of seniors overall report that they have used such loans, thirteen percent (13%) in both Central Jefferson County (A3) and East Jefferson County (A4) report receiving loans from a payday or Title Loan business. Those seniors who are low-income, African Americans, and those reporting poor health are more likely to report that they have taken out these types of predatory loans.



Priorities for Action: Maximizing Independence for the Frail and Disabled

Transportation

- Advocate to improve transportation services
- Develop innovative transportation options, such as identifying and harnessing excess capacity of existing infrastructure (e.g. using church vehicles when they are idle, developing a ride sharing service with a special focus on rural areas)

"For seniors, basic tasks such as cooking, cleaning and paying bills can be difficult. Having someone come in for one or two hours per week to help can enable them to stay in their homes for a relatively low cost."
Lauren Perlman,
Collat Jewish Family Services

Access to Information

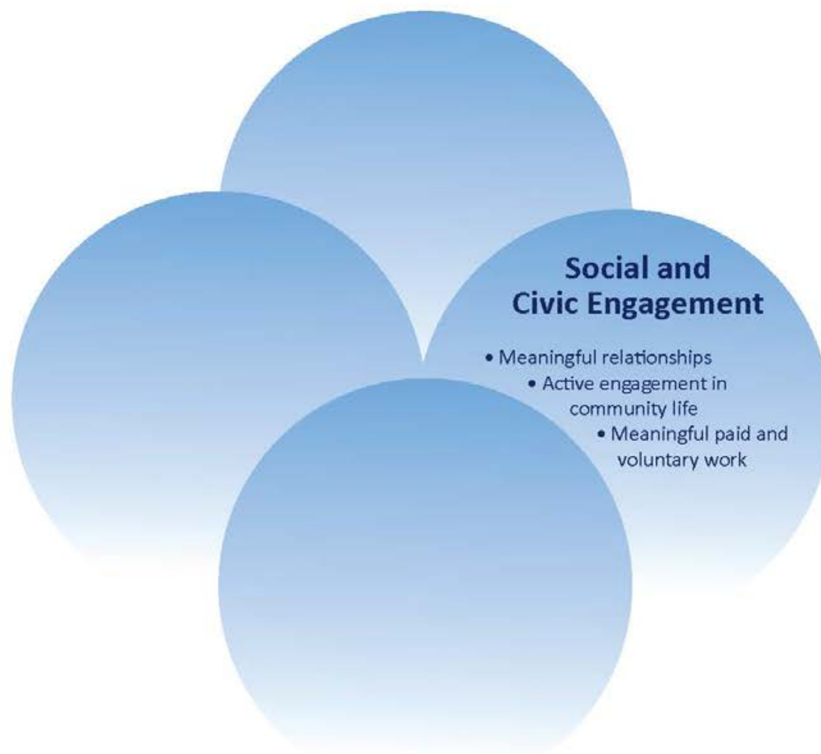
- Establish a one-stop shop utilizing a centralized, well-marketed information and referral resource, with special consideration given to rural communities and an emphasis on in-home services

Medication Management

- Work to increase assistance in paying for medication
- Improve medication adherence by helping seniors understand what their medications are for, why they are taking them, and the importance of taking the right medication at the right time; as well as assessing patients' cognitive ability to ensure that they are able to manage their medications

Caregiving

- Increase the availability of respite services for caregivers
- Focus on home modifications to enable older adults to age safely in place, with a special emphasis on technology
- Increase caregiver education
- Advocate parity between nursing homes and in-home care services



Domain IV: Promoting Social and Civic Engagement

Overview

Of the four domains in the study, this may be the one that receives the least attention from public policy makers and service providers. Yet it is, perhaps, the most important in this age of declining resources. Social and civic engagement opportunities for older adults provide access to social capital* through relationship networks that can be "budget neutral" while contributing to the richness of social life in the entire community. In the AdvantAge survey, questions in this domain address the social and cultural lives of seniors, as well as their contributions and perspectives as citizens of the community.

*Social capital is a sociological term that refers to the collective or economic benefits derived from cooperation between individuals and groups.

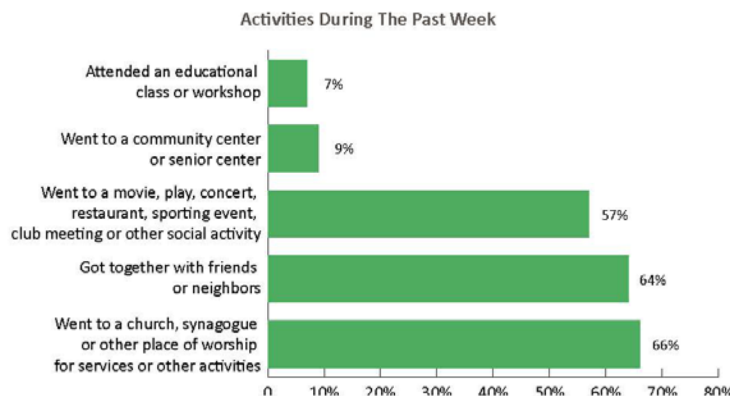
Seniors are connected

Research has long shown that meaningful relationships with family and friends and active involvement in community life can affect older adults' health in positive ways. For the most part, it seems that older adults in the six-county area are connected to their families and friends. Most have contact with family, friends and neighbors on a regular basis – e.g. every day (50%) or a few times a week (30%). A minority (15%) have contact only a few times per month. Twenty-two percent (22%) do not have any close friends or family members who live in their neighborhood or nearby and ten percent (10%) have no living children. One in four seniors (25%) lives alone, less than the national average of older adults living alone (29%). While living alone does not automatically mean that the person is isolated, it could be a contributing factor.

Older adults participate in social activities

Older adults in the six-county area are civic-minded: 92% voted in local elections; 40% contacted their elected official(s); 29% notified the police or other government agency about a problem in their community; and 92% made a donation of money or goods to a charity. There was very little variation in these percentages across geographic areas.

Seniors throughout the six-county area are more likely to engage in social activities at church or at another place of worship (66%); attend a social activity such as a movie, play, sporting event, club meeting, or card game (57%); or get together with friends or neighbors in other settings (64%) than they are to attend a community or senior center (10%) or educational classes or workshops (7%). In West Jefferson County (A2), older adults were more likely than others to attend a senior center; and older adults in West Jefferson County (A2), Central Jefferson County (A3), Walker County, and Chilton County were less likely to attend a movie, play, concert, sporting event, etc. than seniors in other areas. This may be due to seniors' lower incomes in these geographic areas or that access to these types of events is limited for other reasons (See Appendix E, Figures 36-37 for variations across geographic areas).



Overall, 28% of seniors attend religious services or meetings more than once a week, and 33% attend once a week. Sixteen percent (16%) said they attend only once a year or never. Regarding the quantity of their social activities, 59% of seniors feel that they are doing "about enough," while 39% would like to be doing more. Three percent (3%) think they are doing too much.

Older adults volunteer

While only 20% of seniors work full or part-time, the good news for our region is that seniors are active volunteers. Even more exciting is that seniors would like to be doing more; fully 2 out of 5 seniors report that they are ready and willing to be more engaged in social and civic activities. Seniors are a vital community asset and want to continue to play a meaningful role in their family, neighborhood and larger community. Our older population is an untapped resource and area organizations could benefit by reaching out to them with volunteer opportunities.

Seniors are civic minded

Social and civic engagement are related but not synonymous. Civic engagement includes such activities as voting, contacting local officials and getting involved in community improvement. Older adults are known for being reliable voters and, as in other parts of the country, the vast majority (92%) of seniors in our six-county area voted in local elections in the past three years. While 29% have contacted police or other government official about a problem, about a quarter (26%) of older adults don't think that their local officials take into account the interests and concerns of residents in their neighborhoods; and 43% think that officials only "somewhat" take into account their concerns. While there may be mixed feelings about elected officials, seniors in our region are overwhelmingly positive about their neighbors. Nearly all (93%) said that most people in their neighborhood are willing to help them if they needed it. These positive feelings were quite consistent across all demographic groups.

Opportunities for volunteer work are readily available

In addition to caring for relatives and friends who aren't able to do some things themselves, and babysitting for grandchildren or great grandchildren, older adults contribute to the community by volunteering their time for a variety of organizations and causes. Forty percent (40%) of seniors in the six-county area do volunteer work in their communities, more than in the state of Alabama as a whole, where only 24% of older adults volunteer. South Jefferson County (A5) was the "winner," with 50% of seniors saying they volunteer, and Chilton County (46%) and Shelby County (45%) are not far behind (See Appendix E, Figure 38 for variations in rates of volunteering across geographic areas).

DOMAIN IV: PROMOTING SOCIAL AND CIVIC ENGAGEMENT

Organizations Where Senior Adults Volunteer

Organization	Percent
Hospital or Nursing Home	6%
Teaching tutoring or mentoring	7%
Sernior services organization	8%
Civic or social organization	33%
Faith-based organization	44%

Forty-four percent (44%) volunteer for religious groups; 10% for civic or social organizations; 8% for other seniors; and 7% do teaching, tutoring, or mentoring. Some seniors volunteer for more than one organization. Thirty-eight percent (38%) spend between 1 and 6 hours per week volunteering; 33% volunteer between 7 and 15 hours per week; 8% spend between 16 and 20 hours; and 21% spend more than 20 hours a week volunteering.

How Many Hours Per Month Seniors Spent Volunteering

Hours	Percent
1 to 6 hours	38%
7 to 10 hours	17%
10 to 16 hours	16%
16 to 20 hours	8%
more than 20 hours	21%

Priorities for Action: Promoting Social and Civic Engagement

Faith-based Outreach and Education

- Identify faith-based organizations in the area that strongly engage and serve seniors; and collect, share, and support best practices of these organizations
- Develop training materials for faith-based organizations on topics related to seniors, such as senior isolation and the challenges of serving seniors in rural areas

Access to Information

- Establish a one-stop shop for information and referral, and develop a communications plan directing families to this resource

"The best thing about any volunteer opportunity for the aging community is that they are healthier and happier when they are working. Older adults are a valuable resource to the community and we believe that both sides benefit by connecting to each other."
Penny Kakoliris, Positive Maturity

Communications and Marketing

- Develop a branding campaign promoting the diversity and abilities of seniors and a media campaign focusing on positive senior stories

Acknowledgements

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Anne Warren, Community Volunteer
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*Facilitators for AdvantAge Initiative Domain Working Groups are indicated in bold

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Appendix A: Zip Codes

ADVANTAGE SURVEY AREAS WITH CORRESPONDING ZIP CODES (Jefferson County, Alabama)

AREA 1 - RURAL	AREA 2 - WEST	AREA 3 - CENTRAL	AREA 4 - EAST	AREA 5 - SOUTH
35063	35224	35203	35217	35226
35180	35127	35204	35212	35244
35172	35061	35205	35206	35216
35091	35064	35233	35235	35243
35116	35228	35234	35215	35242
35126	35208	35207	35222	35213
35146	35218	35214	35210	35223
35062	35211	35068	35094	35173
35073	35209			
35036	35020			
35117	35221			
35005	35254			
35130	35060			
35118				
35023				
35006				
35111				
35022				
35444				
35071				
35119				
35139				
35048				

SURVEY AREA PARAMETERS

AREA 1 (RURAL): All zip codes have population density (p.d.) under 1000.

AREA 2 (WEST): All zip codes have p.d. 1000 or over except 35060 (included because it is more urban than rural in character). All zip codes have median household incomes below $50K except 35127.

AREA 3 (CENTRAL): All zip codes have p.d. 1000 or over except 35214 and 35068 (included because they are more urban in character). All zip codes have median household income below $50K.

AREA 4 (EAST): All zip codes have p.d. 1000 or over except 35217, 35210, and 35094 (included because they are more urban in character). All zip codes have median household income below $50K except 35217 and 35210 (these are just above $50K).

AREA 5 (SOUTH): All zip codes have p.d. 1000 or over except 35173 and 35242 (included because they are more urban in character). All zip codes have median household incomes above $50K.

Note that some zip codes in Areas 1 and 5 extend into other counties.

Data sources: Zip Code Tabulation Areas from U.S. Census Bureau; full Jefferson Co. zip code list from mapszipcode.com checked against USPS.com zip code locator to confirm valid zip codes.

Appendix A: Indicators

Indicators List: Essential Elements of an Elder Friendly Community

Percentage of people age 65+ who report their community is a good place to live

ADDRESSES BASIC NEEDS

- **Affordable housing is available to community residents**
  1. Percentage of people age 65+ who spend >30%/≤30% of their income on housing
  2. Percentage of people age 65+ who want to remain in their current residence and are confident they will be able to afford to do so
- **Housing is modified to accommodate mobility and safety**
  3. Percentage of householders age 65+ in housing units with home modification needs
- **The neighborhood is livable and safe**
  4. Percentage of people age 65+ who feel safe/unsafe in their neighborhood
  5. Percentage of people age 65+ who report few/multiple problems in the neighborhood
  6. Percentage of people age 65+ who are satisfied with the neighborhood as a place to live
- **People have enough to eat**
  7. Percentage of people age 65+ who report cutting the size of or skipping meals due to lack of money
- **Assistance services are available and residents know how to access them**
  8. Percentage of people age 65+ who do not know whom to call if they need information about services in their community
  9. Percentage of people age 65+ who are aware/unaware of selected services in their community
  10. Percentage of people age 65+ with adequate assistance in ADL and/or IADL activities

OPTIMIZES PHYSICAL AND MENTAL HEALTH AND WELL-BEING

- **Community promotes and provides access to necessary and preventive health services**
  11. Rates of screening and vaccination for various conditions among people 65+
  12. Percentage of people age 65+ who thought they needed the help of a health care professional because they felt depressed or anxious and have not seen one (for those symptoms)
  13. Percentage of people age 65+ whose physical or mental health interfered with their activities in the past month
  14. Percentage of people age 65+ who report being in good to excellent health
- **Opportunities for physical activity are available and used**
  15. Percentage of people age 65+ who participate in regular physical exercise
- **Obstacles to use of necessary medical care are minimized**
  16. Percentage of people age 65+ with a usual source of care
  17. Percentage of people age 65+ who failed to obtain needed medical care
  18. Percentage of people age 65+ who had problems paying for medical care
  19. Percentage of people age 65+ who had problems paying for prescription drugs
  20. Percentage of people age 65+ who had problems paying for dental care or eyeglasses
- **Palliative care services are available and advertised**
  21. Percentage of people age 65+ who know whether palliative care services are available

MAXIMIZES INDEPENDENCE FOR THE FRAIL AND DISABLED

- **Transportation is accessible and affordable**
  22. Percentage of people age 65+ who have access to public transportation
- **The community service system enables people to live comfortably and safely at home**
  23. Percentage of people age 65+ with adequate assistance in activities of daily living (ADL)
  24. Percentage of people age 65+ with adequate assistance in instrumental activities of daily living (IADL)
- **Caregivers are mobilized to complement the formal service system**
  25. Percentage of people age 65+ who provide help to the frail or disabled
  26. Percentage of people age 65+ who get respite/relief from their caregiving activity

PROMOTES SOCIAL AND CIVIC ENGAGEMENT

- **Residents maintain connections with friends and neighbors**
  27. Percentage of people age 65+ who socialized with friends or neighbors in the past week
- **Civic, cultural, religious, and recreational activities include older residents**
  28. Percentage of people age 65+ who attended church, temple, or other in the past week
  29. Percentage of people age 65+ who attended movies, sports events, clubs, or group events in the past week
  30. Percentage of people age 65+ who engaged in at least one social, religious, or cultural activity in the past week
- **Opportunities for volunteer work are readily available**
  31. Percentage of people age 65+ who participate in volunteer work
- **Community residents help and trust each other**
  32. Percentage of people age 65+ who live in "helping communities"
- **Appropriate work is available to those who want it**
  33. Percentage of people age 65+ who would like to be working for pay

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Visiting Nurse Service of New York

Appendix B

Figure 1, page 13: Percentage of seniors who are confident they will be able to afford to stay in their residences

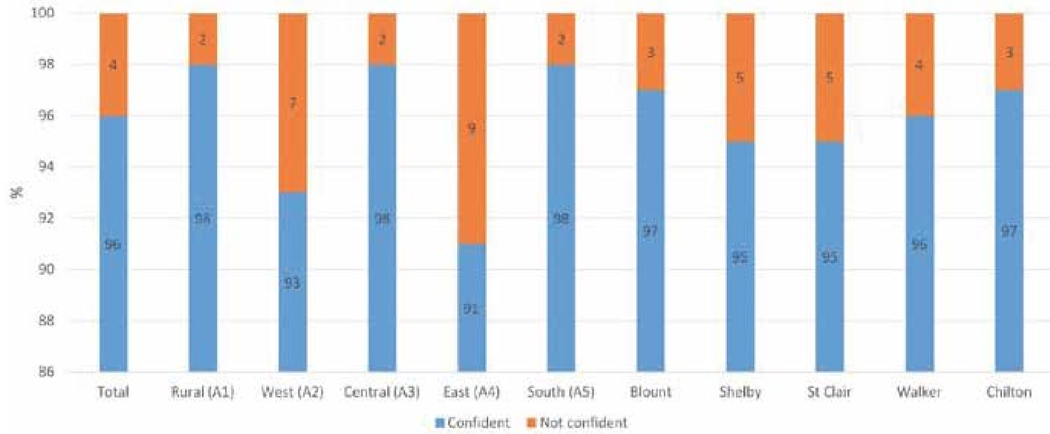


Figure 2, page 13: Percentage of seniors who did not have money in the past 12 months to pay for rent, mortgage or taxes

