Minnesota State Plan on Aging
FFY 2024-2027

Contents

Verification of Intent

The Minnesota Board on Aging hereby submits its State Plan on Aging for the State of Minnesota October 1, 2023, through September 30, 2027, as required under Title III of the Older Americans Act of 1965.

All required assurances and plans to be carried out by the Minnesota Board on Aging which is the state unit on aging and has been given authority as defined in Minnesota statue 256.01 and 256.975 to develop and administer the State Plan on Aging in accordance with all requirements and purposes of the Act are on file.

The State Plan, when approved by the U.S. Assistant Secretary for Aging, constitutes authorization to proceed with activities under the plan.

Kari Benson, Executive Director Date: 6/30/2023 Minnesota Board on Aging

Maureen Schneider, Interim Chair Date: 6/30/2023 Minnesota Board on Aging

Executive Summary

Minnesota consistently performs well on a range of metrics, including overall resident health, volunteerism rates, and quality medical care. This success can be attributed in large part to the services and supports provided by the Minnesota Board on Aging (MBA) and Minnesota Department of Human Services (DHS), which enable older adults to live with autonomy, dignity, and maximal independence. Minnesota took early action to recognize and prepare for demographic shifts toward an older population. In 1997, Minnesota launched Project 2030, an effort to understand how demographic trends would impact our communities and the futures of older Minnesotans. Why 2030? That's the year baby boomers start to turn 85 years old, a milestone age when many individuals require additional support and possible transition to congregate settings. Through Project 2030, Minnesota took proactive measures to prepare for this turning point, which led to the MN2030 Looking Forward strategic planning effort that prepared Minnesota to pursue the status of an Age-Friendly State.

In December 2019, Minnesota began the process of becoming an Age-Friendly State, kickstarted by the Governor's Executive Order 19-38 (PDF), which established the Governor's Council on an Age-Friendly Minnesota. As directed by the executive order, the Council on Age-Friendly Minnesota released eight preliminary recommendations (PDF) in 2020. These preliminary recommendations, along with eight Age-Friendly "Status Check" issue briefs, helped to guide the five Minnesota State Plan Goals:

1. Advance equity and eliminate disparities, while empowering rural and diverse communities and respecting the sovereignty of Tribal Nations
2. Make aging in community truly possible for all Minnesotans
3. Support families, friends and neighbors in sustaining their caregiving roles
4. Promote and support healthy aging for all Minnesotans
5. Dismantle ageism and promote older adult rights, autonomy, and protection

The Minnesota State Plan will serve as a work plan for MBA and its partners. This document outlines key demographic information, important concepts and innovative ideas that will help shape and drive the future of Minnesotans. Additionally, this State Plan prioritizes equity and disparities reduction at a new level and reflects on a statewide commitment to listening to, learning from, and empowering historically underserved Minnesotans.

In 2020, MBA developed a strategic planning directive (PDF) focusing on diversity, equity, inclusion and access (DEIA). Many points in this document reference equity and MBA is committed to advancing equity in service outcomes and addressing disparities experienced by the following groups with the greatest social and economic need:

- Low-income
- Identify as American Indian
- Identify as Black, Asian Pacific Islander, and/or Latine
- Veterans

- Live with a disability, including those living with mental health conditions and mental illnesses
- Identify as lesbian, gay, bisexual, transgender, queer (LGBTQ+)
- New immigrants
- Limited English proficiency
- Live in rural areas
- Identify as solo (defined as individuals who, by choice or circumstance, function without the support system traditionally provided by family).[1]

Aging and Living Well in Minnesota

As with many other states, Minnesota's population is becoming both older and more diverse. Thoughtful planning ensures that we seize the opportunities to build upon the knowledge and experience of older adults, as well as strategically respond to support all Minnesotans, as we grow older, to age with dignity and respect, build upon their invaluable contributions as older adults, whether as workers, volunteers, caregivers or entrepreneurs. We must continue to recognize that as we age, older adults contribute to our families and communities, and we need to strive to create systems that enable us to do so for as long as possible.

Additionally, we must prioritize developing supports that will help older adults access the assistance needed when the time comes, ensuring that aging with dignity and maintaining independence is a priority.

Growing older

Currently, about 1.3 million (or 23%) of Minnesotans are age 60 or older. Of those, 107,000 (or about 8%) are people of color.[2] And recently, for the first time, Minnesota's 65-plus population eclipsed the number of school- age children. These changes are not happening uniformly across the state, greater Minnesota is collectively older than the Twin Cities metro. Residents of rural and small-town Minnesota are more than twice as likely to be age 80 or older than residents in urban parts of the state.[3] By 2033, older residents (65-plus) will make up 32% of rural Minnesota counties compared to 19% in urban counties.[4]

Older adults living in rural areas often face significant challenges in accessing essential services, such as caregiver support, transportation assistance, housing, and healthcare. Unfortunately, as more rural hospitals and nursing homes close these challenges are becoming more acute. The Rural Health Research Center at the University of Minnesota underscores the critical role that states play in supporting older rural residents, given that many aging-related resources and services originate at the state level.

