CCH National Learning Community

Network Development Participant Profiles

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CCH National Learning Community Participant Profile

Network: Age Well
Community Care Hub: Age Well (AAA)

Lead Contact: Jane Catton; jcatton@agewellvt.org
Co-Lead Contact: Amy Ahern; aahern@agewellvt.org

Geographic Coverage:
Northwestern Vermont

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health
- Housing Assistance
- Volunteer Services and Programs

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age (on Long Term Care Medicaid)
- Individuals with chronic illness (including behavioral health) of any age
- Veterans over the age of 60 years
- Caregivers of older adults and adults under 60 with a diagnosis of dementia

Housing Partnership:

- Coordination of referrals

Network Partners:

- ACL Congressionally Directed Earmark Funding
- DAIL
- Department of Veterans Affairs
- Money Follows the Person from ACL (DAIL)
- OneCare Vermont Accountable Care Organization
- Vermont Association of Area Agencies on Aging (V4A)
  - Accounting Services
  - SHIP Program

Public Health Partnership: Vermont Department of Health

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC
- Serves as subject matter experts for an FQHC
- Cooperates with an FQHC on COVID responses
- Representation on our AAA advisory council by a FQHC

CCH National Learning Community Participant Profile

Network: AgingNY
Community Care Hub: Association on Aging in New York (AAA Membership Association)

Lead Contact: Rebecca Preve; becky@agingny.org
Co-Lead Contact: Katy Carroll; kathryn@agingny.org

Geographic Coverage:
State of New York

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health
- Housing Assistance

Public Health Partnership: NY State Dept of Health

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC
- Works jointly with an FQHC to provide programming or services
- The FQHC serves as subject matter experts for the CCH
- Serves as subject matter experts for an FQHC
- Represented on an FQHC board
- Cooperates with an FQHC on COVID responses

Housing Partnership:

- Cross training of staff
- Coordination of referrals

Network Partners:

- New York State Office for the Aging
- New York State Department of Health
- 59 Area Agencies on Aging in New York
- Self Help Virtual Senior Centers
- GetSetUp
- DOROT
- Lifespan of Greater Rochester
- The Clowder Group
- Joy for All Pets
- BloomingHealth
- Trualta
- NASGATE
- ElliQ
- Ostroff Associates
- Medicare Rights Center
- Boston University of Social Work, The Center for Aging & Disability Education & Research
- Glencove Senior Center
- National Association of Home Builders
- Developmental Disabilities Planning Council
- ArchAngels
- BellAge
- Polco
- Albany Guardian Society
- Everyone Columbia Inc.

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Veterans of any age
- Caregivers of any age

CCH National Learning Community Participant Profile

Network: Alaska CILs
Community Care Hub: Access Alaska Inc - Center for Independent Living

Lead Contact: Linda Soriano; lsoriano@accessalaska.org
Co-Lead Contact: Eric Gurley; egurley@accessalaska.org

Geographic Coverage:
Anchorage, Southcentral Alaska, Fairbanks, and Western Alaska.

Network Development Track

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Housing Assistance

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Veterans of any age
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age

Network Partners:

- Alaska Senior & Disabilities Services
- Alaska Aging & Disability Resource Center
- CHOICES, Inc
- Municipality of Anchorage/Health Department

Public Health Partnership: Anchorage Health Department

- Works jointly with a public health to provide programming or services
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses
- Access Alaska has a contract with the Anchorage Health Department to provide services for transition-age youth with disabilities.

Housing Partnership:

- Memorandum of Understanding (MOU)
- Cross training of staff
- Coordination of referrals

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

December 2022

CCH National Learning Community Participant Profile

Network: Allegheny County AAA - Dept. of Human Services
Community Care Hub: Allegheny County Area Agency on Aging (AAA)

Lead Contact: Shannah Gilliam; shannah.gilliam@alleghenycounty.us
Co-Lead Contact: Rainna Bernesser; Rainna.bernesser@alleghenycounty.us

Geographic Coverage: Allegheny County of Pennsylvania

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Health Care Contract

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Protective Services
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- In-home services

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Caregivers of any age

Network Partners:

- Primary Care Health Services
- Allegheny County Health Department
- Allegheny Health Network

Public Health Partnership: Allegheny County Department of Health

- Part of a workgroup or coalition that also includes a public health department
- A public health department serves as subject matter experts for the agency
- Cooperates with a public health on COVID responses

Federally Qualified Health Center: Primary Care Health Services

- Works jointly with an FQHC to provide programming or services
- The FQHC serves as subject matter experts for the CCH

Housing Partnership:

- Coordination of referrals

CCH National Learning Community Participant Profile

Network: Center for Independence of the Disabled, NY
Community Care Hub: Center for Independence of the Disabled, NY (CIL)

Lead Contact: Sharon McLennon-Wier; smclennowier@cidny.org
Co-Lead Contact: Alyssa D'Agosto; adagosto@cidny.org

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Health Care Contracts

Network Development Track

Geographic Coverage:
Parts of New York City

Network Services:

- Care Transition Support
- Transportation
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Housing Assistance

Housing Partnership:

- Coordination of referrals

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age

Network Partners:

- NCOA
- NOEP
- American Association of Health and Disability (AAHD)
- New York State Department of Health
- New York State Department of Education
- ILRU/Memorial Herman
- New York Community Trust
- New York Health Foundation (NYHealth)
- Disbursement Order between United States of America v. Glenwood Management Corporation
- New York State Office for the Aging (NYSOFA)
- NIDLRR/ACL
- Association of Programs for Rural Independent Living (APRIL)
- New York City Civic Engagement (NYCCEC)
- Community Service Society (CSS)

CCH National Learning Community Participant Profile

Network: Coalition for Barrier Free Living
Community Care Hub: Coalition for Barrier Free Living (CIL)

Lead Contact: Frankie Watson; fwatson@cbfl.cc
Co-Lead Contact: Ana Urena; aurena@hcil.cc

Network Development Track

Geographic Coverage:
Houston and Gulf Coast of Texas

Network Services:

- Care Transition Support
- Case Management
- Housing Assistance

Housing Partnership:

- Coordination of referrals

Populations Served:

- Individuals with disability or impairment of any age

CCH National Learning Community Participant Profile

Network: Community Council of Greater Dallas/Dallas Area Agency on Aging
Community Care Hub: Community Council of Greater Dallas/Dallas AAA

Lead Contact: Jessica Walker; jwalker@ccadvance.org
Co-Lead Contact: Doris Soler; dsoler@ccadvance.org

Geographic Coverage:
Dallas County of Texas

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Health Care Contracts

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Case Management
- Assessment for Social Determinants of Health
- Housing Assistance
- Workforce Development,
- Emergency Services,
- Engagement and Education
- Mental health Services
- Outreach

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Low-income individuals and families, formally incarcerated and homeless individuals

Network Partners:

- Senior Source
- Baylor Scott and White
- WellMed
- Texas Healthy @ Home
- DFW Hospital Council
- North Texas Council on Government/N. Central AAA
- Tarrant Council Public Health
- Texas Women University
- University of Texas at Arlington
- Southwest Family Medical Center
- Dallas County Public Health
- Visiting Nurses Association
- Louisiana Organizations: New Orleans AAA, Caddo AAA, Capital AAA
- California Black Health Network
- Harris County AAA
- AARP
- Tarrant County AAA
- Dallas and Tarrant County United Way
- Alzheimer's Association
- Salvation Army of Metropolitan Dallas
- Los Barrios Unidos Community Clinic
- Martin Luther King Health Center/Foremost Family Health Centers
- Dallas Housing Authority
- Catholic Charities
- Communities in School
- MetroCare Services

Public Health Partnership: Dallas County Public Health, Tarrant County Public Health, Harris County Public Health

- Part of a workgroup or coalition that also includes a public health department
- Work jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for us
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC
- Works jointly with an FQHC to provide programming or services
- Cooperate with an FQHC on COVID responses

Housing Partnership:

- Coordination of referrals arrangement in place

CCH National Learning Community Participant Profile

Network: Connect Mat-Su
Community Care Hub: Mat-Su Health Foundation (CBO- I&R)

Lead Contact: Ashley Peltier; apeltier@connectmatsu.org
Co-Lead Contact: Brian Tiefenbrun; btiefenbrun@connectmatsu.org

Geographic Coverage:
Matanuska Susitna (Mat-Su) borough of Alaska

Network Development Track

Network Services:

- Information & referral/Person-centered planning,
- Social connection opportunities
- Assessment for Social Determinants of Health (SDOH)
- Other: Information and referral, person-centered interventions and support for individuals that utilize a number of community resources, participation in a pilot project that streamlines referrals for SDOH resources through an e-referral process, and provides funding for housing, transportation, and other needs through our Basic Needs Support Fund.

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

Network Partners:

- LINKS Mat-Su/ADRC
- Set Free Alaska
- State of Alaska DHSS
- United Way Mat-Su
- Matanuska Electrical Association Charitable Foundation

Public Health Partnership: Mat-Su Public Health

- Part of a workgroup or coalition that also includes a public health department
- A public health department serves as subject matter experts for the agency
- Has representation from a public health partner on agency board
- Cooperates with a public health on COVID responses

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Cross training of staff
- Coordination of referrals

Federally Qualified Health Center:

- Partnered with two different FQHCs on different projects. Mat-Su Health Services and Sunshine Community Health Center are both members of the multi-disciplinary team that Connect Mat-Su facilitates.

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CDC Centers for Disease Control and Prevention

December 2022

CCH National Learning Community Participant Profile

Network: Connected Community Networks
Community Care Hub: Health Education Council (CBO- private nonprofit)

Lead Contact: Roxana Garcia-Ochoa; rgarciaochoa@healthedcouncil.org
Co-Lead Contact: Peggy Agron; pagron@healthedcouncil.org

Geographic Coverage:
Placer County and Yolo County in California

Multiple
Health Care Contracts

Network Development Track

Network Services:

- Evidence-based Programs
- Case Management
- Social Isolation Interventions
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance

Populations Served:

- Older adults (age 60+ or 65+, as defined by the
- program)
- Individuals with chronic illness (including behavioral health) of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

Housing Partnership:

- Co-location of staff
- Coordination of referrals
- Contract or other financial arrangement in place

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC
- The FQHC serves as subject matter experts for the agency
- Serves as subject matter experts for an FQHC
- Cooperates with an FQHC on COVID responses

Network Partners:

- Center for Land-based learning
- Cities of West Sacramento; Roseville
- Communicare Health Care Centers
- Elica Health Centers
- International Rescue Committee
- Kaiser Permanente
- Meals on Wheels Yolo
- National Alliance on Mental Illness- Yolo County
- Partnership Health Plan of California
- River City Medical Group
- West Sacramento Housing Development Corp.
- Yolo County Children's Alliance
- Yolo and Placer Food Banks
- Project Go Inc.
- Lighthouse Counseling & Family Services
- Prosper Placer
- Placer People of Faith Together

Public Health Partnership: Yolo and Placer County Health Department

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Serves as subject matter experts for a public health department
- Contracted by a public health department to provide services
- Cooperates with a public health on COVID responses

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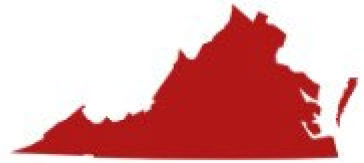
CCH National Learning Community Profile

Network: Cuyahoga Hub
Community Care Hub: United Way of Greater Cleveland (ADRC)

Lead Contact: Jennifer Kons; jkons@unitedwaycleveland.org
Co-Lead Contact: Maryam Keifer; mkeifer@unitedwaycleveland.org



Geographic Coverage:
Cuyahoga County of Ohio

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Health Care Contracts

Network Development Track

Public Health Partnership: Cuyahoga County Board of Health, Cleveland Department of Public Health, and other local hospital systems and community health centers

- Is part of a workgroup or coalition with public health partner
- Provides programming or services and is contracted to provide services
- Serves as subject matter experts
- Public health partner serves as subject matter experts

Housing Partnership:

- Cross training of staff
- Coordination of referrals

Federally Qualified Health Center:

- Is part of a workgroup or coalition with FQHC, provides programming or services

Network Partners:

- The local Area Agency on Aging (Western Reserve Area Agency on Aging) contracts with United Way of Greater Cleveland (UWGC) to serve as the ADRC for Geauga County and provide information and referral for older adults in Cuyahoga County via its 211 services. UWGC includes Cuyahoga County and United Way Services of Geauga.

Network Services:

- Evidence-based Programs
- Nutrition Services (e.g, meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for Social Determinants of Health (SDOH)

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

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CCH National Learning Community Participant Profile

Network: Denver Regional Community Care Hub
Community Care Hub: Denver Regional Council of Governments (AAA)

Geographic Coverage:
Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Gilpin, and Jefferson Counties of Colorado

Lead Contact: AJ Diamontopoulos; adiamontopoulos@drcog.org
Co-Lead Contact: Jayle Sanchez-Warren; jswarren@drcog.org

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Care Navigation
- Service for Veterans and refugees

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

Public Health Partnership:

- Part of a coalition that includes a public health department

Housing Partnership:

- Contract or other financial arrangement in place
- Coordination of referrals

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC

Network Partners:

- A Little Help
- Aging Resources of Douglas County
- Alzheimer's Association
- Arapahoe County Community Resources
- Asian Pacific Development Center
- Benefits in Action
- Blue Spruce Habitat for Humanity
- Brothers Redevelopment, Inc
- Catholic Charities and Community Services
- City and County of Broomfield
- City and County of Denver, Office on Aging
- City of Lakewood
- Colorado Gerontological Society
- Colorado Health Network
- Colorado Legal Services
- Colorado Visiting Nurse Association
- Denver Inner City Parish
- Dominican Home Health Agency
- Douglas County Department of Community Development: Community and Resource Services
- Jefferson Center for Mental Health
- Jewish Family Service of Colorado
- Mount Evans Home Health Care and Hospice
- Project Angel Heart
- Rebuilding Together Metro Denver, Inc
- Senior Support Services
- Seniors' Resource Center
- Southwest Improvement Council
- The Senior Hub
- Via Mobility Services
- Volunteers of America

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

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CCH National Learning Community Participant Profile

Network: ElderSource- Northeast Florida
Community Care Hub: ElderSource (AAA)

Lead Contact: Linda Levin; linda.levin@myeldersource.org
Co-Lead Contact: Tameka Gaines Holly; tameka.g.holly@myeldersource.org

Geographic Coverage:
State of Florida

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Health Care Contract

Network Development Track

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Social Isolation Interventions
- Assessment for LTSS
- Assessment for Social Determinants of Health (SDOH)

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Veterans of any age
- Adults (age 18 to 65) with a disability, impairment, or chronic illness

Network Partners:

- Veterans Administration Medical Centers
- Area Agencies on Aging
- Under development with CILs

Public Health Partnership: Florida Department of Health in Duval County

- A public health department serves as subject matter experts for us
- Cooperates with a public health on COVID responses

Housing Partnership:

- Coordination of referrals

Federally Qualified Health Center: Agape

- Works jointly with an FQHC to provide programming or services
- Cooperates with an FQHC on COVID responses

ACL Administration for Community Living

CDC Centers for Disease Control and Prevention

CCH National Learning Community Participant Profile

Network: Governor's Office of Elderly Affairs
Community Care Hub: Governor's Office of Elderly Affairs (SUA)

Lead Contact: Jessica Ross; Jessica.Ross@la.gov
Co-Lead Contact: Shavon Humphrey; shavon.humphrey@la.gov

Geographic Coverage:
State of Louisiana

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Health Care Contracts

Network Development Track

Network Services:

- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance

Network Partners:

- 34 Area Agencies on Aging
- 33 Councils on Aging
- 8 ADRCs
- 2 Louisiana advocacy Centers