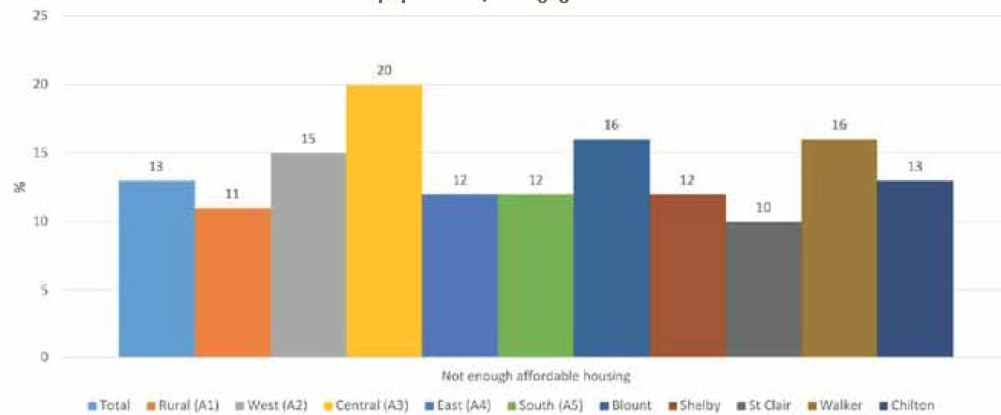


Figure 3, page 13: Percentage of seniors who did not have money in past 12 months to pay utility bills

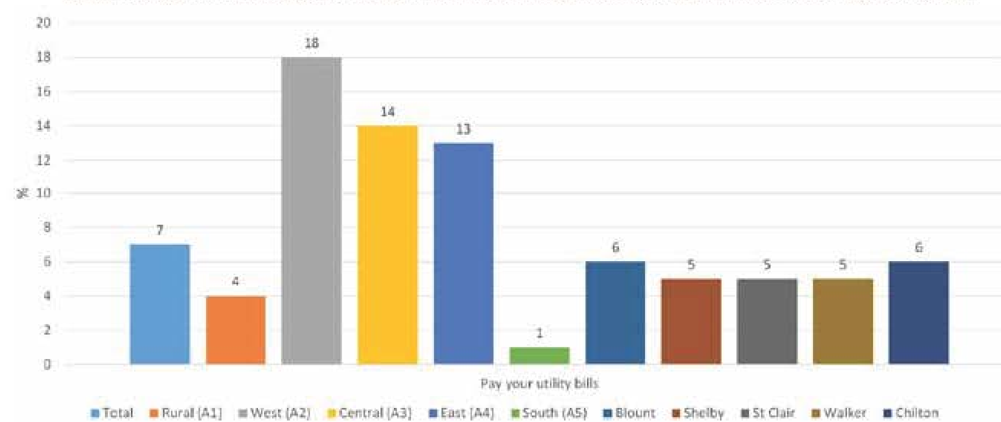


Figure 4, page 15: Percentage of seniors who feel their neighborhoods are not safe

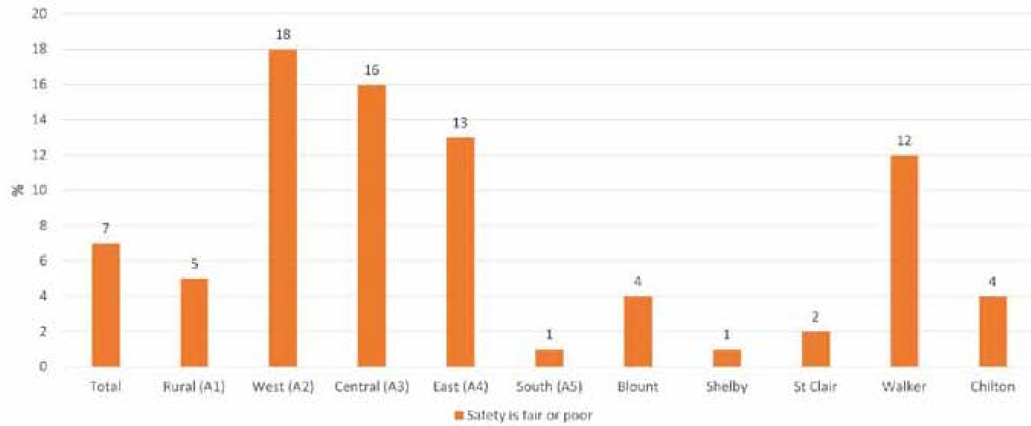


Figure 5, page 15: Top 5 neighborhood problems

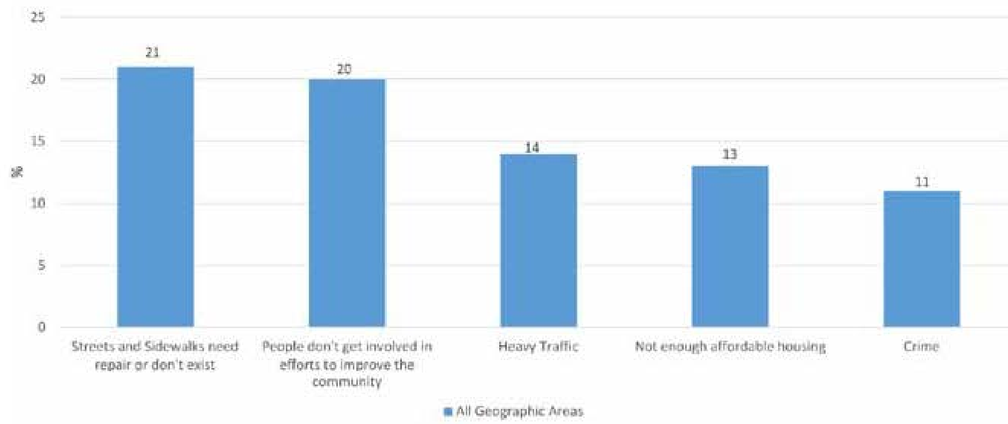


Figure 6, page 15: Percentage of seniors who said people don't get involved in community improvement

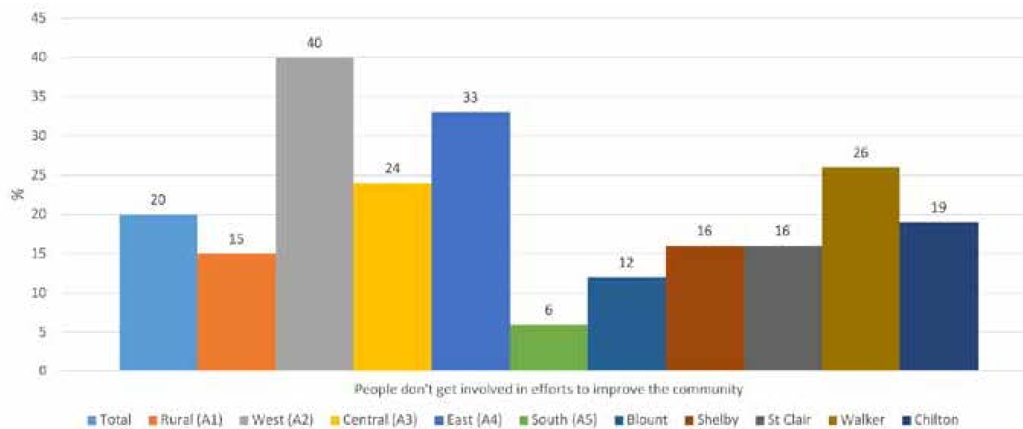


Figure 7, page 25: Percentage of seniors who said heavy traffic is a problem

Heavy Traffic	%
Total	14
Rural (A1)	10
West (A2)	16
Central (A3)	23
East (A4)	20
South (A5)	13
Blount	12
Shelby	13
St Clair	11
Walker	11
Chilton	11

Figure 8, page 15: Percentage of seniors who said there is not enough affordable housing

Not enough affordable housing	%
Total	13
Rural (A1)	11
West (A2)	15
Central (A3)	20
East (A4)	12
South (A5)	12
Blount	16
Shelby	12
St Clair	10
Walker	16
Chilton	13

Figure 9, page 15: Percentage of seniors who said crime is a problem

Crime	%
Total	11
Rural (A1)	10
West (A2)	19
Central (A3)	27
East (A4)	24
South (A5)	4
Blount	9
Shelby	3
St Clair	4
Walker	18
Chilton	10

Figure 10, page 17: Percentage of seniors who cut the size of or skipped meals due to lack of money

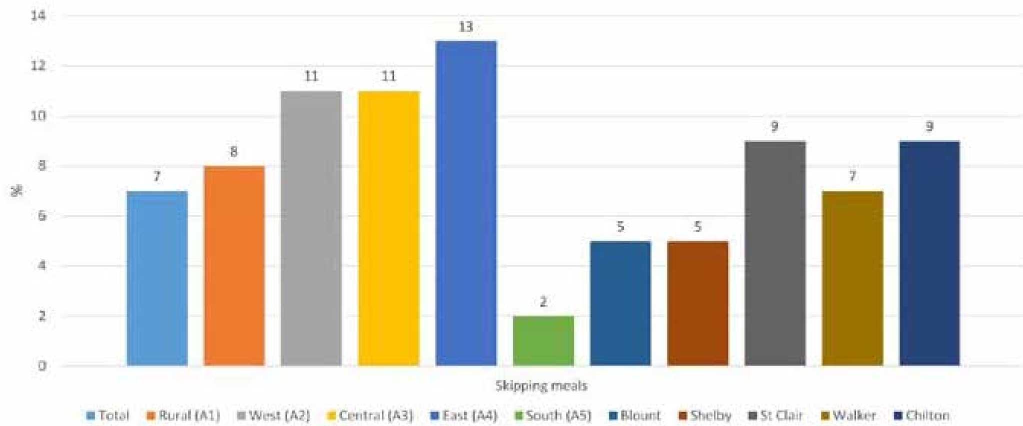
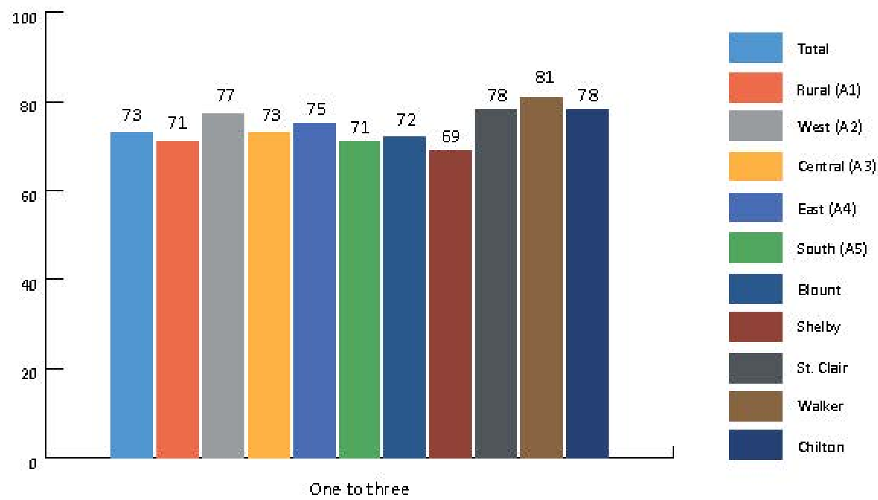


Figure 11, page 18: Number of servings of fruits and vegetables consumed daily: One to three



APPENDIX B

Figure 12, page 18: Four fruit and vegetables

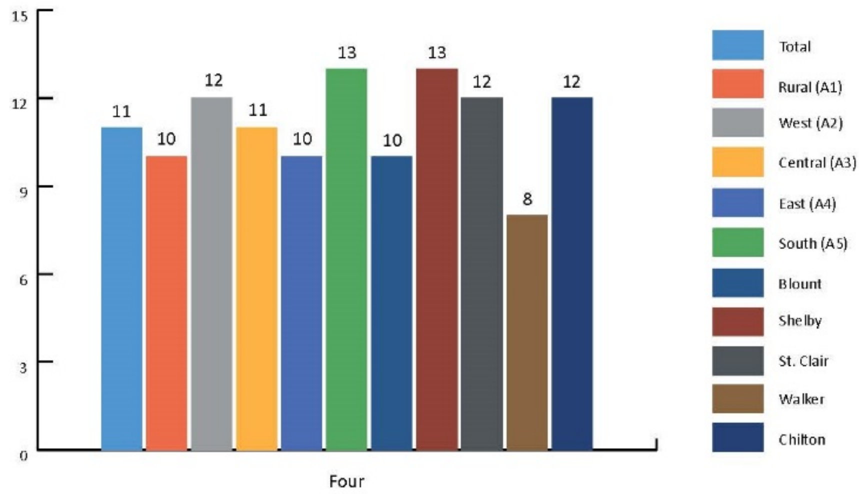
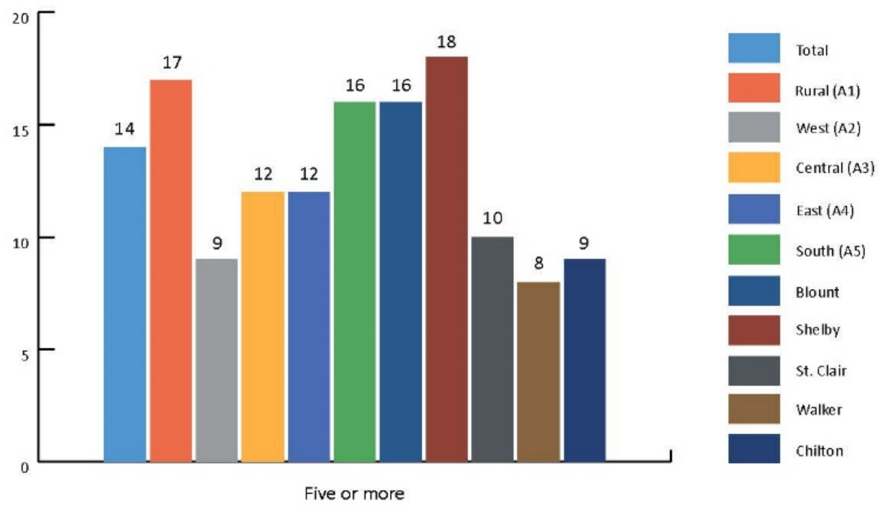


Figure 13, page 18: Five or more fruits and vegetables



Appendix C

Figure 14, page 22: Percentage of seniors reporting excellent/good or fair/poor health status

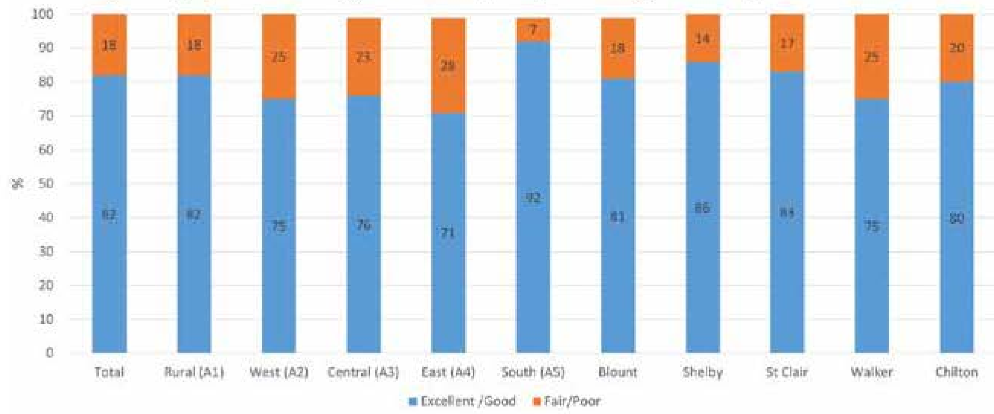


Figure 15, page 23: Percentage of seniors reporting fair/poor mental health status

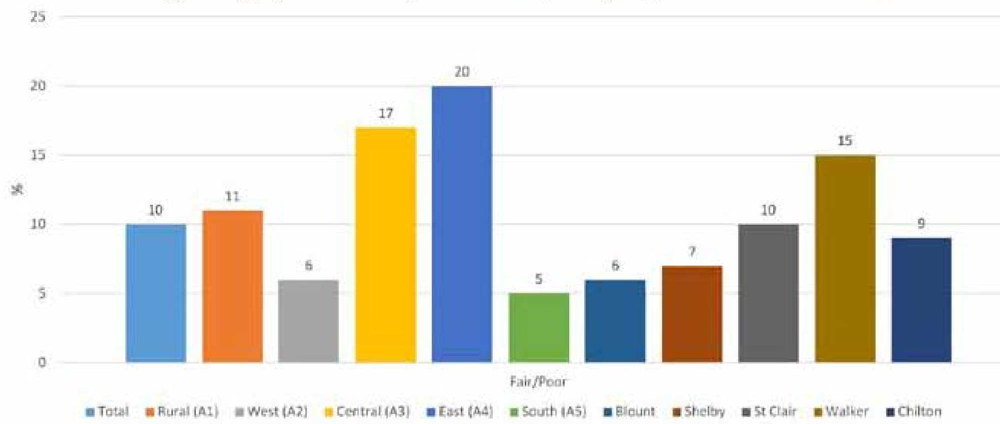


Figure 16, page 23: Percentage of seniors who did not receive care for symptoms of depression and anxiety