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[1] A Backup Plan for Solos: Health Care Decision Making for People Aging Alone (PDF), Citizens League, 2019

[2] Population 60 Years and Over in the United States, American Community Survey 5-year estimates, U.S. Census Bureau, 2021.

[3] Greater Minnesota: Refined and Revisited (PDF), Minnesota State Demographic Center, 2017.

[4] Rural Healthcare in Minnesota: Data Highlights (PDF), Minnesota Department of Health, 2022.

Minnesota's long-term services and supports (LTSS) system is being called on to meet increased demand associated with these demographic shifts. For example, demands in additional funding for long-term services and supports, Area Agencies on Aging (AAAs), and other state agencies are instrumental in helping older rural residents age in place by allocating resources to rural communities. In Minnesota, AAAs, Live Well at home® grants, MBA Dementia grants and Grants, Equity, Access and Research (GEAR) division grants are working to build up service capacity, test innovative approaches, and provide choices for older residents in rural Minnesota communities.[5]

Through statewide data gathering, and stakeholder engagement this plan prioritizes addressing workforce shortages, caregiver burnout, as well as the diverse residents and geography of Minnesota. Its goal is to ensure that services and supports will be available to us, and to the family, friends and neighbors who care for us, when and where we need them.

We are becoming more diverse

Minnesota's demographic shifts also include an increase in our racial diversity. From 2013 to 2018, the state's population of black, indigenous and people of color grew by 18%, adding more than 167,000 people, while the non-Hispanic white population, currently comprising 79% of the population, saw only 1% growth in the same period. Projections indicate that populations of color are expected to increase, with over one million additional residents by 2053, exceeding one-third of the total population[6]. Conversely, the number of non-Hispanic white residents is projected to decline within the next decade.

This demographic shift has significant implications for aging-related services and supports, as cultural norms, expectations and circumstances can vary considerably when it comes to aging. Providers must be prepared to offer respectful, culturally sensitive care to older Minnesotans from a range of backgrounds. And efforts must be accelerated to shift resources to diverse communities to serve their older members.

Tribal Nations

Minnesota values the relationships we are actively building with the tribal nations whose geography overlaps that of the state. This guides us to follow our established government-to-government approach to seek consultation and participation by representatives of the tribal governments in policy development and service program activities. MBA has partnered extensively with Indian Country leadership to update the planning and service area of the Minnesota Indian Area Agency on Aging (MIAAA). Starting in June 2024, MIAAA will expand the Planning and Service Area (PSA) to serve 10 of the 11 tribal nations that share a geographic area with Minnesota. Historically, since 1980, MIAAA has served the tribal communities of the Bois Forte Band of Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, and the White Earth Nation.

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[5] Aging in Place in Rural America: What Does It Look Like and How Can It Be Supported? Rural Health Research Center, University of Minnesota, 2021.

[6] Data by Topic: Aging Minnesota State Demographic Center, accessed 2020.

The newly reorganized MIAAA will be housed at Red Lake Nation's Ombimindwaa Gidinawemaaganidog (Uplifting Our Relatives), formally Red Lake Family and Children Services, and begin operations July 1, 2024. The new MIAAA PSA includes Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Prairie Island Indian Community, Red Lake Nation, Upper Sioux Community, and White Earth Nation. While we are ecstatic to partner with 10 of the 11 tribes that share geography within Minnesota, the MBA through the Metropolitan Area Agency on Aging will still serve tribal elders in the Shakopee Mdewakanton Sioux Community (SMSC). If SMSC should voice interest in joining the MIAAA, the MBA would welcome and support the effort.[7]

There are two distinct tribal nations within Minnesota: the Dakota and the Ojibwe, which include 11 federally recognized tribal governments. The four Dakota communities include Lower Sioux Indian Community, Prairie Island Indian Community, Shakopee Mdewakanton Sioux Community, and Upper Sioux Community. The seven Ojibwe communities include Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Mille Lacs Band of Ojibwe, Red Lake Nation and White Earth Nation. In Minnesota, the Native American 60+ population is about 9,100.[8] More information on serving older adults in the tribal nations is in the Older Americans Act - Title VI section.

The Minnesota Board on Aging

The Minnesota Board on Aging (MBA) is Minnesota's federally designated State Unit on Aging (SUA). The 25-member board is appointed by the governor and represents diverse backgrounds, ages, interests, and communities across the state. MBA has three major roles: administrator, advisor and advocate.