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Caregivers of any age

Public Health Partnership: Louisiana Department of Health (LDH)

- Work jointly with a public health to provide programming or services
- Represented on a public health department board
- Cooperate with a public health on COVID responses

Federally Qualified Health Center:

- Cooperate with an FQHC on COVID responses

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

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CCH National Learning Community Participant Profile

Network: Healthy Aging at Home Network (HAHN)
Community Care Hub: Center for Health & Research Transformation (Policy & Research Center)

Lead Contact: Deana Smith; dgrabel@med.umich.edu
Co-Lead: Jennifer Black; jeblack@med.umich.edu

Geographic Coverage: Washtenaw, Jackson, and Livingston Counties of Michigan

Network Development Track

Network Services:

- Medically Tailored Meals
- Transportation
- Caregiver Support
- Nutrition Counseling
- Social Isolation Interventions
- Behavioral Health
- Assessments for Social Determinants of Health
- Chore services

Network Partners:

- Jewish Family Services of Washtenaw County
- Ypsilanti Meals on Wheels
- Catholic Social Services of Washtenaw County
- Chelsea Senior Center
- Area Agency on Aging 1-B

Populations Served:

- Older adults (age 65+)
- Individuals with disability (50+)

Public Health Partnership: Washtenaw County Public Health Department

- Part of a workgroup or coalition that also includes a public health department

CCH National Learning Community Participant Profile

Network: Independent Resources, Inc.
Community Care Hub: Independent Resources, Inc. (CIL)

Lead Contact: Dr. Despina Wilson; DWilson@iri-de.org
Co-Lead Contact: Dr. Jacqueline Reyes; JReyes@iri-de.org

Network Development Track

Geographic Coverage:
All Delaware Counties

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Pandemic education
- Pre employment Training
- Peer support

Network Partners:

- Division of Vocational Rehabilitation

Public Health Partnership: Aging and Adults with Physical Disabilities, Developmental Disabilities Services, Div. of Visually Impaired and Div. of Deaf and Hard of Hearing, Social Services, Emergency Preparedness

- A public health department serves as subject matter experts for us
- Dr. Reyes is part of DE Medical Reserve and has volunteered in COVID response (vaccine and testing)

Housing Partnership:

- Cross training of staff

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

December 2022

CCH National Learning Community Participant Profile

Network: Iowa Community HUB
Community Care Hub: CHPcommunity (CBO- nonprofit)

Lead Contact: Trina Radske-Suchan; tsuchan@chpcommunity.org
Co-Lead Contact: Linda Hildreth; assistant@i4a.org

Network Development Track

Geographic Coverage:
State of Iowa

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Translational research

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)
- Priority populations such as ethnic minorities, individuals with HIV/AIDS, homelessness, mental health/SUD

Network Partners:

- CyncHealth; Unite Us
- Findhelp
- Happy at Home
- Iowa Area Agencies on Aging (I4A)
- Iowa Compass & Easterseals of Iowa
- Iowa Department on Aging
- Iowa Department of HHS
- Iowa State University
- Primary Health Care (FQHC)
- Telligen
- University of Iowa
- United Way 211

Public Health Partnership: Iowa Department of Health and Human Services

- Work together on the Iowa Falls Prevention Coalition and member of Iowa HHS SDOH Workgroup
- Work jointly with public health to provide programming to prevent and manage diabetes in Iowa
- Public Health partners are members of the HUB Advisory Group

Federally Qualified Health Center:

- Works jointly with an FQHC to provide programming to address childhood obesity
- The FQHC serves as subject matter experts for us on HUB Advisory group
- Contracted with FQHC to support diabetes prevention
- Have representation from FQHC on our board

ACL Administration for Community Living
CDC Centers for Disease Control and Prevention

December 2022

CCH National Learning Community Participant Profile

Network: Kentucky Community Healthcare Connections Network
Community Care Hub: Kentucky Council of Area Development Districts (CBO)

Lead Contact: Bill Cooper; dcbcoop@gmail.com
Co-Lead Contact: Celeste Robinson; crobinson@bgadd.org

Geographic Coverage: State of Kentucky

1 Health Care Contract

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Caregivers of any age
- Children (up to age 18)

Network Partners:

- KY Council of Area Development Districts (ADD)
- Barren River ADD, Big Sandy ADD, Bluegrass ADD, Buffalo ADD, Cumberland ADD, FIVCO ADD, Gateway ADD, Green River ADD, Kentucky River ADD, KIPDA ADD, Lake Cumberland ADD, Lincoln Trail ADD, Northern Kentucky ADD, Pennyrile ADD, Purchase ADD

Public Health Partnership: All fifteen of our Kentucky Area Agencies on Aging and Independent Living (AAAIL) partner on a variety of program with their local/regional Health Departments.