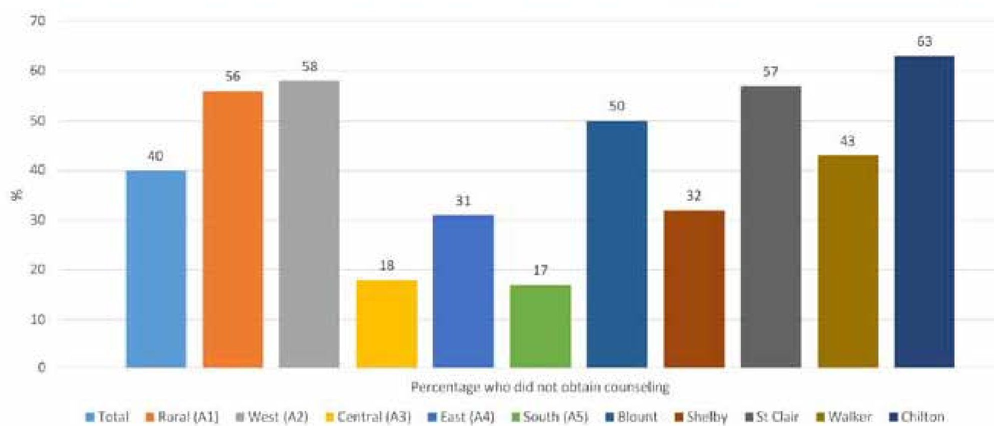


Figure 17, page 24: Percentage of seniors who see a dentist at least once a year

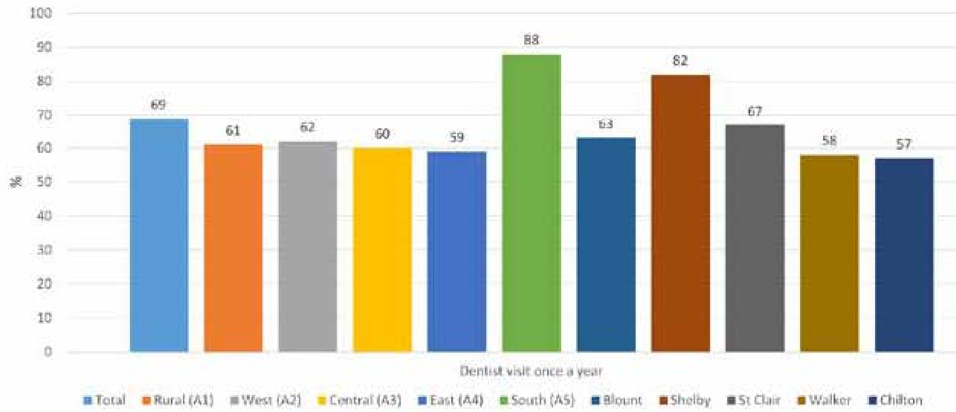


Figure 18, page 26: Percentage of seniors who say they don't visit the dentist because "dentist visits are too expensive"

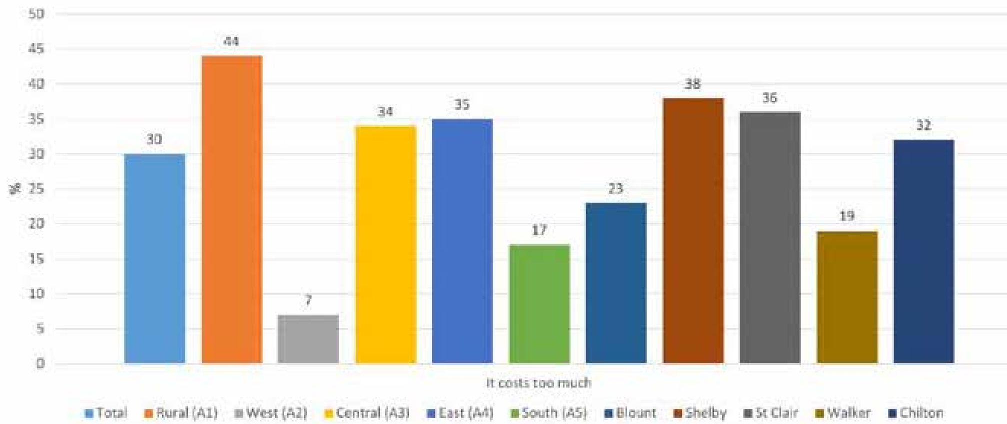


Figure 19, page 26: Percentage of seniors who say they don't visit the dentist because "I wear dentures/I don't have my own teeth"

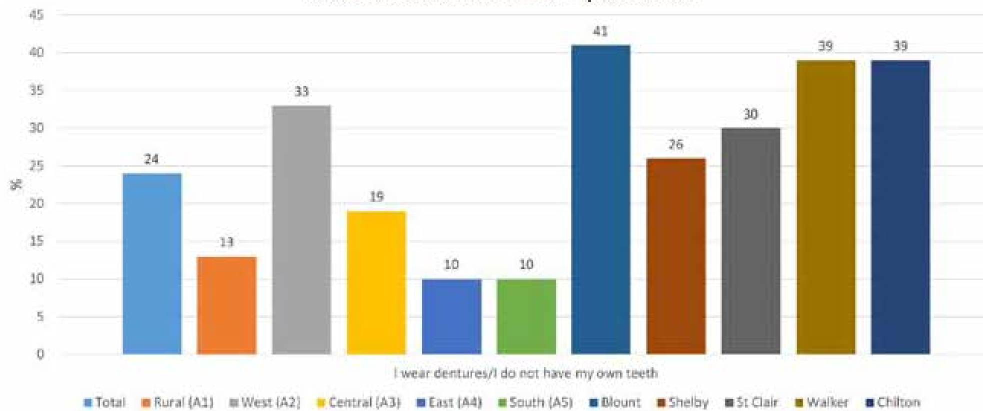


Figure 20, page 26: Percentage of seniors who say they don't visit the dentist because "I don't think I need to see a dentist"

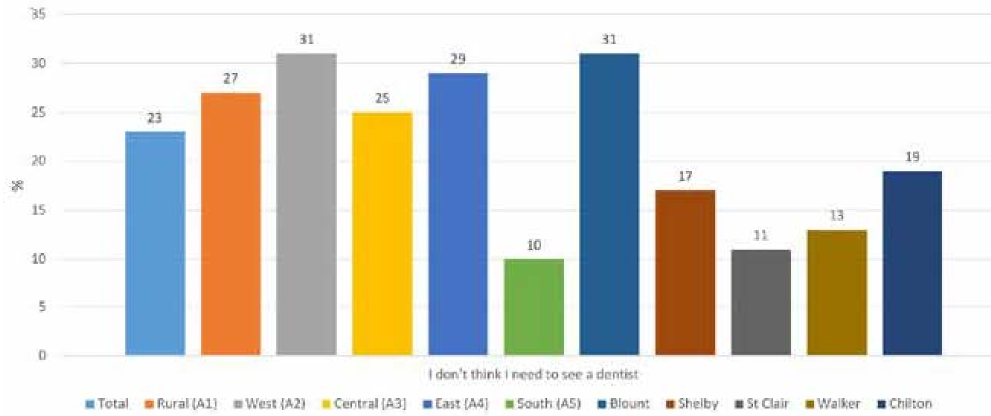


Figure 21, page 27: Percentage of seniors who are very active

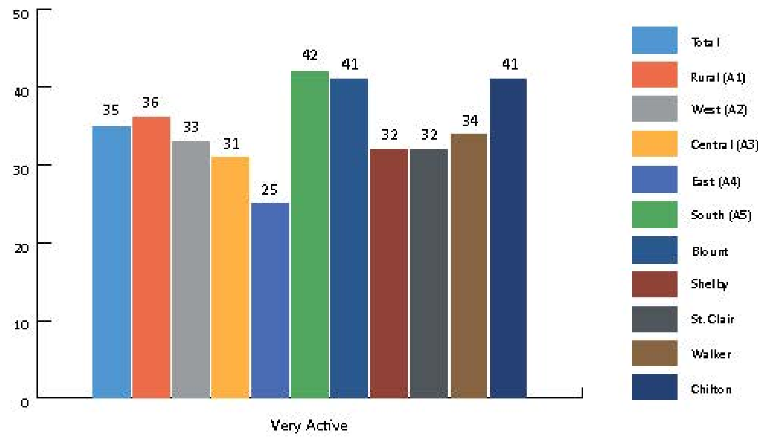


Figure 22, page 27: Percentage of seniors who are somewhat active

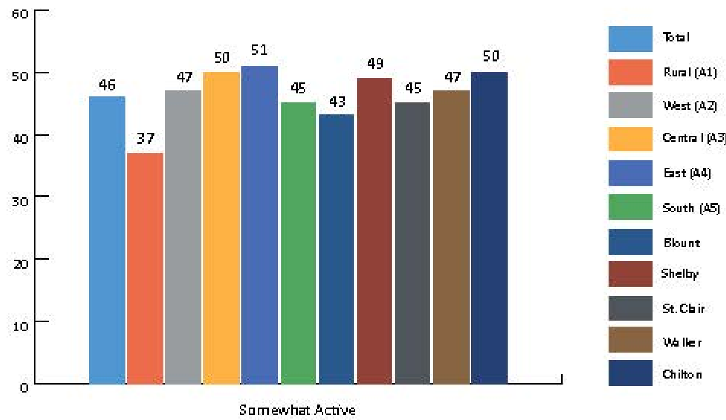


Figure 23, page 27: Percentage of seniors who are not very active/not active at all

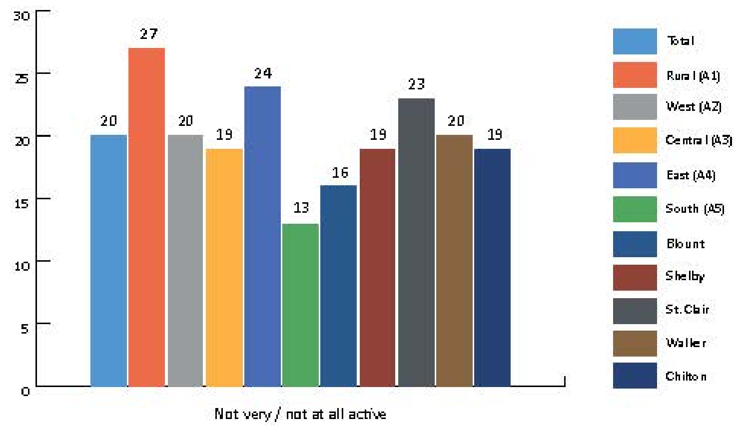


Figure 24, page 27: Percentage of seniors with problems paying for medical care

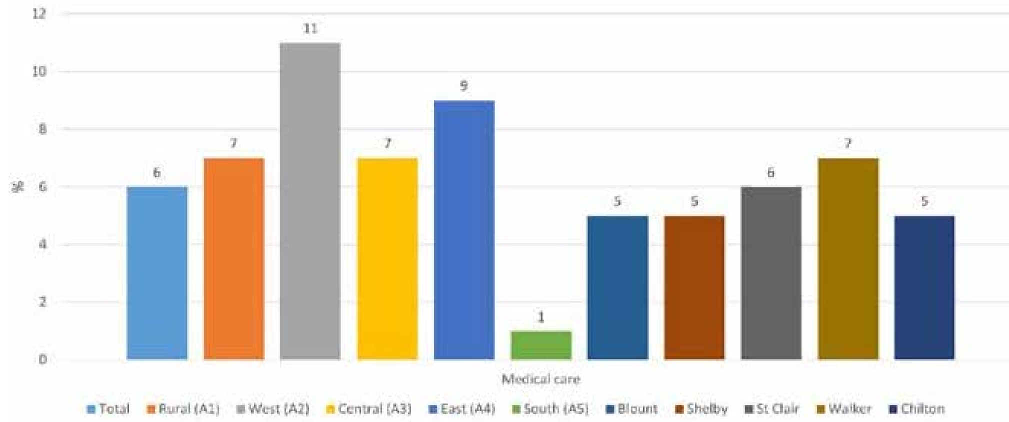


Figure 25, page 27: Percentage of seniors with problems paying for prescription drugs

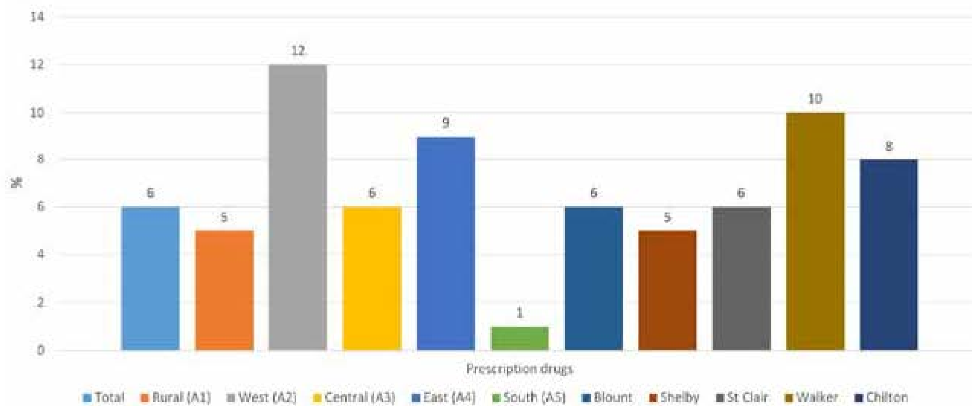


Figure 26, page 27: Percentage of seniors with problems paying for dental care

30
25
20
15 %
10
5
0

Total	Rural (A1)	West (A2)	Central (A3)	East (A4)	South (A5)	Blount	Shelby	St Clair	Walker	Chilton
12	12	12	18	24	3	13	12	11	9	14

Dental care

Appendix D

Figure 27, page 30: Percentage of seniors who use selected service

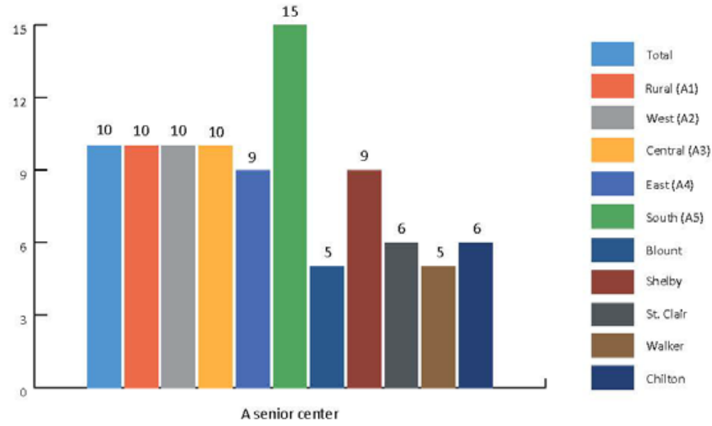


Figure 28, page 30: Percentage of seniors who use selected service

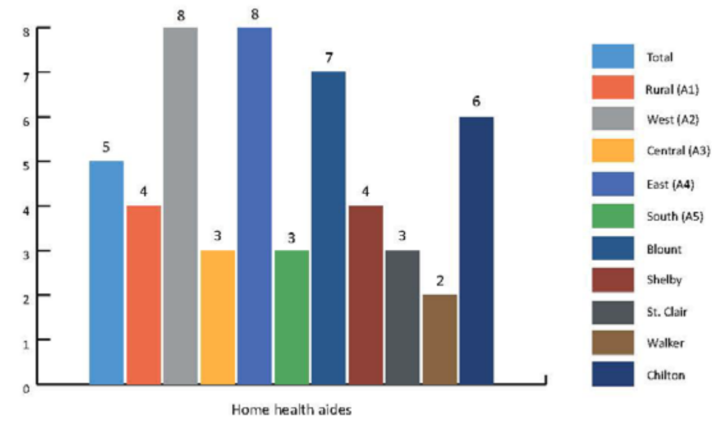


Figure 29, page 30: Percentage of seniors who use selected service

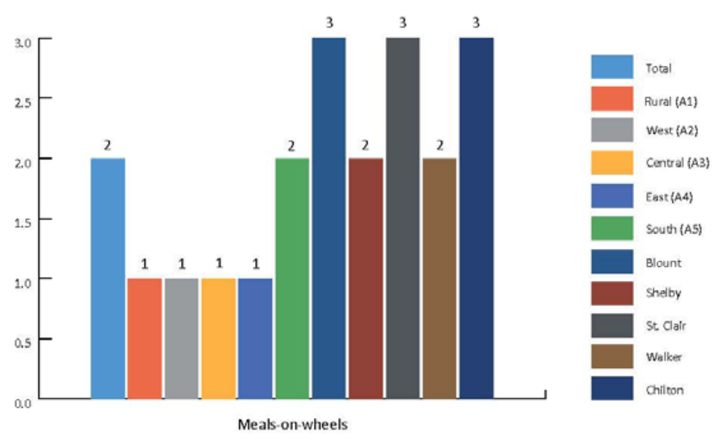


Figure 30, page 30: Percentage of seniors who use selected service

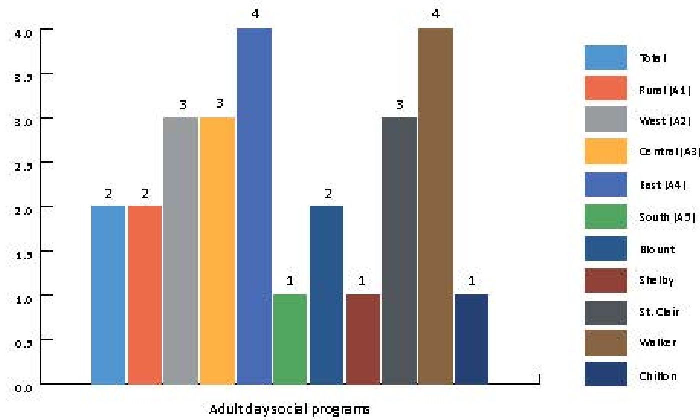


Figure 31, page 30: Percentage of seniors who use selected service

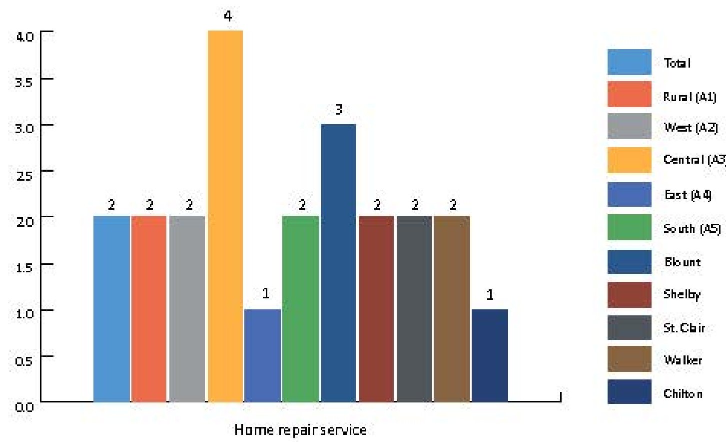
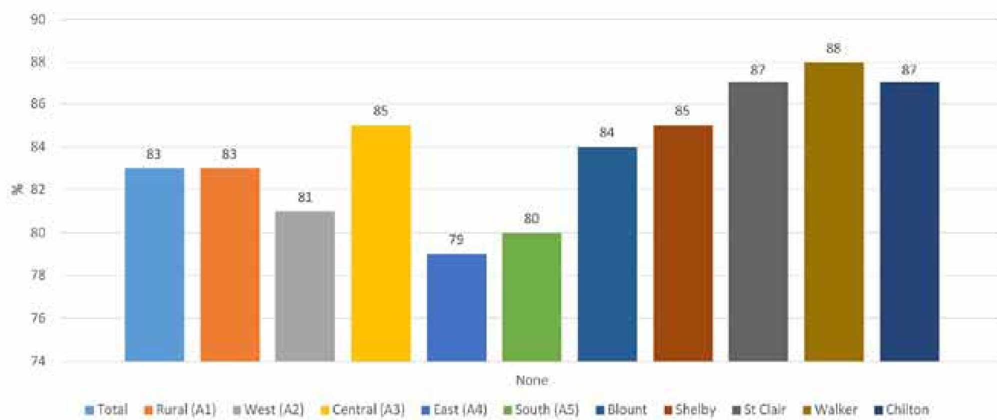