Administrator

MBA administers federal and state funds to deliver a wide range of in-home and supportive services to older adults and family, friends and neighbors involved in their caregiving. To deliver these supportive services, MBA manages two direct service programs:

- Office of Ombudsman for Long-Term Care (OOLTC)
- Senior LinkAge Line (SLL)

Additionally, the Older Americans Act (OAA) instructs MBA to designate a statewide network of Area Agencies on Aging (AAAs). MBA partners with Minnesota's AAAs and others to administer and oversee the effective use of OAA and state funds to support older Minnesotans.

[7] Since the approval of this Amendment 1, SMSC has expressed interest in joining MIAAA. The MBA will follow OAA regulations to incorporate into the PSA of MIAAA.

[8] Population Data Age 60 Plus by State AGID, accessed 2021.

Advisor

MBA provides objective, unbiased information and promotes public education on ways we can all meet the changing needs of the state's older population so we can all live well and age well.

Advocate

MBA promotes state and local policies that allow older adults to age well and live well at home. MBA promotes policies to the state legislature, the Governor and state agencies that accurately reflect the needs and interests of older Minnesotans.

Age-Friendly Minnesota

Age-Friendly Minnesota (AFMN) is a collaborative statewide effort to make our systems and communities more inclusive of and responsive to older adults. The AFMN Council's members include leadership from nine state agencies and representatives from greater Minnesota, age-friendly and faith communities, and tribal nations. One of its key efforts is developing the state's first Multi-Sector Blueprint for an Age-Friendly Minnesota, which is envisioned as a cross-sector plan that engages and coordinates the work of a range of partners, old and new, related to aging.

As one of the member state agencies, MBA plays a critical role in advancing the vision of an age-friendly Minnesota. This State Plan on Aging includes several strategies that involve partnering with AFMN and others that are aligned with our shared goals. These goals encompass a range of important objectives, including promoting equity and reducing disparities, fostering coordination among state agencies, and creating livable communities that cater to the needs of Minnesotans at every stage of life. Some of these partnerships are through the AFMN Grants Program, launched in late 2022, which is granting $2.9 million over state fiscal years (SFY) 2023 and 2024 to encourage age-friendly community work across the state. The grant program is prioritizing diversity, equity, inclusion and accessibility (DEIA) to ensure that historically underserved communities will benefit from this funding.

The aging network is a crucial component in AFMN, with AAAs leading age-friendly efforts across Minnesota's diverse regions. Through various strategies, such as providing technical assistance to communities, educating municipal leaders, and partnering with foundations, these agencies play a critical role in ensuring that older residents have access to high quality services that enable them to remain in their homes and communities of choice. Minnesota has earned a strong reputation for its commitment to supporting the well-being of its aging population.

Multi-Stage Needs Assessment on Aging

Beginning in 2021, Minnesota conducted a multi-stage needs assessment focused on the state's older residents. The assessment was to inform plans and priorities of DHS, MBA, and the AFMN Council. It also represented a key step in the AARP Network of Age-Friendly States and Communities, which Minnesota joined in January 2022. This work started with the "status check" briefs which provided updates and explored the approaches and impact of the aging network over the years 2020-2021. The briefs served as a basis for a series of structured discussions

with AAAs, MBA board members and MBA staff over several months. Through these discussions, we sought to identify priority needs and opportunities related to the development of this State Plan. See Appendix D for the status check briefs. Additionally, in 2017, four key service access issues were identified through "gaps analysis" work: shortages in crisis services, housing, transportation and workforce. Since then, the state and partners have been working towards creative solutions to address gaps.

Status check briefs key findings:

- Need for more equitable and culturally responsive services
- Sustaining a quality, caring workforce to serve older residents and support caregivers
- Create transportation options and pursue affordable, equitable, appropriate housing
- Recognize and treat social connection as essential
- Increase access to broadband and technology

After completing the status check briefs, the state engaged Rainbow Research, a contractor, to conduct targeted phone interviews, statewide surveys, and focus groups. Our aim was to reach historically underserved groups, including people of color, Native Americans, members of the LGBTQ+ (lesbian, gay, bisexual, transgender, and queer) community, low-income residents, rural communities, veterans, and those with disabilities. Additionally, DHS contracted with the National Resource Center on Native American Aging (NRCNAA) to engage American Indian tribal and urban elders in the survey, ensuring that their voices were heard, and their unique needs were considered.

DHS built on Rainbow Research's work and developed a longer survey organized into ten sections: nine domains plus demographics. The survey included some questions from the Rainbow Research survey, AARP's livability questionnaire, and additional sources, as well as some original questions. At a high-level, Table 1 displays some of the key findings from the statewide and American Indian and Urban Tribal Elders Survey that tie together the needs described throughout this state plan. Minnesota will build on the work completed through the needs assessments by continued collaboration with our community partners. For a summary of the needs assessment activities, see Appendix F.