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses
- Jointly provides Disease Prevention and Health Promotion programs
- Outreach through billboards

Federally Qualified Health Center:

- Jointly with an FQHC to provide programming or services

Housing Partnership:

- Coordination of referrals
- Co-location of staff

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CCH National Learning Community Participant Profile

Network: TBD
Community Care Hub: Area Agency on Aging 3 (AAA)

Lead Contact: Allison Stehlik; astehlik@psa3.org
Co-Lead Contact: Lacy Washam; lwasham@psa3.org

Geographic Coverage:
Multiple Counties in Ohio

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Health Care Contracts

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)

Public Health Partnership: Allen County Department of Health

- Work jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for us
- Serve as subject matter experts for a public health department
- Cooperate with a public health on COVID responses

Federally Qualified Health Center:

- The FQHC serves as subject matter experts
- Serve as subject matter experts for an FQHC
- No formalized MOUs with an FQHC

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Caregivers of any age
- Children (up to age 18)
- Volunteers, aged 55+

CCH National Learning Community Participant Profile

Network: North Carolina NLE
Community Care Hub: North Carolina Center for Health and Wellness (CBO)

Geographic Coverage:
State of North Carolina

Lead Contact: Jeff Bachar; jbachar@unca.edu
Co-Lead Contact: Linda Miller; lmiller@centlina.org

Network Development Track

Network Services:

- Evidence-based Programs
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Assessment for Social Determinants of Health (SDOH)
- Healthy home assessments for falls prevention
- Family caregiver support services

Network Partners:

- North Carolina Area Agencies on Aging
- NC Council of Governments
- Healthy Aging NC

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age

Public Health Partnership: Mecklenburg County Department of Public Health, Eastern Band of Cherokee Indians Health and Medical Division, Swain County Department of Public Health, Cabarrus Health Alliance

- Work jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for us
- Cooperate with a public health on COVID responses

Housing Partnership:

- Coordination of referrals

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CCH National Learning Community Participant Profile

Network: North Country Chronic Disease Prevention Coalition
Community Care Hub: North Country Healthy Heart Network, Inc. (CBO)

Lead Contact: Ann Morgan; amorgan@heartnetwork.org
Co-Lead Contact: Anne Marie Snell; anne@gethealthyslc.org

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Health Care Contract

Network Development Track

Geographic Coverage:
Northeastern counties of New York

Network Services:

- Evidence-based Programs

Public Health Partnership: Clinton County Public Health, Essex County Public Health, Franklin County Public Health, St. Lawrence County Public Health

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- Serves as subject matter experts for a public health department
- Have representation from a public health partner on our board
- Network co-lead meets weekly with St. Lawrence County Public Health to support county's community health assessment and community health improvement planning effort

Federally Qualified Health Center:

- Works jointly with an FQHC to provide programming or services
- Have representation from an FQHC on agency board

Network Partners:

- Adirondack Health
- Adirondack Health Institute
- Adirondacks ACO
- UVM-Alice Hyde Medical Center
- UVM - Champlain Valley Physicians Hospital
- UVM - Elizabethtown Community Hospital
- Champlain Valley Family Services
- Citizen Advocates
- Claxton-Hepburn Medical Center
- Clinton County Mental Health & Addiction Services
- Public Health Agencies in Clinton, Essex, Franklin, & St. Lawrence counties
- Offices for the Aging in Clinton, Essex, Franklin, Hamilton, St. Lawrence, Warren, and Washington counties and Saint Regis Mohawk Tribe
- Community Connections
- Community Health Centers of the North Country
- Glens Falls Hospital
- Hudson Headwaters Healthcare Network
- Irongate Family Practice
- St. Lawrence Health Systems
- St. Lawrence County Health Initiative

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with chronic illness (Including behavioral health) of any age
- Caregivers of any age

CCH National Learning Community Participant Profile

Network: Pennsylvania Association of Area Agencies on Aging
Community Care Hub: P4A (AAA)

Lead Contact: Rebecca May-Cole; rmaycole@p4a.org
Co-Lead Contact: Paul Cantrell; paul@clearview-strategies.com

Geographic Coverage:
State of Pennsylvania

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- HCBS provider contracting, management, and monitoring

Network Partners:

- All 52 AAAs in Pennsylvania
- Comprehensive Care Connections (C3)

Federally Qualified Health Center: Primary Care Health Services

- The FQHC serves as subject matter experts for the agency (The President/CEO of the Pennsylvania Association of Community Health Centers (FQHCs) serves on P4A's Strategic Advisory Council.)
- Cooperates with an FQHC on COVID responses

Housing Partnership:

- Memorandum of Understanding (MOU)
- Coordination of referrals

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Caregivers of any age

CCH National Learning Community Participant Profile

Network: Planning & Service Area 4, California
Community Care Hub: Area 4 Agency on Aging (AAA)

Lead Contact: Will Tift; wtift@agencyonaging4.org
Co-Lead Contact: Anson Houghton; ahoughton@agencyonaging4.org

Geographic Coverage:
Nevada, Placer, Sacramento, Sierra, Sutter, Yolo and Yuba Counties of California

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs,
- Participant-directed Care
- Caregiver Support
- Person-centered Planning,
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH),
- Housing Assistance
- Employment Training

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Caregivers of any age
- Adults with a disability, impairment, or chronic illness

Public Health Partnership: Sacramento County DHS

- Part of a workgroup or coalition that also includes a public health department
- Work jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for agency
- Serves as subject matter experts for a public health department
- Contracted by a public health department to provide services
- Cooperate with a public health on COVID responses

Housing Partnership:

- Cross training of staff
- Coordination of referrals

Federally Qualified Health Center:

- We are part of a workgroup or coalition that also includes an FQHC

Network Partners:

- 2 Bits Café, 2 Bits Express
- ACC Senior Services
- Bingocize [License]
- CA Dept. of Aging
- CA Dept. of Food and Agriculture
- CA Health Collaborative: MSSP
- CIL Suite
- Community Link - 211 Sacramento/Yolo
- Costa Vida Mexican Restaurant
- CottonWood Post-Acute Rehab
- County of Placer, Dept. of Health & Human Services
- County of Sacramento, Dept. of Child, Family & Adult Services
- DEEP [License]
- Del Oro Caregiver Resource Center
- Dignity Community Care dba Woodland Memorial Hospital
- DoorDash Delivery [In-kind Agreement]
- Drewski's Hot Rod Kitchen
- FREED Center for Independent Living
- GetSetUp [Subscription]
- Gold Country Community Services
- Inc. Senior Citizens of Sierra County
- Las Brasas Mexican Restaurant
- Legal Services of Northern California (LSNC)
- MOW by ACC
- MOWA [Branding License]
- Nevada-Sierra Regional IHSS - Connecting Point
- Northwest Media
- Pacific Gas & Electric (PG&E)
- People Resources, Inc. dba MOW by Yolo
- Placer Community Foundation
- Placer Independent Resource Services
- Placer People of Faith Together
- Rebuilding Together
- Resources for Independent Living (RIL)
- SAGE
- Seniors First
- Sierra Senior Services
- Stanford Settlement
- State Council on Developmental Disabilities (SCDD)
- The Arc of CA
- Tracey's Diner
- United Domestic Workers
- Wayfinder Family Services
- Yolo Food Bank
- Yolo Healthy Aging Alliance (YHAA)
- Yuba Sutter Legal Center

CCH National Learning Community Participant Profile

Network: Resources for Independent Living, Inc.
Community Care Hub: Resources for Independent Living, Inc. (CIL)

Lead Contact: Lisa Killion-Smith; lsmith@rilnj.org
Co-Lead Contact: Jamie Cole; jcole@rilnj.org

Geographic Coverage:
Multiple counties in New Jersey

Network Development Track

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Social Isolation Interventions
- Assessment for LTSS
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Advocacy
- Life skills training
- Transitions
- Peer support
- I&R

Network Partners:

- Burlington County Office on Aging
- Cumberland County Office on Aging
- NJ Department of Human Services
- Division of Aging Services
- NJ Division of Disability Services
- NJ Division of Developmental Disabilities
- Cornell University
- NJ Department of Transportation
- Veteran's Affairs
- Division of Vocational Rehabilitation Services (DVRS)

Housing Partnership:

- Coordination of referrals

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

CCH National Learning Community Participant Profile

Network: Rooted Together Village
Community Care Hub: Community ConneXor (CBO)

Lead Contact: Vickie W Harris; VHARRIS@COMMUNITYCONNEXOR.COM
Co-Lead Contact: Uwakieme Eligwe; kieme@fortuneages.com

Geographic Coverage:
Davidson County of Tennessee

Network Development Track

Network Services:

- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Determinants of Health (SDOH) Screening
- Home Modification Services
- DSMES Services

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)

Network Partners:

- Knowles Home Assisted Living and Adult Day Care
- Happy Hearts Smiles
- Rebuilding Together Nashville
- The Help Center
- Urban Housing Solutions
- Tennessee Supportive Integrated Living for Vulnerable Elderly Residents (TNSILVER)
- Greater Nashville Regional Council (GNRC) AAAD
- Meharry Medical College - Elam Mental Health Center & Family and Community Medicine

Public Health Partnership: Metro Public Health Department-Lentz Health Center, Healthy Nashville Leadership Council CHIP Work Groups Access to Resources, Healthy Food Access and Community Safety

- Part of a workgroup or coalition that also includes a public health department

Federally Qualified Health Center: Greater Nashville Health Disparities Coalition, Meharry Vanderbilt Alliance Faith and Health Collaborative (includes the Matthew Walker Health Center)

- Part of a workgroup or coalition that also includes an FQHC

Housing Partnership: Urban Housing Solutions (26th and Clarksville Highway)

- Contract or other financial arrangement in place

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CCH National Learning Community Participant Profile

Network: SeniorAge Area Agency on Aging
Community Care Hub: SeniorAge (AAA)

Lead Contact: Juli Jordan; juli.jordan@senioragemo.org
Co-Lead Contact: Janice Piper; janice.piper@senioragemo.org

Geographic Coverage:
Southwest Missouri

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Information and assistance

Public Health Partnership: Springfield Greene County Health Department

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Cooperates with a public health on COVID responses
- Partnerships via local events and education outreach

Federally Qualified Health Center:

- Make referrals to Jordan Valley Community Health Center

Housing Partnership:

- Coordination of referrals

Network Partners:

- Department of Health and Senior Services
- Affordable Care Act
- Tax Counseling for the Elderly through the IRS
- Advantage Home Care
- Charitable Adults Rides & Service, Inc.
- City of West Plains (West Plains Transit)
- Cities of Mountain Grove and Mountain View
- Council of Churches of the Ozarks
- Ade County Senior Center
- Ava Senior Center (Douglas County Council on Aging)
- Grace Health Services
- HealthCare Services of the Ozarks (d/b/a CoxHealth at Home)
- Integrity Home Care
- Legal Services of Southern Missouri
- LHC Group d/b/a Access In-Home
- OATS, Inc.
- Premier Home Health
- Ozarks Healthcare at Home, Community Care
- Show Me Systems, LLC
- SMTS, Inc.
- Texas County Mem. Hosp.-DBA Home Health of the Ozarks