Figure 32, page 30: Percentage of seniors who have not used any of the services



55 | EngAge: A report on the age-friendliness of our community

Figure 33, page 31: Percentage of seniors who do not know whom to call if they need information about services in their community

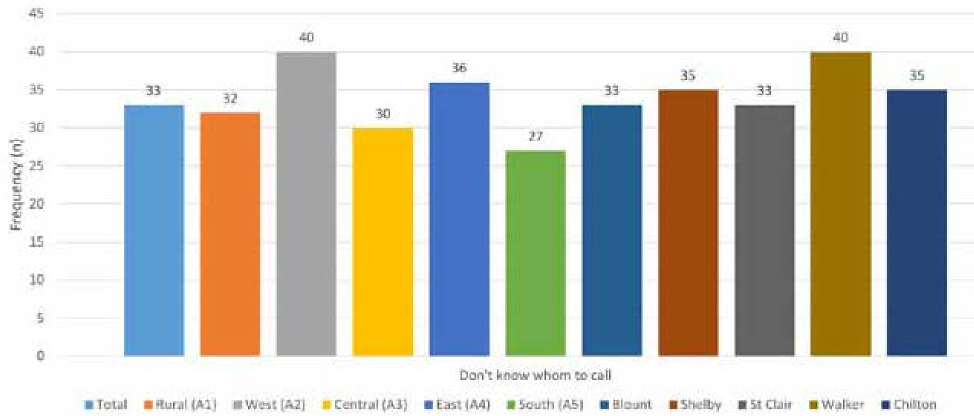


Figure 34, page 32: Percentages of seniors who are caregivers to relatives or friends

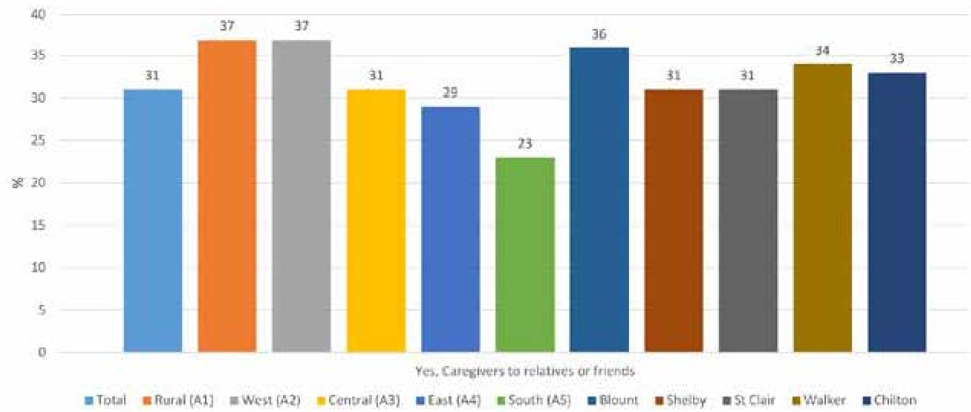
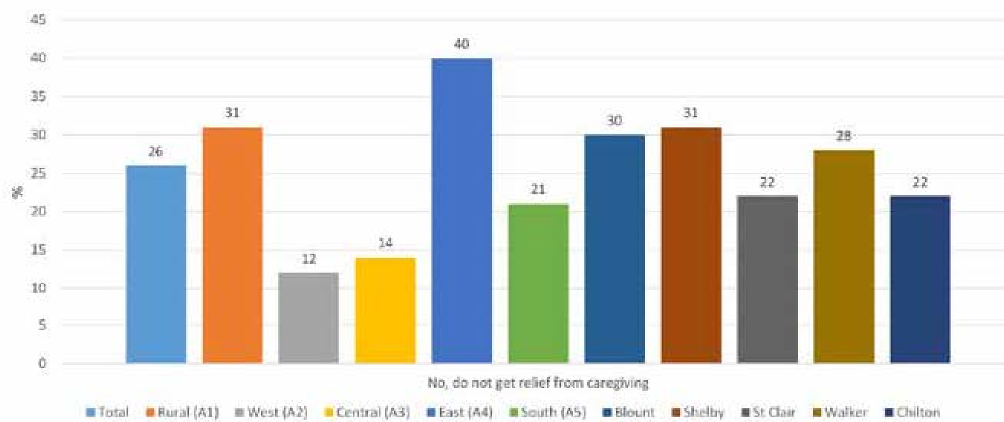


Figure 35, page 32: Percentage of seniors who do not get time off from caregiving duties



Appendix E

Figure 36, page 36: Percentage of seniors who attended a community or senior center in the past week

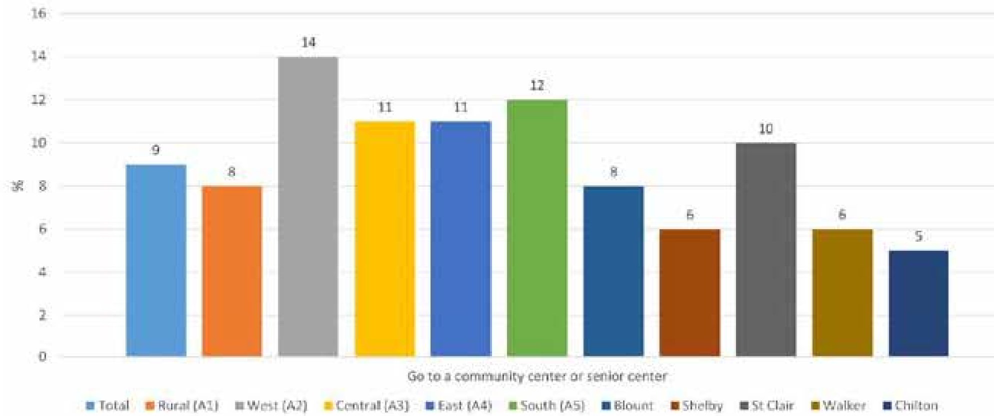


Figure 37, page 36: Percentage of seniors who attended a movie, play, concert, restaurant, sporting event, etc. in the past week

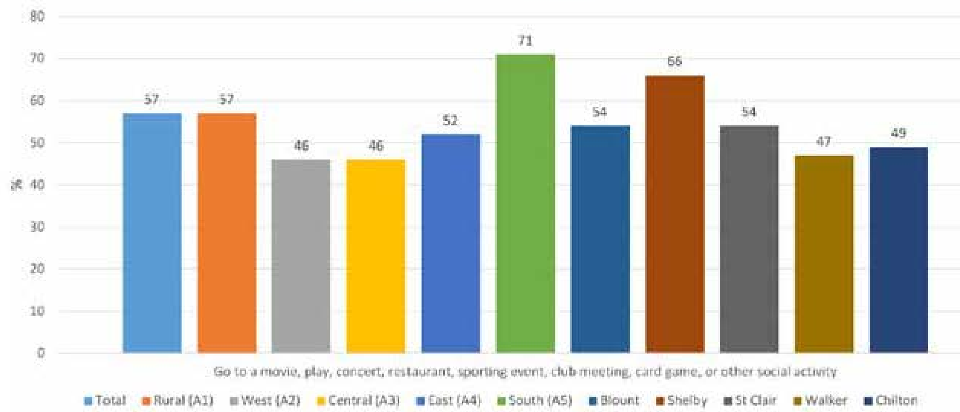
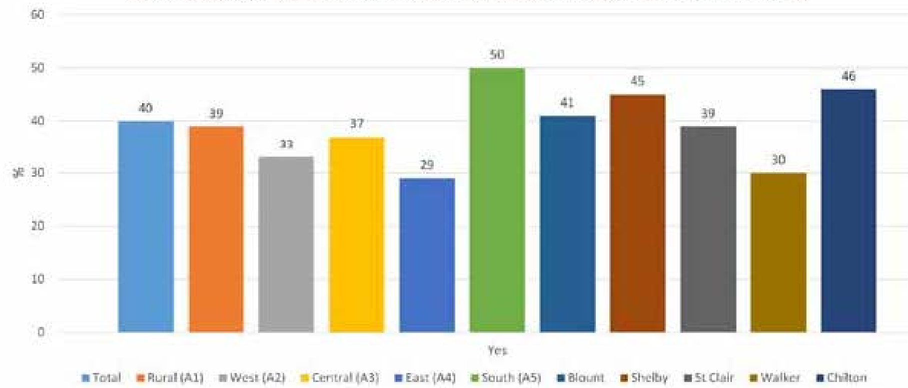


Figure 38, page 37: Percentage of seniors who participate in volunteer work



COMMUNITY FOUNDATION
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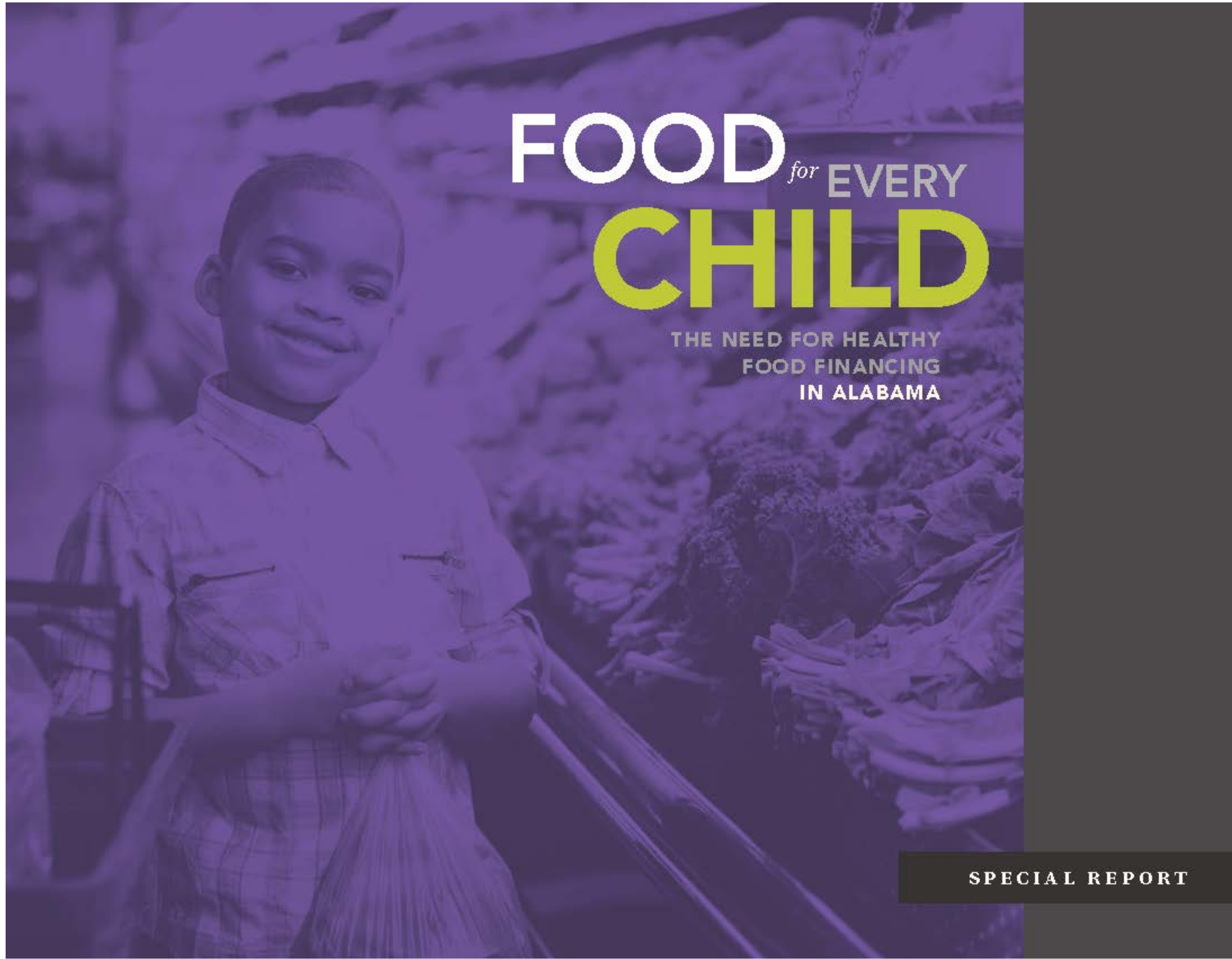
Appendix G: Food Deserts by County

RPCGB							
State	AL	AL	AL	AL	AL	AL	AL
County	Blount	Chilton	Shelby	St. Clair	Walker	M4A	Jefferson
Population, low access to store, 2010	1,548	1,457	52,014	3,744	7,530	66,292	209,261
Population, low access to store (%), 2010	2.70084	3.33771	26.662	4.47846	11.2346		31.7801
Low income & low access to store, 2010	609	737	7,449	972	2,598	12,364	75,210
Low income & low access to store (%), 2010	1.06247	1.6886	3.81812	1.1629	3.87594		11.422
Children, low access to store, 2010	385	333	13,435	918	1,671		50,219
Children, low access to store (%), 2010	0.67149	0.76414	6.88675	1.09838	2.49244		7.62667
Seniors, low access to store, 2010	195	242	5,550	496	1,162	7,644	26,851
Seniors, low access to store (%), 2010	0.34027	0.5538	2.84483	0.59285	1.73345		4.07774
Households, no car & low access to store, 2010	705	500	969	944	1,252	4,370	7,538
Households, no car & low access to store (%), 2010	3.26938	3.01851	1.30801	2.98417	4.71149		2.86012

https://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas/

Appendix H: Food for Every Child Report



Dear Neighbors,

Alabama's health crisis can be summed up by two staggering statistics: Our state has the highest rate of diabetes in adults and the third-highest rate of obesity in children. In fact, over the past 30 years, obesity has more than doubled in children and quadrupled in adults.

Reversing this epidemic could position the state to save over $3 billion in obesity-related health care costs by 2020. If that's not reason enough for Alabama to prioritize addressing this crisis, consider what inaction would mean for our children—many of whom now suffer from what were traditionally considered adult diseases: If we don't correct the course of obesity in America, we could be raising the first generation of children with a shorter life expectancy than their parents.

One critical factor driving the rise of obesity and diet-related disease is food access. Over 1.8 million Alabama residents—including nearly half a million children—live in communities without grocery stores. Far too many families live in these places where fresh, healthy food is hard to come by, where processed, unhealthy products are the only viable option. This scenario places Alabamians at increased risk for cardiovascular disease, diabetes and other diet-related illnesses.

To examine the growing concern around food access in Alabama and identify potential solutions, VOICES for Alabama's Children joined the Alabama Grocers Association and the Joseph S. Bruno Foundation to convene the Alabama Grocery Summit in November of 2014, bringing together 50 state and community leaders to identify solutions in the fight against childhood obesity. Subsequent to a rich discussion centered on the food access issue in our state and various challenges faced by food retailers to operate in food desert communities, the general consensus was one of urgency and resolution.

Stakeholders agreed that a promising solution to the problem of limited food access is establishing a healthy food financing initiative. Such effective and economically sustainable policies attract healthy food retailers—from grocery stores and farmers' markets to cooperatives, mobile markets and other vendors of healthy, affordable foods—to underserved communities, not only helping combat obesity by increasing access to healthy food options, but also boosting local economies and creating new jobs for Alabamians. This simple solution is good for health and good for business.

Together, VOICES for Alabama's Children and the Alabama Grocers Association urge state decision makers to prioritize healthy food access and champion healthy food financing to help bring healthy food options closer to home for Alabama's children and families.

Sincerely,

Melanie R. Bridgeforth, MSW
Executive Director
VOICES for Alabama's Children

Ellie Taylor
President
Alabama Grocers Association

ALABAMA must address the significant need for supermarkets and other fresh food resources in many of its communities. Many factors have led supermarkets to limit investments in lower-income communities across the state, leading to a public health crisis. The Food Trust, a nationally recognized nonprofit, issued *Food for Every Child: The Need for Healthy Food Financing in Alabama* to document these findings and to ensure that Alabama's 1.2 million children and their families live in communities that have access to healthy and affordable food.[1] This report demonstrates the need for a statewide financing program to encourage healthy food retail development in Alabama.

Many communities in Alabama have too few supermarkets or other places to purchase healthy, affordable food. Large areas of Birmingham, Mobile, Montgomery and rural areas in every region of the state are underserved, and many residents have to travel long distances to purchase foods necessary to maintain a healthy diet.

The lack of access to affordable and nutritious food has a negative impact on the health of children and families in both rural and urban areas of Alabama. A growing body of research indicates that people who live in communities without a supermarket suffer from disproportionately high rates of obesity, diabetes and other diet-related health problems. In contrast, when people live in a community with a supermarket, they tend to eat more servings of fruits and vegetables and are more likely to maintain a healthy weight.[2]

Increasing the availability of nutritious and affordable food in communities with high rates of diet-related diseases does not guarantee a reduction in the incidence of these diseases. However, removing barriers to supermarket access is a key step toward enabling people to maintain a healthy diet. Furthermore, the development of new supermarkets sparks economic revitalization and brings jobs into communities that need them most.[3]

Access to supermarkets and other healthy food retail is a key factor in the health and development of a community. **Section One** of this report highlights the many lower-income places in Alabama with poor supermarket access and a high incidence of diet-related deaths. **Section Two** of this report recommends the creation of a statewide healthy food financing program to incentivize healthy food retail development in communities of need, in response to a recent meeting between Alabama's grocery industry leaders, children's advocates, public health and community development experts. In cities and states throughout the country, such programs have improved healthy food access while creating jobs and strengthening the economic well-being of surrounding areas.

Alabama has the nation's highest rate of diabetes, and spends billions of dollars each year treating diet-related diseases.

This study builds on the work undertaken over the past several years by a variety of government, private and civic leaders in Alabama, including efforts in Birmingham and research conducted by the Emerging Changemakers Network. This report demonstrates that there is still more work to be done in Alabama, particularly in its cities and its rural areas, to ensure that all residents have convenient access to stores selling fresh and affordable foods.

EXECUTIVE SUMMARY

SECTION ONE:

THE NEED FOR HEALTHY FOOD ACCESS IN ALABAMA

Many communities in Alabama have poor access to a full-service grocery store, and there are numerous communities where none exist.

This shortage of healthy food retail means that residents, particularly those in lower-income communities and rural areas, must travel out of their neighborhoods to reach the nearest store that sells fresh produce and other foods necessary to maintain a healthy diet. Over 1.8 million Alabama residents, including nearly half a million children, live in lower-income communities underserved by supermarkets.[4]

Alabama's adult diabetes rate of 13.8% is the highest in the country, and its 17.1% obesity rate among high school students is the third highest.[5] Lower-income residents in Alabama are likely to suffer from obesity and other diet-related health problems at rates significantly higher than those of the population as a whole. Economists estimate that if the state could reduce obesity by 5% by 2020, it could save an estimated $3.38 billion.[6]

17.1 percent of Alabama high school students are obese, the third-highest rate in the nation.

At the same time, many families across Alabama have few, if any, places in their communities in which to shop for reasonably priced, nutritious foods, and often have to travel long distances to reach the nearest food store. A growing body of research demonstrates that access to healthy food retail has a measurable impact on people's diet and health outcomes. Both the Institute of Medicine and the Centers for Disease Control and Prevention have independently recommended that increasing the number of supermarkets in underserved areas would reduce the rate of childhood obesity in the United States. They also suggest that state and local governments should create incentive programs to attract healthy food retail to these neglected neighborhoods.[7,8]

Inadequate access to healthy food could be eased and diet-related health problems reduced by investing in an initiative to build more supermarkets and other healthy food retail in underserved communities, resulting in the improved health of children and families. Such an investment would have positive economic impacts, as well. Supermarkets create jobs and revitalize communities, serving as retail anchors and sparking complementary development nearby. Specifically, independent, family-owned grocers in Alabama have more than $2 billion a year in sales, and generate more than $198 million in state and local taxes.[9]

This section of the report outlines the extent and implications of the supermarket shortage by identifying the gaps in food availability within Alabama and highlights the relationship between supermarket access, diet-related diseases and neighborhood income levels.

Methodology

To demonstrate which neighborhoods lack supermarket access, a series of maps was created using Geographic Information Systems computer mapping software. A geographic representation of food access, income and diet-related disease was created by mapping the locations of supermarket sales, income and diet-related mortality data.

All supermarkets were plotted and then classified into two categories: high and low weekly sales volumes. Median household income was multiplied by the number of households and the result was divided by total population to create a per capita income per person. The term "lower-income" in this report is used to define areas where households have less than median income, except when citing a separate study.

A total of 16,729 diet-related deaths were mapped across the state, and the ratio of deaths per total population was mapped. "High" diet-related mortality areas are defined as having diet-related death rates greater than the statewide average, and "low" areas have diet-related death rates lower than the statewide average. Only data for Alabama were analyzed, so no comparisons were made with rates outside of the state. (See Appendix: Methodology for more detail.)

KEY FINDINGS

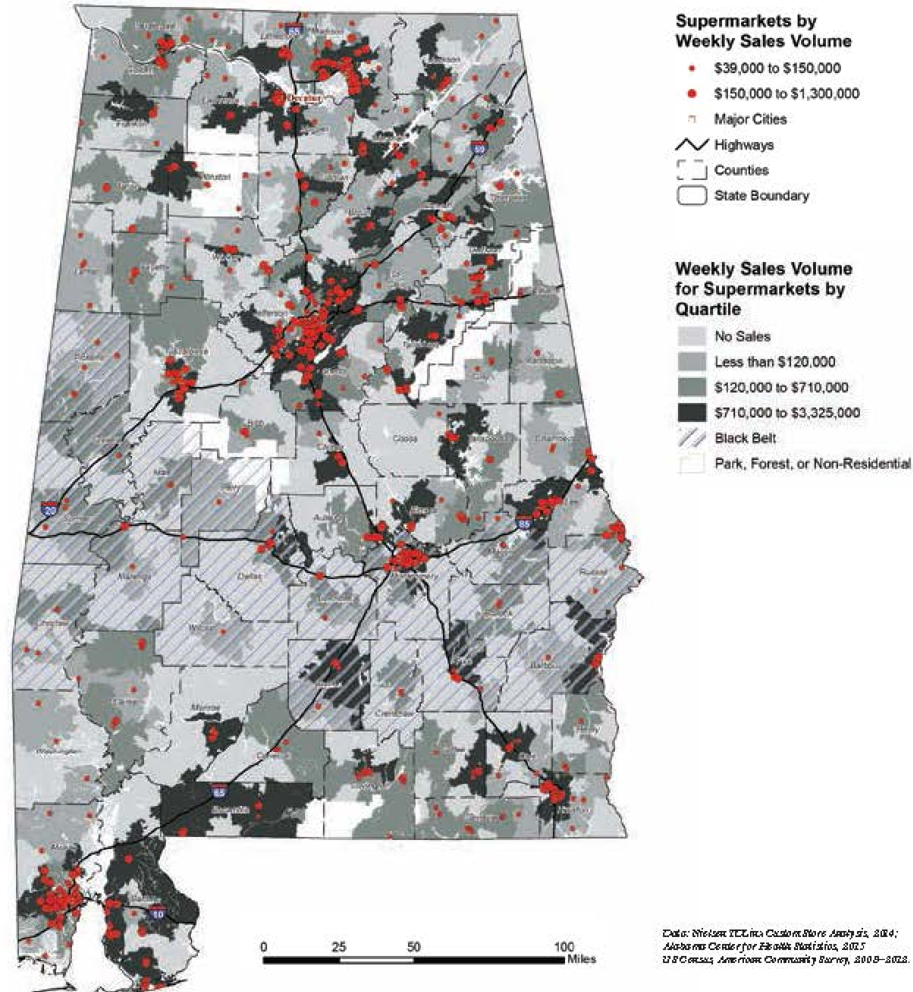
Access to healthy, affordable foods is not evenly distributed in Alabama. Many people have to travel excessive distances to buy food at a supermarket.

- The following pages walk through maps to display the need across the state of Alabama. There are large areas with few supermarkets and many communities where none exist at all.
- The need for improved food access is then highlighted in four metropolitan areas (see pages 10–11).

MAP 1: *Weekly Sales Volume for Supermarkets* shows the location of 715 stores in Alabama and the weekly sales volume at each store. The smaller red circles represent lower weekly sales volume; the larger red circles represent higher weekly sales volume. The gray shading shows how supermarket sales are distributed across each census tract. The darkest areas have the highest concentration of supermarket sales, whereas the light areas have the lowest sales, indicating that few or no supermarkets are located there.

Map 1 features supermarkets in Alabama and the concentration of sales across the state. Sales tend to be concentrated in the suburban communities surrounding the state's major cities, and along the state's major transportation routes.

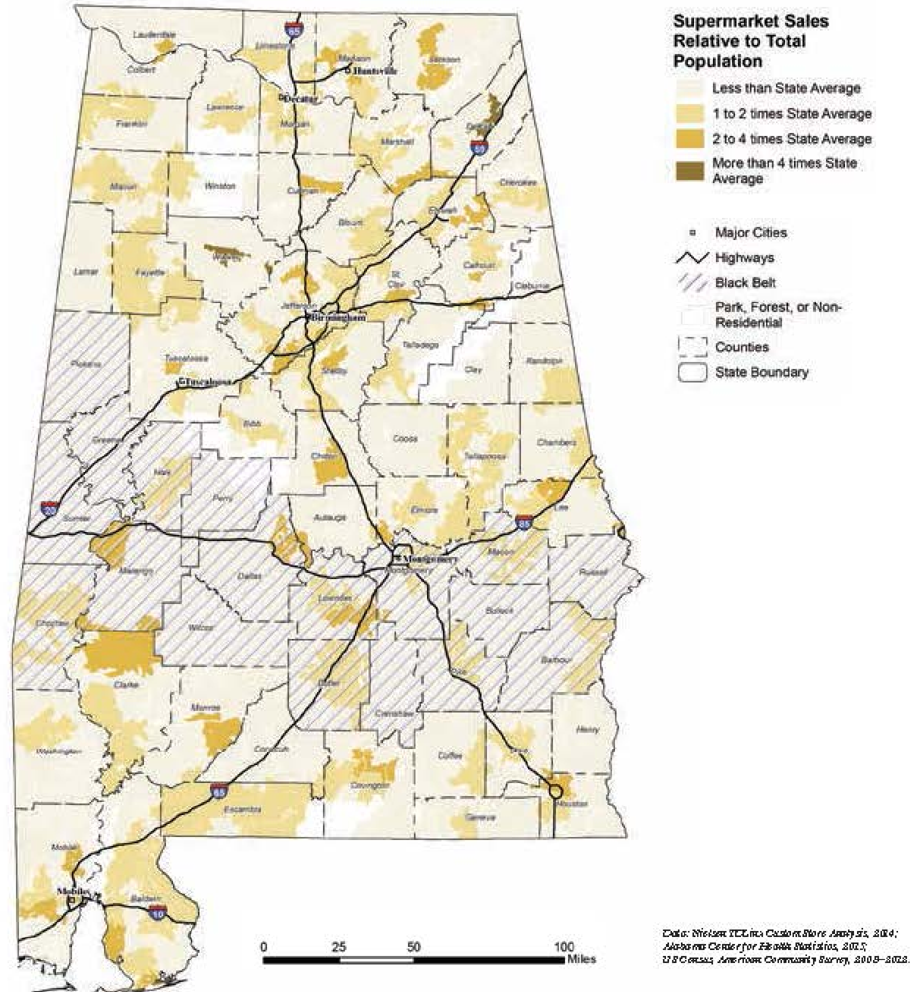
1: *Weekly Sales Volume for Supermarkets*



MAP 2: *Supermarket Sales and Total Population* shows that the amount of supermarket sales in a particular location does not seem to be associated with the population of that area. Neighborhoods with greater than average supermarket sales relative to total population are shown in yellow and brown tones. In these neighborhoods, people are either spending more than average in supermarkets, as might be the case in higher-income communities, or more people are buying groceries in these communities than the number of people who live there, indicating that people are traveling from outside the area to shop there.

In nearly every county across the state of Alabama, residents face challenges accessing fresh foods.

2: *Supermarket Sales and Total Population*



KEY FINDINGS

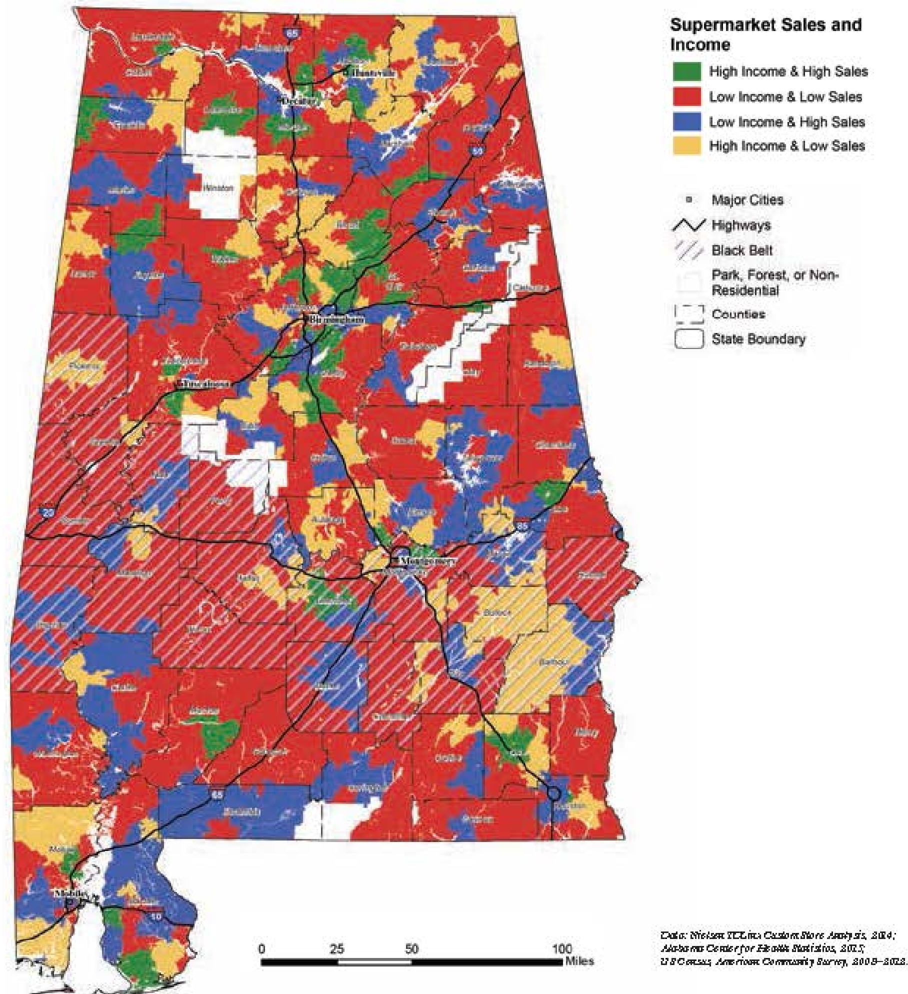
The uneven distribution of supermarkets in Alabama leaves a disproportionate number of lower-income families without access to nutritious food.

- This problem is impacting families across the state. Over 1.8 million Alabama residents, including nearly half a million children, live in lower-income communities underserved by supermarkets.

MAP 3: *Supermarket Sales and Income* shows the distribution of supermarket sales and the distribution of income throughout Alabama. Higher-income areas with higher supermarket sales have the best access to food resources and are indicated by the green areas of the map. In some lower-income areas, there are communities with higher-than-average supermarket sales volumes, as highlighted in blue. People in the areas shown in yellow have fewer supermarkets at which to shop in their community. However, since these communities are higher-income and often have high car ownership rates, residents are likely able to drive to stores or to stop at small specialty food purveyors.

The red areas represent lower-income neighborhoods that are not adequately served by supermarkets.