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Spouses of individuals that are age 60 and over on our services

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CCH National Learning Community Participant Profile

Network: Southern Nevada Pathways Community HUB
Community Care Hub: Comagine Health (CBO- nonprofit)

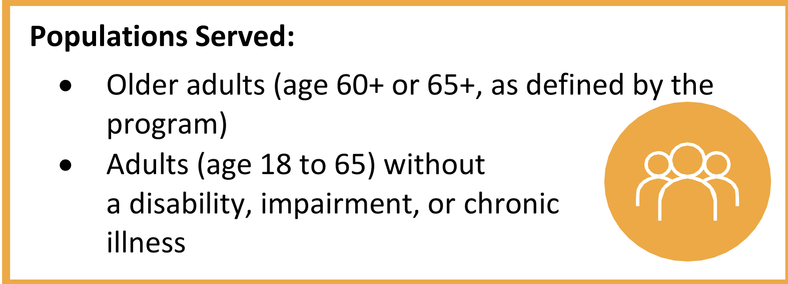
Lead Contact: Brian Parrish; bparrish@comagine.org
Co-Lead Contacts: Casey Lyn Domingo; Caseylyn.Domingo@dignityhealth.org
Mary Karls; mkarls@comagine.org & Nicole Taylor; jtaylor@comagine.org

Geographic Coverage:
Clark County, Nevada

Network Development Track

Network Services:

- Transportation
- Evidence-based Programs
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Behavioral Health
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Workforce Development

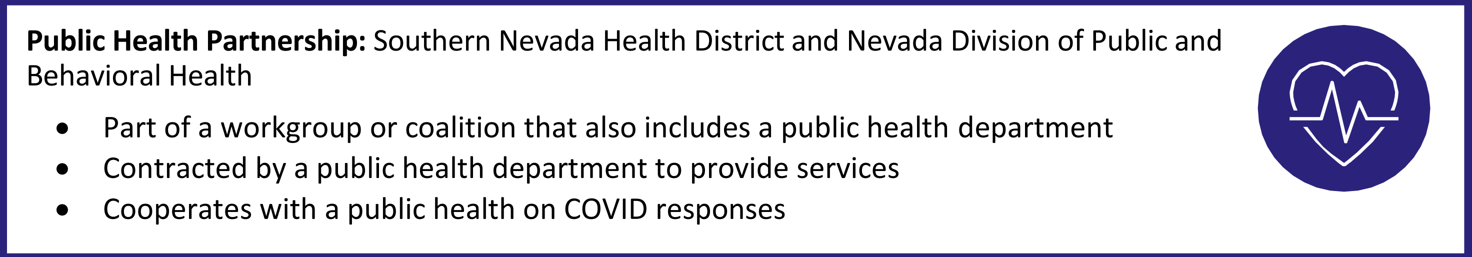


Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Adults (age 18 to 65) without a disability, impairment, or chronic illness

Network Partners:

- Nevada's Quality Technical Assistance Center (QTAC) Dignity Health
- Access to Healthcare Network
- Nevada Department of Health and Human Services (DHSS) Division of Public and Behavioral Health (DPBH) Chronic Disease Prevention and Health Promotion (CDPHP)
- Unite US
- Albany Designs LLC (Compass Data System)
- Self-Management Resource Center
- Arthritis Foundation
- CommonSpirit Health



Public Health Partnership: Southern Nevada Health District and Nevada Division of Public and Behavioral Health

- Part of a workgroup or coalition that also includes a public health department
- Contracted by a public health department to provide services
- Cooperates with a public health on COVID responses

CCH National Learning Community Participant Profile

Network: Independent Resources, Inc.
Community Care Hub: Independent Resources, Inc. (CIL)

Lead Contact: Dr. Despina Wilson; DWilson@iri-de.org
Co-Lead Contact: Dr. Jacqueline Reyes; JReyes@iri-de.org

Geographic Coverage:
All Delaware Counties

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Pandemic education
- Pre employment Training
- Peer support

Network Partners:

- Division of Vocational Rehabilitation

Public Health Partnership: Aging and Adults with Physical Disabilities, Developmental Disabilities Services, Div. of Visually Impaired and Div. of Deaf and Hard of Hearing, Social Services, Emergency Preparedness

- A public health department serves as subject matter experts for us
- Dr. Reyes is part of DE Medical Reserve and has volunteered in COVID response (vaccine and testing)

Housing Partnership:

- Cross training of staff

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age

CCH National Learning Community Participant Profile

Network: Texas Healthy at Home
Community Care Hub: Texas Healthy at Home (CBO- 501 (c)3)

Lead Contact: Jennifer Gardiner; J.Gardiner@texashealthyathome.org
Co-Lead: Christina Bartha; c.bartha@texashealthyathome.org
Co-Lead: Jayme Taylor; jtaylor@texashealthyathome.org

Geographic Coverage:
State of Texas

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Health Care Contracts

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs,
- Participant-directed Care
- Caregiver Support
- Person-centered Planning,
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance

Network Partners:

- Baylor Scott & White Health
- Alzheimer's Association of Texas
- James L West
- Texas Association of Promotores and Community Health Workers
- Texas A&M AgriLife Extension
- TX Assn. of Regional Councils l TX Assn. of AAAs
- WellMed Charitable Foundation