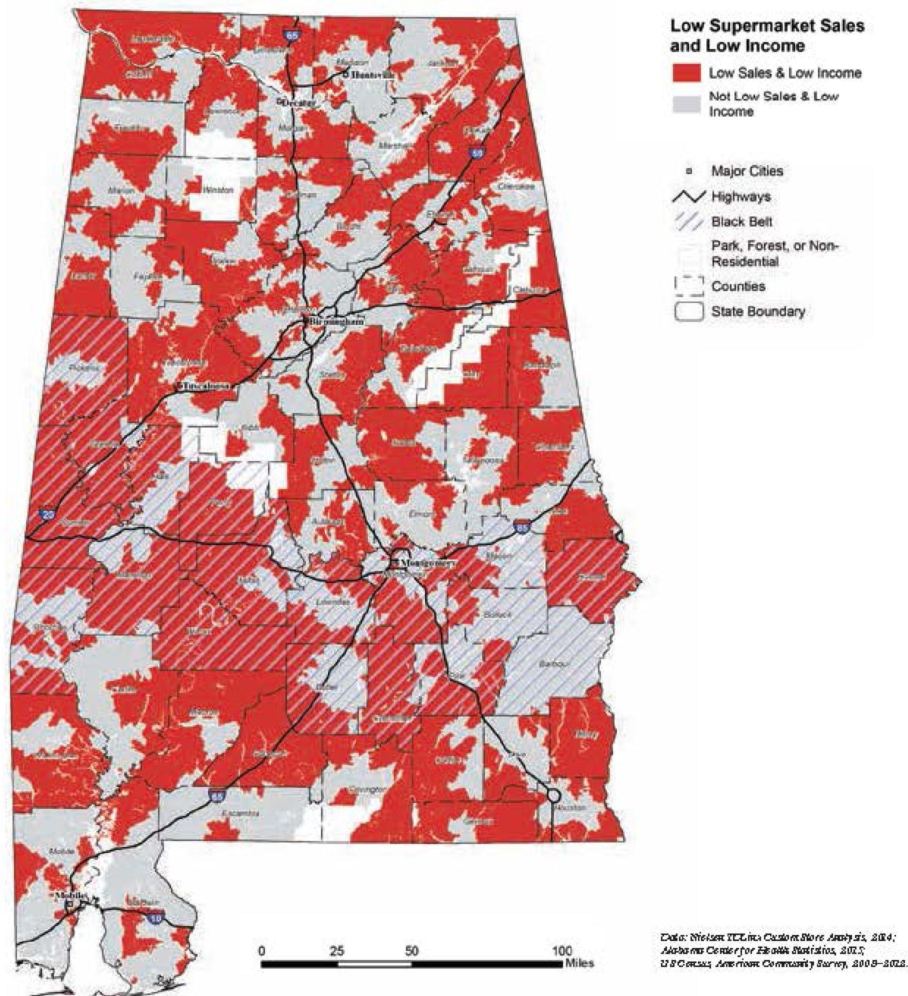
3: *Supermarket Sales and Income*



MAP 4: *Low Supermarket Sales and Low Income* further highlights areas with low supermarket sales because there are few to no supermarkets located there. Since income is also lower in these areas, families face more difficulty traveling to the areas where supermarkets are concentrated, especially when public transit is not accessible or convenient. In Alabama, underserved communities are concentrated in urban areas such as Birmingham and Montgomery, and in rural counties across the state.

Leading public health experts agree that increasing access to supermarkets and other stores selling healthy, affordable foods in underserved communities is critical to the health outcomes of residents.

4: *Low Supermarket Sales and Low Income*



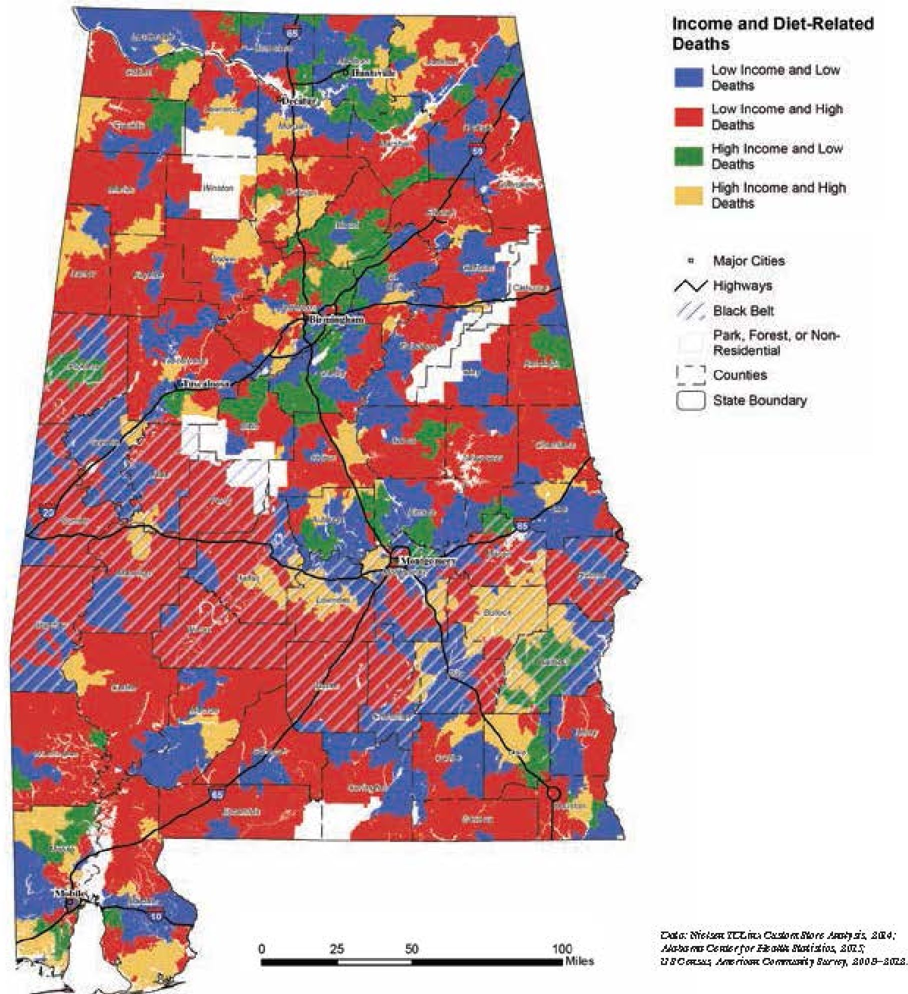
KEY FINDINGS

There is a connection between lack of supermarkets and diet-related disease.

- The Food Trust and PolicyLink, a national research and advocacy organization, conducted a comprehensive literature review which found that studies overwhelmingly indicate that people living in communities without a supermarket suffer from disproportionately high rates of obesity and other diet-related health issues, while people living in communities with a supermarket are more likely to maintain a healthy weight.[10] One study, for example, found lower body mass index and better health among residents who live near a supermarket.[11] Another study documented that as distance to a supermarket increased in a metropolitan community, obesity rates increased and fruit and vegetable consumption decreased.[12]

MAP 5: *Income and Diet-Related Deaths* shows diet-related mortality data by income in Alabama. The red areas indicate a higher-than-average rate of diet-related deaths occurring in lower-income areas. The yellow areas display higher rates of diet-related deaths occurring in higher-income areas. The blue and green areas have lower rates of diet-related deaths.

5: *Income and Diet-Related Death*



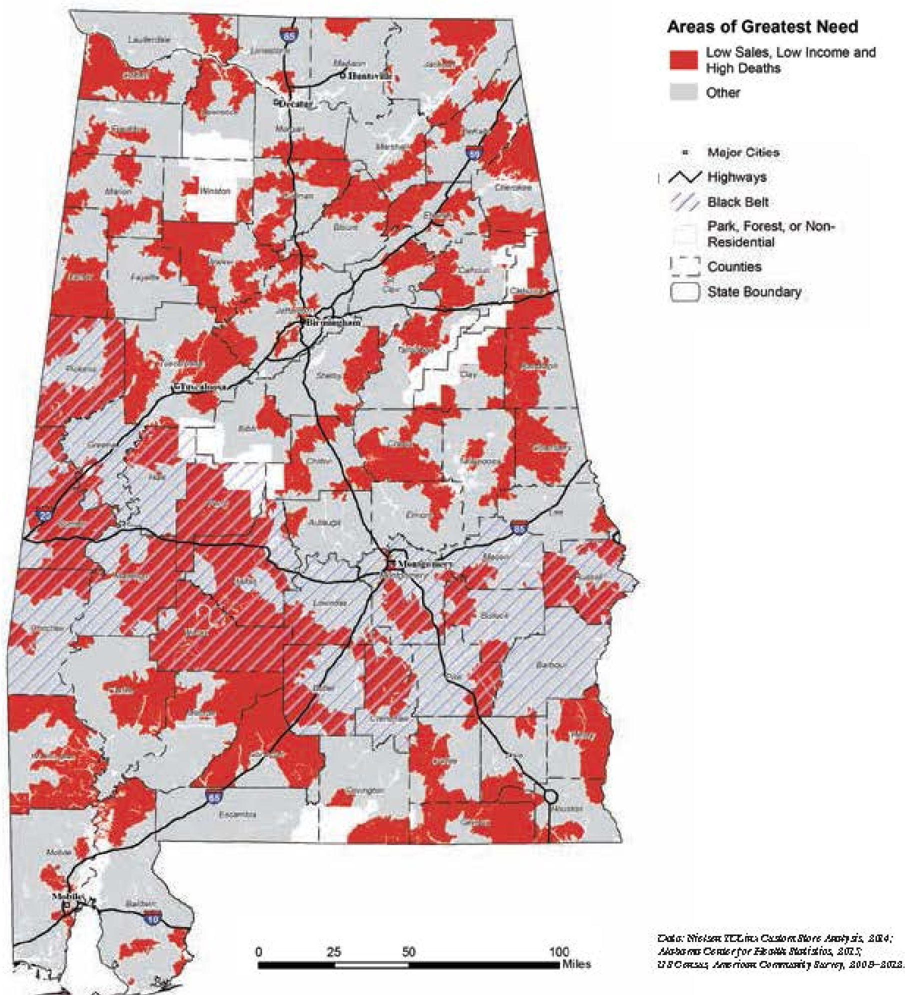
Diet-related diseases, such as hypertension, obesity and diabetes, create untold suffering and expense in families and communities. Heart disease and stroke are among the top three leading causes of death in Alabama, and overweight or obese adults are significantly more likely to suffer from these conditions.[13] Diet-related deaths are associated with many factors, including the lack of access to a nutritionally adequate diet.

MAP 6: *Areas with Greatest Need* displays lower-income communities where there are low supermarket sales and a high number of deaths due to diet-related disease in Alabama. These areas have the greatest need for more supermarkets and other fresh food retail venues.

To provide affordable and nutritious food in these neighborhoods and others throughout the state and to address the high rates of obesity and other diet-related diseases, Alabama should encourage new supermarket and other fresh food retail development in lower-income areas where there are few or no supermarkets. Increasing the availability of healthy, affordable food in neighborhoods with high rates of diet-related diseases does not guarantee a reduction in their incidence. However, leading public health experts, including the Centers for Disease Control and Prevention and the Institute of Medicine, agree that it is a critical component of the fight against obesity.

The need for more supermarkets in Alabama exists in nearly every county across the state. Neighborhoods in large cities, including Birmingham, Mobile, Montgomery and Tuscaloosa, and many rural areas, such as Monroe, Russell, Walker and Wilcox counties, lack access to healthy, affordable food.

6: *Areas with Greatest Need*



KEY FINDINGS

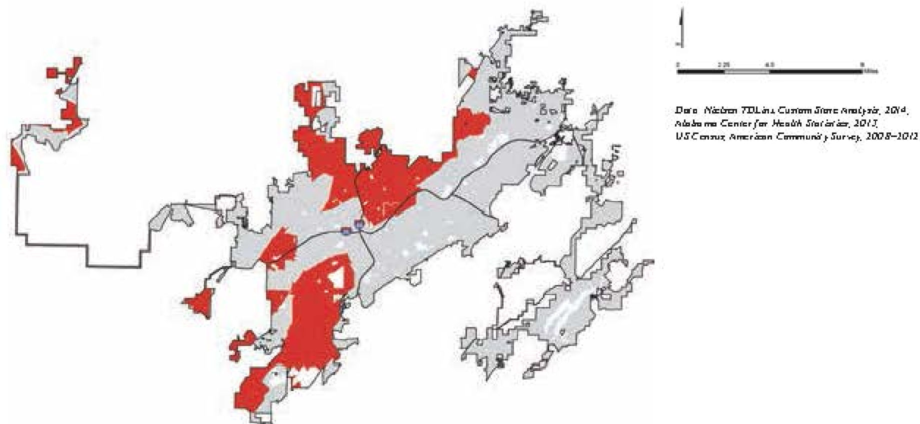
Communities within Alabama's major metropolitan areas lack access to healthy, affordable food.

- These maps highlight lower-income neighborhoods where there are low supermarket sales and a high number of deaths due to diet-related disease. These areas have the greatest need for more supermarkets and other fresh food retail venues, a need that could be addressed by a statewide initiative to build more supermarkets and other healthy food retail in these and other underserved communities.

MAP 7: *Areas with Greatest Need in Birmingham* include: West End, Woodlawn, Ensley, Druid Hills, Norwood, North Birmingham, Collegeville and Tarrant

MAP 8: *Areas with Greatest Need in Mobile* include: the area north along I-165 around Prichard; the area west of I-65 around Springhill and Cottage Hill; the area east of I-65 around Brookley, Oakdale and Maysville; and the area south of I-10 around South Brookley

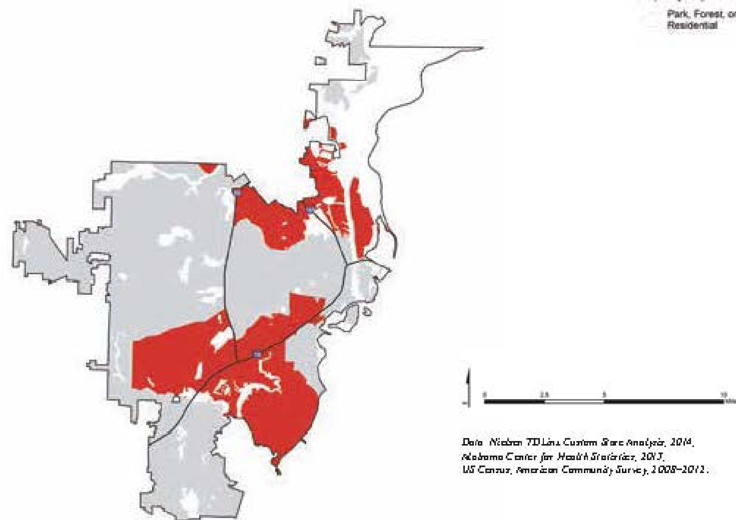
7: *Areas with Greatest Need in Birmingham*



Data: Nielsen TDLinx Custom Store Analysis, 2014, Alabama Center for Health Statistics, 2013, US Census, American Community Survey, 2008–2012.

Areas of Greatest Need
- Low Sales, Low Income and High Deaths
- Other
- Highways
- Park, Forest, or Non-Residential

8: *Areas with Greatest Need in Mobile*



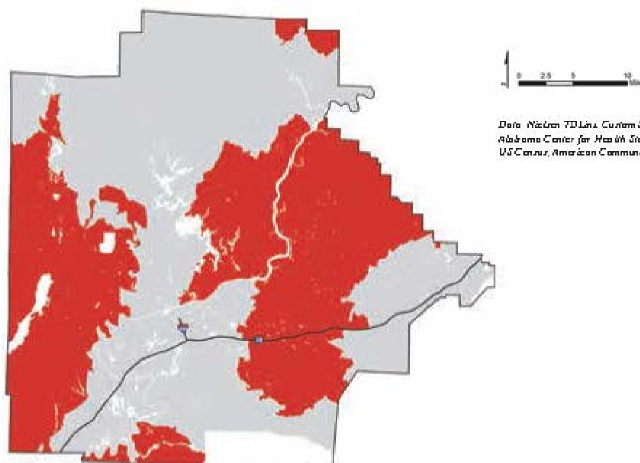
Data: Nielsen TDLinx Custom Store Analysis, 2014, Alabama Center for Health Statistics, 2013, US Census, American Community Survey, 2008–2012.

MAP 9: *Areas with Greatest Need in Tuscaloosa County* include: the area around Lake Lurleen State Park; areas neighboring the Black Belt Counties; and areas surrounding the Black Warrior River

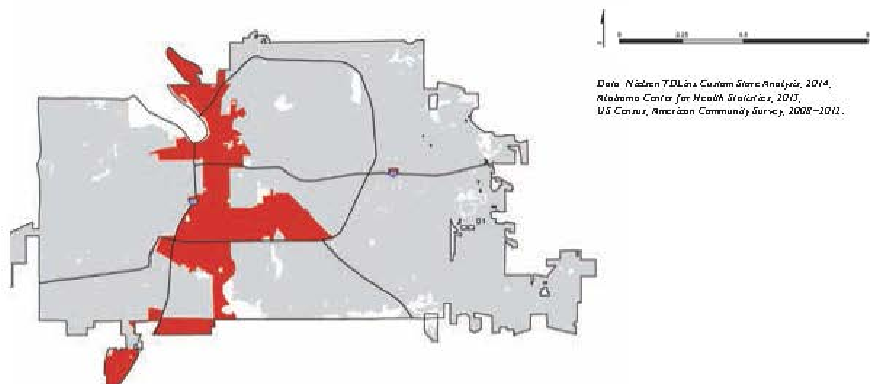
MAP 10: *Areas with Greatest Need in Montgomery* include: Downtown, the Garden District, the Cloverdale Region, South Montgomery, North Montgomery and the area near Maxwell Air Force Base

The areas in red have the greatest need for more supermarkets and other fresh food retail venues.

9: *Areas with Greatest Need in Tuscaloosa County*



10: *Areas with Greatest Need in Montgomery*



SECTION TWO:

HEALTHY FOOD FINANCING IN ALABAMA

Alabama must address the critical need for more healthy food resources in many communities across the state.

Access to healthy food retail is a key factor contributing to the health and economic development of neighborhoods. As shown in the first section of this report, people living in lower-income areas without access to supermarkets and other healthy food retail suffer from diet-related deaths at a rate higher than that experienced by the population as a whole. In response to this need, VOICES for Alabama's Children and the Alabama Grocers Association recently convened the Alabama Grocery Summit to better understand the nature of the problem, and to hear about how other places in the country have responded to inadequate access to healthy food. At the meeting there was consensus that, through a public-private partnership, we could help increase the number of healthy food retail outlets in underserved communities and improve the health of children and families across the state.

Why a Healthy Food Financing Program?