Public Health Partnership: Tarrant County Public Health, Healthy Tarrant Co. Collaboration, Texas Health & Human Services, Texas A&M School of Public Health, Houston Health Department

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health entity to provide programming or services

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

CCH National Learning Community Participant Profile

Network: tilinet.org
Community Care Hub: Tri-County Independent Living

Lead Contact: Lisa Leon; lisa@tilinet.org
Co-Lead Contact: Eddie Morgan; eddie@tilinet.org

Geographic Coverage:
Humboldt County, Del-Norte County, Trinity County of California

Network Development Track

Network Services:

- Care Transition Support
- Transportation
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers SNAP enrollment)
- Assessment for LTSS
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Other: Advocacy, Assistive Technology, Independent Living Skills, Training, Information & Referral, Peer Support, Youth Transition and Coordination

Network Partners:

- North Coast ADRC
- Area One Agency on Aging

Public Health Partnership: Humboldt County Department of Health and Human Services

- Cooperates with a public health partner on COVID responses

Housing Partnership: The Housing Authorities City of Eureka and County of Humboldt

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age
- Children (up to age 18)

CCH National Learning Community Participant Profile

Network: TogetherNow
Community Care Hub: TogetherNow (CBO)

Lead Contact: Laura Gustin; laura.gustin@systemsintegration.org
Co-Lead Contact: Nikisha Johnson; nikisha.johnson@systemsintegration.org

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Health Care Contracts

Network Development Track

Geographic Coverage:
Monroe County of New York

Network Services:

- Care Transition Support
- Transportation
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Behavioral Health
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Housing Assistance
- Implementing integrated service pathways across 11 domains including: Employment, Income, Financial Management, Education, Health, Food Access, Transportation, Housing, Safety, and Social Connection

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Individuals with chronic illness (including behavioral health) of any age
- Veterans of any age
- Adults (age 18 to 65) without a disability, impairment, or chronic illness
- Caregivers of any age

Housing Partnership:

- A Memorandum of Understanding (MOU)
- Contract or financial arrangement in place
- Coordination of referrals

Network Partners:
Action for a Better Community, Catholic Charities Family and Community Services, CCSI, Children's Institute, City of Rochester, Common Ground Health, Education Success Foundation, Excellus BCBS, Finger Lakes Performing Provider System, Finger Lakes Regional Economic Development Council, Foodlink, Ibero American Action League, Lifespan, Monroe County Department of Human Services, Monroe County Medical Society, Monroe County Department of Public Health, Monroe County School Boards Association, Nazareth College, ROC the Future Alliance, Rochester City School District, Rochester Regional Health, Regional Transit Service, United Way of Greater Rochester and the Finger Lakes, University of Rochester Medical Center, Connected Communities, Charles Settlement House, Community Place of Greater Rochester, Encompass, Exercise Express, Greece Central School District, Hillside Children's Center, Starbridge, Hub 585, Planned Parenthood, Monroe 2 Orleans BOCES

Public Health Partnership: Monroe County Department of Public Health

- Part of a workgroup or coalition that also includes a public health department
- A public health department serves as subject matter experts
- Serves as subject matter experts for a public health department
- Representation from a public health partner on board
- Cooperates with a public health on COVID responses

Federally Qualified Health Center:

- Part of a workgroup or coalition that also includes an FQHC
- Work jointly with an FQHC to provide programming or services
- FQHC serves as subject matter experts for us
- Contracted by an FQHC to provide services

CCH National Learning Community Participant Profile

Network: Washington County Commission on Aging, Inc.
Community Care Hub: Washington County Commission on Aging, Inc. (AAA)

Lead Contact: Amy Olack; aolack@wccoaging.org
Co-Lead Contact: Sandy Wood; swood@wccoaging.org

Geographic Coverage: Washington County of Maryland

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Health Care Contract

Network Development Track

Network Services:

- Care Transition Support
- Evidence-based Programs
- Participant-directed Care
- Caregiver Support
- Person-centered Planning
- Nutrition Services (e.g., meals, counseling, vouchers, SNAP enrollment)
- Social Isolation Interventions
- Assessment for LTSS
- Case Management
- Assessment for Social Determinants of Health (SDOH)
- Referrals to local organizations
- Application assistance
- Elder abuse support
- Recreation for seniors
- Ombudsman services
- Guardianship services for seniors
- Some legal services
- Minor home repairs

Populations Served:

- Older adults (age 60+ or 65+, as defined by the program)
- Individuals with disability or impairment of any age
- Caregivers of any age
- 55+ are eligible to participate in senior center

Network Partners:

- Meritus Medical Center
- Department of Social Services

Public Health Partnership: Washington County Health Department

- Part of a workgroup or coalition that also includes a public health department
- Works jointly with a public health to provide programming or services
- A public health department serves as subject matter experts for the agency
- Serves as subject matter experts for a public health department
- Cooperates with a public health on COVID responses
- Participates in outreach events together and they are a part of our Advisory group/Interagency support system responses

Federally Qualified Health Center:

- A part of a workgroup or coalition that also includes an FQHC
- Works jointly with an FQHC to provide programming or services
- The FQHC serves as subject matter experts for the agency
- Serves as subject matter experts for an FQHC
- Participates in outreach events together and they are a part of our Advisory group/Interagency support system

Housing Partnership:

- Coordination of referrals
- A part of advisory group