To overcome the high cost and risk associated with store development in underserved areas, the food retail industry needs public sector support. Healthy food financing programs incentivize supermarket and other healthy food retail development, thereby increasing food access in communities that need it most. This innovative model was first established in Pennsylvania with the state's Fresh Food Financing Initiative (FFFI) in 2004. FFFI took the form of a public-private partnership and encouraged grocery store development in underserved communities throughout the state. Seeded with $30 million from the state's Department of Community and Economic Development, FFFI was designed to accommodate the diverse financing needs of large chain supermarkets, family-owned grocery stores, farmers' markets and other healthy food retailers, whether located in cities, small towns or rural communities. The program has had a tremendous impact in Pennsylvania, supporting 88 fresh food retail projects across the state, representing more than 5,000 jobs created or retained and improved access to healthy foods for over 400,000 state residents.[14]

Since the launch of FFFI, several other states and cities have launched or are making preparations to launch their own versions of the Pennsylvania program (see page 18 for more information). Similarly, the federal government introduced the national Healthy Food Financing Initiative, which has provided financial awards and New Markets Tax Credits to Community Development Financial Institutions, Community Development Corporations and banks investing in new or expanded healthy food retail in underserved communities throughout the country.

In addition to increasing families' access to healthy foods, new and improved grocery stores can help revitalize lower-income neighborhoods by generating foot traffic and attracting complementary services and stores such as banks, pharmacies and restaurants. Studies have found that employees at urban supermarkets in distressed areas tended to live nearby, and the average supermarket hires 90 people or more directly from the areas where they operate.[15] By employing local residents, grocery stores create jobs for those who need them most and help create a virtuous cycle that enables local residents to increase economic activity. At the same time, it takes between five and seven years before the initial investment costs of a typical new supermarket ($8 million to $25 million) are recovered[16], so start-up costs are a strong consideration for any new grocery project, particularly in a distressed community.

A statewide Alabama Healthy Food Financing Program would be a vital resource for increasing healthy food access in underserved communities throughout the state. **The goals of the program should include:**

- Providing grants and loans to supermarkets, grocery stores, co-ops, farmers' markets and other fresh food retailers for the construction, expansion and renovation of those stores in lower-income, under-served areas of rural and urban Alabama.
- Improving the health of families and individuals living in those communities by increasing access to fresh foods in rural and urban underserved communities. There is growing evidence that better access to fresh food retail reduces the risk of developing diet-related diseases such as obesity, heart disease and diabetes.
- Creating or maintaining local jobs in lower-income, underserved communities through new hiring opportunities at fresh food stores or, by providing for the upgrades and renovations needed to keep a store viable, helping to retain existing jobs in local communities.
- Spurring economic development and neighborhood revitalization by bringing supermarkets and other fresh food retailers back into Alabama neighborhoods, which will attract complementary businesses, make these areas more desirable places to live and increase property values. According to a study of the Pennsylvania Fresh Food Financing Initiative by The Reinvestment Fund, the introduction of new supermarkets to underserved neighborhoods resulted in increased appreciation of home prices near the new stores.[17]

HEALTHY FOOD FINANCING
CASE STUDY

Circle Food Store
New Orleans, Louisiana

When it originally opened in 1938, Circle Food Store was the first African-American-owned grocery store in New Orleans, and it became a community hub for the Treme neighborhood. In 2005, Hurricane Katrina severely damaged the store, forcing it to close and leaving a major void in the Seventh Ward. In 2014, owner Dwayne Boudreaux was finally able to reopen the store with support from various funding sources, including $1 million from the New Orleans Fresh Food Retailer Initiative, a public-private partnership administered by Hope Enterprise Corporation and The Food Trust in collaboration with the city. In addition to groceries, the new-and-improved 22,000-square-foot Circle Food Store has a pharmacy and a credit union, and it has created 65 jobs, 95% of which are filled by local residents. According to the United States Department of Housing and Urban Development (HUD), 28,000 low- to moderate-income residents live within a one-mile radius of the store and now have improved access to healthy food.

Grocery Summit in Alabama to Discuss Healthy Food Financing

PARTICIPANTS

Stan Alexander, Associated Grocers of the South
Melissa Baker, Fenwick Capital Group
Melanie R. Bridgeforth, VOICES for Alabama's Children
Jeff Brown, Country Delite Farms
Jessica Brown, Alabama Grocers Association
Graham Champion, Public Strategies LLC
Taylor Clark, REV Birmingham
Terri Coley, Jefferson County Department of Human Resources
Johnny Collins, Barber's Dairy
Bill Davis, A & R Supermarkets
Bob Durand, Associated Wholesale Grocers
John D. Fox Jr., Moore's Marinades and Sauces
Jennifer Gray, The Daniel Foundation
Brandon Hardin, Alabama Department of Public Health
James Harris, The Brogdon Group
Mac Higginbotham, Alabama Farmers Federation
Ellen Jackson, VOICES for Alabama's Children
Irenilo Johnson, City of Birmingham
Dr. Karen Landers, Alabama Department of Public Health
Brian Lang, National Healthy Food Access Campaign, The Food Trust
Benny Larussa, The Joseph S. Bruno Charitable Foundation
Billy Leverett, Associated Grocers of the South
Chris Litz, Publix Super Markets, Inc.
Patrick McWhorter, The McWhorter Group
Darwin Metcalf, Western Supermarkets
Kim Milbrath, American Heart Association
Jay Mitchell, Mitchell Grocery Corporation
Wade Payne, Food Giant
Commissioner Jeanna Ross, Alabama Department of Children's Affairs
Deak Rushton, VOICES for Alabama's Children
Jim Searcy, Economic Development Association of Alabama
Jada Shaffer, VOICES for Alabama's Children
Jera S. Stribling, The Joseph S. Bruno Charitable Foundation
Ellie Taylor, Alabama Grocers Association
Yoshida Thomas, Neighborhood Concepts
John Wilson, Super Foods Supermarkets
Lillian Wilson, Super Foods Supermarkets
Alison Wingate Hosp, Alabama Retail Association
Jimmy Wright, Wright's Markets
Assistant Commissioner Glenn Zorn, Alabama Department of Agriculture

STRATEGIES

Participants at the Alabama Grocery Summit discussed a variety of tools that state and local governments could develop to encourage supermarket investment in underserved communities, including:

Economic Development Programs: Create and promote economic development incentive programs to the grocery retail industry in identified high-need areas. Specifically, a flexible business financing program, including grants, loans and tax credits, could support the development, renovation and expansion of grocery stores and other stores that carry or want to carry healthy foods in underserved communities. The program could be leveraged with additional private investment.

Land Assembly: Provide assistance with the land assembly process and building reuse in identified high-need areas where local support exists for grocery store and other healthy food retail development.

Security: Create partnerships between police departments, commercial retail security and community representatives to ensure a safe and secure environment for both customers and store personnel.

Transportation: Work with regional transportation agencies and private carriers to develop safe, affordable and convenient transportation for shoppers who do not have access to a supermarket, grocery store or other healthy food retail.

Job Training and Placement Programs: Create new and expand existing training programs to ensure there is a quality workforce for supermarkets and grocery stores and that employees are drawn from local neighborhoods.

Alternative Distribution Models: Gather concrete examples of mobile food operations and emerging distribution models for rural areas.

Gridlock Prevention: Create a one-stop shop for supermarket operators to interface with state government agencies; navigate local ordinances; market public incentives to the supermarket industry; and provide guidance on how to keep a project moving forward.

Implementation Work Group: Create an advisory group of leaders from the supermarket industry and civic sector to guide the implementation of these concepts.

MEETING HIGHLIGHTS

Research has shown a significant need to improve healthy food access in key areas of Alabama. Section One of this report demonstrates the need for more healthy food retail in both rural and urban parts of the state. Maps highlighted in this section show how over 1.8 million Alabama residents, including nearly half a million children, can benefit from new healthy food retail outlets.

In response to this need, the Alabama Grocers Association and VOICES for Alabama's Children convened the Alabama Grocery Summit in November 2014 to understand the challenges local grocers face when trying to develop or expand their businesses in underserved communities. The meeting was co-chaired by Jera Stribling and Benny LaRussa from the Bruno Foundation, who, as civic leaders from a foundation started with proceeds from the sale of Bruno's Supermarkets, shared their perspectives on the issue. It was attended by more than 40 representatives from the grocery industry, government and civic sector. Over the course of the meeting, a series of presentations were delivered highlighting different aspects of healthy food access:

- Dr. Karen Landers from the State Health Department reviewed data documenting health problems in the state, and highlighted community need for improved grocery access.
- Jim Searcy from the Alabama Economic Development Association discussed techniques employed by local governments to encourage grocery retail development in the absence of state resources.
- Bob Durand from Associated Wholesale Grocers delivered a presentation on grocery store development and how policies such as healthy food financing can reduce the cost of store development and encourage grocery investment in communities where it is unlikely to happen under base market conditions.
- Ellie Taylor from the Alabama Grocers Association facilitated dialogue among her members that highlighted the various challenges grocers encounter when they look to develop or expand stores in underserved communities, including high start-up and labor training costs, challenging regulatory processes, rural distribution challenges, high insurance costs and more.
- Brian Lang from The Food Trust made remarks about how the commonwealth of Pennsylvania worked to improve grocery access over the past 10 years, and discussed how a similar effort might be structured in Alabama.

At the meeting, attendants discussed different strategies to encourage grocery store development and expressed interest in working toward the development of an Alabama healthy food financing program that could be modeled on comparable programs elsewhere in the country. To initiate such a program, Alabama would need to house the program in a state agency or attract a regional Community Development Financial Institution to implement a healthy food financing program effectively and efficiently. Stakeholders at the meeting expressed a commitment to working through those issues in the months ahead.

The meeting served as indicative of the important impact a dedicated statewide healthy food financing program would have on both the need for improved access and market demand for healthy food retail. A healthy food financing initiative in Alabama would help build on the momentum around healthy food retail development, leverage existing federal and other resources, and help improve access to healthy food for the many areas of need throughout the state.

HEALTHY FOOD FINANCING
CASE STUDY

Vowell's Market Place

Natchez, Mississippi

Vowell's Market Place is an independent, family-owned chain that has operated grocery stores across Mississippi and Alabama since 1945. The business has demonstrated strong commitment to serving all communities and expanding healthy food access. In the fall of 2014, the Vowell family opened a new store in Natchez, Mississippi, in a vacant site where a previous grocer had shuttered. Owner Todd Vowell was able to utilize federal New Markets Tax Credits to finance the store's development, as the census tract of the store is considered highly distressed. According to an economic impact study conducted by the Stennis Institute at Mississippi State University, the new Vowell Cash Saver store is projected to contribute an estimated $6,034,538 to the economy of Adams County on an annual basis.[18] The 50,000-square-foot store has also created nearly 100 direct jobs.

Structuring an Alabama Healthy Food Financing Program Based on National Best Practices

Multiple regions across the country have recognized the need to increase access to nutritious food through the development of supermarkets and grocery stores in underserved communities, resulting in the creation of healthy food financing programs (see chart, page 18). These programs have all been based on the Pennsylvania Fresh Food Financing Initiative, a public-private partnership jointly managed by The Reinvestment Fund, a Community Development Financial Institution (CDFI), and The Food Trust, a Food Access Organization (FAO). Established in 2004 to encourage supermarket development in underserved neighborhoods, the program was designed to accommodate the diverse needs of large chain supermarkets, family-owned grocery stores, farmers' markets and other fresh food retailers, whether located in high-density cities, small towns or rural communities. A program in Alabama should follow these best practices learned from Pennsylvania and other established initiatives:

1. Public-Private Partnership Structure

Healthy food financing programs have traditionally relied on a public-private partnership model, wherein seed money from the government is provided to a Community Development Financial Institution (CDFI), who then partners with a Food Access Organization (FAO) to co-administer the program. In emerging cases, a philanthropic foundation has provided seed money to initiate the fund, and in some instances government agencies have played a more direct role in program management. Each of the partners of the healthy food financing initiative brings special expertise needed to successfully administer the program. The CDFI partner typically has experience in underwriting grocery store projects or other retail projects and has the capacity to build the fund by attracting additional investment, manage the fund and work closely with an FAO on a variety of sizes and types of fresh food retail projects. The FAO is typically a nonprofit organization that has experience in food access issues and the capacity to work closely with a CDFI on project administration and to work with grocers, state officials and others in the marketing, pipeline development, screening of applicants, implementation and evaluation of the program. Together, these organizations are able to effectively administer program dollars and achieve significant impacts statewide. In regions that lack a CDFI with the capacity to manage a healthy food financing program, local stakeholders have opted to house the program within a city or state agency, and may additionally seek the expertise of a national CDFI.

> *It takes between five and seven years before the initial investment costs of a typical new supermarket ($8 million to $25 million) are recovered.*

In Alabama, program guidelines should include clear eligibility criteria to ensure that financing is dedicated to projects in underserved communities. As healthy food retailers apply for financing through the program, eligibility criteria can work to vet applicants to ensure their projects will serve a lower-income, underserved community and fit the community's needs. In addition to meeting these guidelines, applicants also must qualify for financing from a financial perspective.

A healthy food financing program in Alabama could include the following partner organizations with the following responsibilities:

Government and/or Foundation:

- Provide seed funding
- Oversee program implementation

Community Development Financial Institution (CDFI) and/or State Agency:

- Manage the fund
- Partner with other CDFIs, private banks, foundations and others to raise capital and leverage funds
- Evaluate applicants' financial eligibility
- Underwrite, structure and service transactions (grants and loans)
- Provide technical assistance to fund recipients, as appropriate, which could include topics such as business planning, marketing and real estate development
- Report impacts in coordination with the FAO

Food Access Organization (FAO):

- Create the program and eligibility guidelines in coordination with the CDFI or state agency
- Identify areas of the state that are underserved. The FAO may also identify underserved areas through site visits and research, including targeted outreach to local community leaders
- Develop marketing and application materials and establish marketing strategies
- Build the project pipeline by establishing relationships with grocers, wholesalers and other operators and owners of fresh food retail projects in the state
- Evaluate applications to determine if the project is located in an underserved area, meets eligibility criteria and aligns with the mission of the program

2. Attracting Additional Funding: Leverage

Funding sources for the creation of a program have typically included seed money from a state government or foundation that is then leveraged with additional dollars from banks, foundations and other sources. Similar financing programs across the country range in size from $14 million to over $200 million, with initial seed funding of $5 million to $30 million in public or philanthropic funds. Many programs have been seeded with an initial investment of $10 million, such as those in Pennsylvania, Illinois and New York. (See Existing Healthy Food Financing Programs chart, page 18.)

CDFIs are particularly adept at pooling together multiple layers of funding and therefore can be critical partners in administering healthy food financing programs. For example, in Pennsylvania, The Reinvestment Fund attracted $145 million in additional investment to leverage the state's $30 million in seed funding.

Funding sources, whether initial seed funding or leveraged funding, may include:

- State agencies such as a state economic development department or department of agriculture
- Legislation or budget authority
- Program Related Investments (PRIs) and grants from foundations, especially those with a health mission
- Commercial banks
- CDFIs
- Federal Healthy Food Financing Initiative awards from the CDFI Fund (Department of Treasury) and the Community and Economic Development Program of the Department of Health and Human Services
- Federal economic development dollars, such as Community Development Block Grants (CDBG) from the Department of Housing and Urban Development
- Federal New Markets Tax Credit allocations (often for large supermarkets and the creation of new stores)
- Owner/developer equity

3. Flexible Uses of Grants and Loans

Grant funds are essential to the closing of deals and deploying loan funds, even with below-market rates and flexible terms and conditions for loans. Generally, grants are paired with traditional loans as well as an equity contribution from the retailer or developer. Flexibility in the use of funds also allows a healthy food financing program to have the most robust impact. Allowable uses for grants and loans could include:

- Predevelopment, including market studies, appraisals, and deposits on land and buildings and other holding costs
- Land assembly, including demolition and environmental remediation
- Infrastructure improvements, including retrofitting existing fluorescent fixtures, installing energy-efficient lighting or refrigeration equipment
- Real estate costs, including acquisition, construction, labor and materials
- Equipment costs associated with providing fresh food, including refrigeration and storage
- Inventory and working capital
- Workforce training and development costs

4. Funding a Variety of Retail Formats

The range of eligible project types takes into consideration the unique needs of a variety of communities—urban, rural and suburban—and the needs of healthy food retailers. Recognizing that one size does not fit all, flexibility in what type of fresh food retail can qualify for healthy food financing funds, as well as how those funds are being used, allows for the program to meet the needs of communities across the state. Project types eligible for funding could include:

- New full-service supermarket or grocery store
- Upgrade, expansion or preservation of an existing supermarket or grocery store
- The portion of a mixed-use or multi-tenant project that will be occupied by a grocery store
- Small and alternative food retailers such as farmers markets, mobile markets, co-ops and others
- Local produce distribution enterprises, such as food hubs

HEALTHY FOOD FINANCING PROGRAMS ACROSS THE COUNTRY

LOCATION	NAME OF PROGRAM	PROGRAM PARTNERS	FUNDING SOURCES	TYPES OF FINANCING
CA	**California FreshWorks Fund** www.cafreshworks.com	The California Endowment, Capital Impact Partners, Emerging Markets and others	The California Endowment and other private funding: $264 million raised from a variety of private investors. Additionally, Capital Impact Partners has leveraged funding for CA projects since 2011 through the national Healthy Food Financing Initiative.	**Loans:** Up to $8 million. **Grants:** Up to $50,000.
CO	**Colorado Fresh Food Financing Fund** www.chfainfo.com/CO4F	The Colorado Health Foundation, Colorado Enterprise Fund and Progressive Urban Management Associates	Seeded with a $7.1 million investment from the Colorado Health Foundation. Additionally, the Colorado Enterprise Fund has leveraged funding for CO projects since 2012 through the national Healthy Food Financing Initiative.	**Loans:** Up to $1.5 million per project. **Grants:** May not exceed $100,000 per project, except in extraordinary, high-impact cases.
IL	**Illinois Fresh Food Fund** www.iff.org/illinois-food	IL Department of Commerce and Economic Opportunity and IFF	Seeded with a $10 million grant from the IL Department of Commerce and Economic Opportunity. The fund is designed to invest approximately $30 million over the next three to four years.	**Loans:** Typical loans range from $250,000 to $1 million. **Grants:** Grants are only available to those who are also applying for a loan. The grant amount can be up to 10% of the loan amount, not to exceed $100,000.
LA	**New Orleans Fresh Food Retailer Initiative** www.hope-ec.org/index.php/new-orleans-fresh-food-retailer-initiative	City of New Orleans, Hope Enterprise Corporation (HOPE) and The Food Trust	Federal and private funding. Seeded with $7 million in Disaster Community Development Block Grant funds. Matched at least 1:1 by HOPE and other investment sources. Additionally, HOPE has leveraged funding for New Orleans projects since 2014 through the national Healthy Food Financing Initiative.	**Loans:** CDBG loans not to exceed $1 million. **Forgivable Loans:** Up to $500,000 or 20% of total financing needs.
NJ	**New Jersey Food Access Initiative** www.trfund.com/wp-content/uploads/2013/05/NJ_HealthyFoodRetailInitiativeBrochure_2013.pdf	NJ Economic Development Authority, The Reinvestment Fund (TRF) and the Robert Wood Johnson Foundation	To date, financial partners include: NJ Economic Development Authority ($4 million), Living Cities ($2 million credit) and the Robert Wood Johnson Foundation ($10 million Program Related Investment). Additionally, TRF has leveraged funding for NJ projects since 2011 through the national Healthy Food Financing Initiative.	**Loans:** Range in size from $200,000 to $4.5 million or larger for New Markets Tax Credit transactions. **Grants:** Range in size from $5,000 to $125,000. **Recoverable Grants:** Early-stage financing with no-interest loans, typically repaid by construction financing.
NY	**New York Healthy Food & Healthy Communities Fund** www.liifund.org/products/community-capital/capital-for-healthy-food/new-york-healthy-food-healthy-communities-fund	NY Empire State Development Corporation, Low Income Investment Fund (LIIF), The Reinvestment Fund (TRF) and The Food Trust	Seeded with $10 million from the state's Empire State Development Corporation. Matched with a $20 million commitment from The Goldman Sachs Group, Inc. Additionally, LIIF has leveraged funding for NY projects since 2011 through the national Healthy Food Financing Initiative.	**Loans:** Range in size from $250,000 to $5 million or larger for New Markets Tax Credit transactions. **Grants:** Range in size from $5,000 to $500,000 for capital grants and $5,000 to $200,000 for predevelopment grants.
OH	**Cincinnati Fresh Food Retail Financing Fund** www.closingthehealthgap.org/fresh-food-fund	Center for Closing the Health Gap and Cincinnati Development Fund	Up to $15 million over three years from the city. Funds appropriated by the city's Focus 52 allotted funds, sponsored by Cincinnati's Department of Trade and Development. Additionally, The Cincinnati Development Fund has leveraged funding for Cincinnati projects since 2012 through the national Healthy Food Financing Initiative.	**Loans:** Pending **Grants:** Pending
PA	**Pennsylvania Fresh Food Financing Initiative** www.trfund.com/pennsylvania-fresh-food-financing-initiative	PA Department of Community and Economic Development, The Food Trust, The Reinvestment Fund (TRF) and the Urban Affairs Coalition	Seeded with $10 million in year one and an additional $20 million over the next two years from the state's Department of Community and Economic Development. Matched with $146 million in additional public and private investment. Additionally, TRF has leveraged funding for PA projects since 2011 through the national Healthy Food Financing Initiative.	**Loans:** Typical loans ranged in size from $200,000 to $3.5 million or larger for New Markets Tax Credit transactions. **Grants:** Up to $250,000 per store and $750,000 in total for one operator. Extraordinary grants of up to $1 million were made available for projects with high potential for serving areas of extreme need.
Federal	**Healthy Food Financing Initiative** www.healthyfoodaccess.org/funding/healthy-food-financing-funds	US Departments of Treasury, Agriculture, and Health and Human Services	Since 2011, HFFI has distributed more than $140 million to over 70 community development entities across the country.	**Financing packages vary.** Financing packages vary. HFFI dollars are given to Community Development Financial Institutions (CDFIs) and Community Development Corporations (CDCs) to provide one-time grants and loans to projects in their regions.

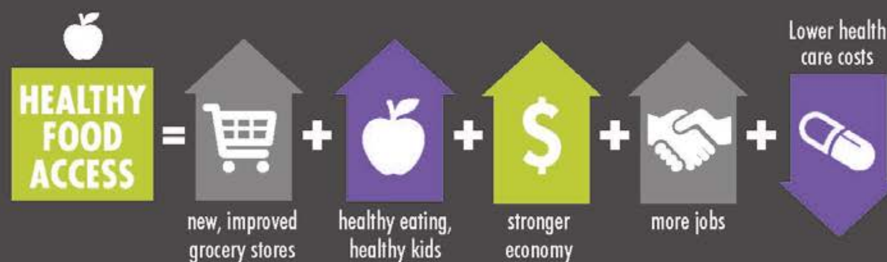
CONCLUSION AND RECOMMENDATIONS

Alabama must address the critical need for more healthy food retail in many communities.

Access to supermarkets is a key factor contributing to the health and economic development of neighborhoods. Through mapping, this study shows that many lower-income communities in Alabama have both poor supermarket access and a high incidence of diet-related deaths.

The increased incidence of obesity and other diet-related diseases in lower-income communities suggests that the public sector needs to invest in supermarket and other healthy food retail development in Alabama's underserved areas to help combat these diseases. Such an investment would have positive economic impacts as well, since supermarkets bring jobs to communities that need them the most.

Following the recently convened grocery summit, Alabama is well-positioned to create and support a statewide healthy food financing program to encourage the development of supermarkets and healthy food retail in underserved communities.



There is already much momentum surrounding this issue in Alabama, and leaders in the civic, public, private, financial and grocery sectors have all expressed the need for a grocery financing program. Current and new funding resources in the state can be appropriated to support a program that will improve the health of residents and create jobs in both rural and urban communities.

Through public investment—and the creation of a program specifically tailored to supporting healthy food retail development in underserved communities—we can increase the availability of affordable and nutritious food in underserved areas.

APPENDIX & ENDNOTES

GIS Methodology

All tabular data was prepared in MS Excel and mapped in ArcGIS 10.2.2 by ESRI. The coordinate system and projection used during mapping and analysis were the North American Datum 1983 and Alabama State Plane East. Analysis was at the US Census Bureau's ZIP code level of geography using vector polygons from the 2014 ESRI Data & Maps shapefiles. Alabama statewide analysis used discrete ZIP code polygons and statewide rates.

Demographic data from the US Census Bureau website (www.census.gov) for the 2008–2012 American Community Survey was chosen due to the presence of income variables not available in the 2010 Decennial Census.

This analysis was performed for the State of Alabama at the level of ZIP code. All of the city and county maps (cities of Birmingham, Huntsville, Mobile and Montgomery; counties of Lee and Tuscaloosa) use the statewide data and are mapped relative to the State rates and odds ratios, not relative to the city/county's own rates and odds ratios.

SUPERMARKET SALES

Supermarkets in the 2014 Trade Dimensions retail database were included in the analysis of sales. For the purposes of this study, the definition of a supermarket is a store that had an SIC code of 541105 and was identified by Trade Dimensions as a "conventional, limited assortment or natural supermarket," a "superette" or a "supercenter" with over $2 million in annual sales. There were 715 supermarkets in Alabama, with an aggregate weekly sales volume of $173,856,000.

All supermarkets were plotted using the latitude and longitude coordinates for each record and then classified into two categories; between $39,000 and $150,000, and more than $150,000 in weekly sales. Aggregate weekly sales volume of all supermarkets was attributed to the ZIP codes within which they occurred through a spatial join. Values of total sales were used to classify the ZIP codes by approximate quartiles into the four categories shown in *Map 1: Weekly Sales Volume for Supermarkets.*

POPULATION

Population data estimates for the State of Alabama by ZIP code were retrieved from the US Census Bureau's 2008–2012 American Community Survey (total of 4,833,722 people). Geographies with no population were removed from the analysis, as indicated on the maps.

SALES AND POPULATION DENSITY

For Alabama, the weekly sales volume was divided by the total population of each ZIP code. The result was then divided by the statewide rate of $35.97 ($173,856,000/4,833,722) to create an odds ratio for weekly supermarket sales per person for Alabama.

An odds ratio of 1 is equivalent to the statewide rate. Anything below 1 is below the statewide rate. An odds ratio of 2 means the rate is twice the statewide rate. This is used for *Map 2: Supermarket Sales and Population Density.* A new binary field recorded whether each ZIP code had a weekly sales odds ratio above or below 1.

INCOME

Local per capita income by ZIP code was divided by Alabama per capita income ($23,587) giving an income odds ratio. A new binary field was created to store whether the ZIP code had an income odds ratio above or below the statewide rate.

SALES AND INCOME

The Sales and Income odds ratio binary fields were combined, resulting in four distinct values which correspond to the four possible combinations of high and low odds ratios, used to classify *Map 3: Supermarket Sales and Income and Map 4: Low Supermarket Sales and Low Income.*

DIET-RELATED DEATHS

The Alabama Center for Health Statistics provided mortality data for a specified list of diet-related ICD-10 codes for the year 2013. A total of 16,857 diet-related deaths were summarized and mapped at the ZIP code level for Alabama.

DIET-RELATED DEATHS AND POPULATION

The number of diet-related deaths attributed to each ZIP code was divided by the total population of that ZIP code. This result was divided by the statewide ratio of diet-related deaths to total population (16,587/4,833,722 = 0.0034874, or 35 diet-related deaths per 10,000 people) to calculate the death odds ratio. A new binary field was created to store whether the ZIP code had a death odds ratio above or below the statewide rate.

INCOME AND DIET-RELATED DEATHS

The two binary fields of Deaths and Income odds ratios were combined through multiplication to calculate a new field. This resulted in four distinct values which correspond to the four possible combinations of high and low deaths and income, used to classify *Map 5: Income and Diet-Related Deaths.*

DIET-RELATED DEATHS, SALES AND INCOME

To combine all three variables for Alabama, a new field was created and calculated by ZIP code as the product of the deaths odds binary variable and the Low Supermarket Sales and Low Income variable. These results were reclassified to only retain one value, Low Supermarket Sales, Low Income and High Deaths, and mapped to produce *Map 6: Areas with Greatest Need.*

ACKNOWLEDGMENTS

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The Food Trust

Ensuring That Everyone Has Access To Affordable, Nutritious Food

For more than 20 years, The Food Trust has been working to ensure that everyone has access to affordable, nutritious food and information to make healthy decisions.

Recognized as a regional and national leader in the prevention of childhood obesity and other diet-related diseases, The Food Trust utilizes a comprehensive approach to improved food access that combines nutrition education and a greater availability of affordable, healthy food. Noteworthy programs include the Healthy Corner Store Initiative and the Pennsylvania Fresh Food Financing Initiative, a public-private partnership which has approved funding for nearly 90 fresh-food retail projects across Pennsylvania.

The Centers for Disease Control and Prevention honored the Fresh Food Financing Initiative in its Showcase of Innovative Policy and Environmental Strategies for Obesity Prevention and Control, and the program was named one of the Top 15 Innovations in American Government by Harvard University.

Learn more about The Food Trust:
www.thefoodtrust.org

VOICES for Alabama's Children

The Trusted Voice of Alabama's Children Since 1992

VOICES for Alabama's Children is a statewide nonprofit with a mission to ensure the well-being of Alabama's children through research, public awareness and advocacy. The organization was founded in 1992 and is the longest-standing multi-issue child advocacy organization in the state, working on policy that benefits all children, birth to graduation.

In 1994, VOICES published the state's first *Alabama Kids Count Data Book*, and has continued to annually publish and distribute this important information on child well-being to help shape policy and to help others identify and address issues in their communities.

Learn more about VOICES for Alabama's Children:
www.alavoices.org

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(215) 575-0444 • Fax: (215) 575-0466 • contact@thefoodtrust.org

Appendix I: M4A Marketing Plan Results

FY 2017 Marketing Plan Results

Re-branding the agency

- M4A developed a new logo, tagline, and mission statement and began re-branding M4A as serving "All Ages At All Stages."

Social Media Efforts

- M4A redesigned the agency website, which has shown an increase of at least 212 new visitors weekly.
- M4A also redesigned the agency's Facebook and Twitter pages, which have shown a large increase in visits each week. M4A's Facebook page allows the agency to buy ads to promote special events. This function has allowed M4A to reach close to an additional 1,000 individuals in various parts of the service region.

Newsletter

- M4A created a new newsletter which is disseminated weekly. Currently, the newsletter reaches over 750 people by email and 145 by hard copy.

Program and Services book and Promotional Items

- "The Book" was developed and, at this time, over 4,500 copies have been disseminated across the service region. (See page 345 for a view of the front cover of "The Book.")
- A new Senior Citizen Services Employment Program (SCSEP) brochure was developed in order to attract more unsubsidized employment partners. (See page 346 for a view of the front cover of the new brochure.)
- Promotional items, such as bags, fans, magnets, and rack cards were also purchased and distributed across all five counties. These items have M4A's contact information so individuals can easily contact the agency.

Advisory Council and Partnerships

- There has been an increase in the number of members participating in all five county advisory council meetings.
- M4A has also seen a large increase in the number of partnerships developed across the five county region, including Emergency Management Agencies (EMA), local hospitals and clinics, and radio stations. Such partnerships have led to M4A receiving an increase in speaking engagements and in-service trainings for professional groups.
    - M4A procured paid radio advertising with different regional stations, as well as magazine ads. Both outlets have allowed M4A to highlight various programs, services, and events.

Dementia Grant and Booklet

- M4A was awarded a "Dementia Friendly Communities Mini-Grant" by the Central Alabama Aging Consortium (CAAC). This grant will allow M4A to develop a Dementia education toolkit for law enforcement and first responders. M4A has scheduled multiple training events targeting these disciplines. (See page 347 for a view of the toolkit cover.)
- A Dementia booklet for Caregivers and Professionals was also created and disseminated.

Middle Alabama Area Agency on Aging

ASSISTING
ALL AGES AT
ALL STAGES

THE BOOK

A GUIDE FOR HELP, INFORMATION, AND RESOURCES

Office: (205) 670-5770
Toll Free: (866) 570-2998
Website: www.m4a.org

M4A'S SENIOR EMPLOYMENT

"YOUR SOLUTION TO HIRING NEEDS"

Hiring an older worker gains your organization valuable experience and knowledge

FOR MORE INFORMATION

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205-670-5770

EMAIL
SCSEP@M4A.ORG

VISIT
WWW.M4A.ORG

TOOLKIT

Creating Dementia Friendly Communities

FOR LAW ENFORCEMENT AND FIRST RESPONDERS

This toolkit was developed for law enforcement, emergency responders and paramedic students to create a dementia friendly culture that embraces, supports and properly responds to residents with dementia and their caregivers.

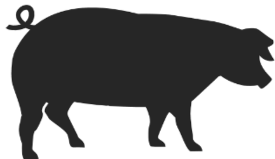
PARTNERSHIPS

In a dementia friendly community, every part of the community plays a role and works together to create a dementia friendly culture. It's all about partnerships!

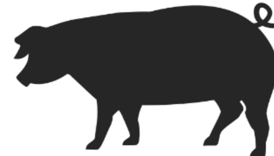
WWW.M4A.ORG

Appendix J: "Senior Feeding Frenzy" Flyer

FEEDING FRENZY



BBQ



Fundraising Event
To feed over 300 seniors in St. Clair County needing delivered meals

Thursday MAY 11th

Dine In or Take Out

11:30 AM TIL 1:00 PM

Lunch Plates- $15.00 Each

Also Support Senior Center Bake Sale Competition

Location

Center for
Performing Arts (CEPA)
Pell City, Alabama

Register @

m4a.ticketleap.com

HOSTED BY

ASSISTING ALL AGES AT ALL STAGES

SPONSORED BY

St. Clair County Commission Chairman, Paul Manning, and wife, Marie Manning, St. Clair County BOE
Wood Appraisal Service
Odenville, Ashville, and Mainstreet Drugs
Judge Mike Bowling
City of Ashville

Appendix K: WIAT News Article

PELL CITY, Ala. (WIAT-Jamie Ostroff) — Local programs that serve the elderly across Alabama are running low on money.

Agencies, like the Middle Alabama Area Agency on Aging, or M4A, are forced to put homebound senior citizens in need on long wait lists. M4A currently delivers meals to roughly 1,700 seniors across St. Clair, Shelby, Blount, Chilton and Walker Counties. There's a wait list of nearly 1,000 people, according to Laura King, the nutrition and transportation supervisor for M4A. "It hurts. It hurts very much. Especially when they're 92 years old, and they're calling and telling you that they don't have any support," King said.

King said M4A directs people on the wait list to local food banks, but it's hard for those people to get to the banks. She said sometimes, volunteers help them. According to Carolyn Fortner, the executive director of M4A, the elderly population in the counties the organization serves increased by 47% in the past decade, but state funding has not increased. "The state has given us as much money right now as they can give us," King added.

Thursday, M4A hosted a fundraiser in Pell City, serving a barbeque lunch donated by local sponsors for $15 per plate. King said $1,000 provides meals for one senior citizen for a year. Thursday's goal was to clear the wait list in St. Clair County, which has about 350 people on it. King said M4A will hold fundraisers in the future to continue to shorten the wait list in other locations.