Table 1

Question	Statewide Survey	American Indian and Urban Tribal Elder Survey
Housing: Needs modifications or significant repairs to their current residence to remain safely at home	50%	53%
Caregiving: Regularly help an aging family member or friend take care of themselves	35%	48%
Caregiving: Rely on friends and/or family to help with daily tasks	18%	48%
Transportation: Lack of transportation negatively impacts my life	19%	36%

Question	Statewide Survey	American Indian and Urban Tribal Elder Survey
Social Participation and Inclusion: Often or sometimes lack companionship	42%	36%

MBA also utilized the Minnesota 2022 LGBTQ Aging Needs Assessment Report (PDF), conducted by University of Minnesota, Geriatrics Workforce Enhancement Program (GWEP), and Rainbow Health, with support from DHS. The report presents the results of a survey and highlights key recommendations in four critical areas. These include trauma-informed care, the development of programs and services for "solos," support for LGBTQ+ caregivers and the need for more data. The survey and assessment results highlight areas Minnesota must continue to build upon for us to age in the communities we choose.

Understanding Intersectionality: Continuing our journey

Despite its reputation for a high quality of life, Minnesota experiences some of the most severe race-based health disparities in the country. Further, older adults who have experienced decades of inequities on many fronts, especially those who are Black, Native American, and members of communities of color, LGBTQ+ individuals and other marginalized groups, often find themselves in a more vulnerable position in their later years. Social determinants of health (SDOH) define intersections in our overall health and well-being that include circumstances of our lives, including our families, homes, neighborhoods, education, employment, access to healthcare, and natural environment.

Minnesota in 2020:

- 26% of older adults 60+ were living alone
- 8% of older adults 60+ were from communities of color
- 6.8% of older adults 60+ were below the poverty level, with 35% of older adults 60+ below 300% of the poverty level.[9]

In addition to advancing equity and addressing disparities across the various groups in Minnesota, the approach to promoting healthier aging is shifting to include more than just healthcare and now considers the intersectionality of our lives. The SDOH domains have recently expanded to include digital inclusion, which encompasses high-speed internet access and the ability to use it, since it is found to be linked closely to the other SDOH, such as health care access and social connectedness.[10] While having virtual services has improved access for some, there are still Minnesotans who do not have access.

[9] American Community Survey (ACS) Demographic and Household Data. AGID, accessed 2020.

[10] Sieck, C.J., Sheon, A., Ancker, J.S. et al. Digital inclusion as a social determinant of health. npj Digit. Med. 4, 52 (2021). https://doi.org/10.1038/s41746-021-00413-8

Digital Access:[11]

- 20% of rural Minnesotans lack internet reliable enough to use for a video visit
- Almost 300,000 Minnesotan households do not have access to high-speed internet

COVID-19 underscored the intersectionality of Minnesota's socioeconomic disparities on race, culture, geography, SDOH and other factors, by highlighting and exacerbating health disparities in some communities, leading to higher risk of vulnerabilities and poor health outcomes. Throughout the COVID-19 pandemic, state and local partners worked diligently to modify and adapt service delivery and programs to meet the needs of Minnesotans. While DHS programs and partners were able to effectively pivot services and offer a variety of options allowing services to continue during the pandemic, the emergency highlighted the need to ensure LTSS programs are equitably accessible, inclusive, and responsive to the diversity of Minnesota's population. Although the pandemic provided lessons learned, it also provided insight in how to provide services differently and created energy to collaborate and create new partnerships.

Advancing Efforts

MBA continues to support and advance efforts around equity; the following includes highlights of work that has been completed.

In 2020, MBA supported statewide LGBTQ+ dementia interviews. The interviews revealed that there is room for improvement around aging issues and a lack of an apparent LGBTQ+ safety net for older adults. The interviews illustrated a need for more targeted information to the LGBTQ+ community about signs, symptoms and strategies related to dementia that is consistently shared as people age.

With the 2020 dementia interviews and the Minnesota 2022 LGBTQ Aging Needs Assessment report as a backdrop, Minnesota is working with the aging network to expand services to LGBTQ+ and AIDs/HIV+ older adults:

- Rainbow Health is supporting dementia awareness for LGBTQ+ and HIV-positive Minnesotans. This program has provided awareness training to almost 40 older adults of different genders, races, and geographies and is working to offer a LGBTQ+ dementia caregiver support group
- Through two recent Live Well at Home® grants, Senior Community Services is conducting outreach efforts to LGBTQ+ older adults in Hennepin County, and Rainbow Health is designing and implementing a comprehensive long-term services plan for LGBTQ+ and HIV-positive older adults in the Twin Cities and Duluth

In 2022, Arrowhead, Central and Trellis AAAs received grant funding from ACL for Expanding the Public Health Workforce within the Aging Network.[12] The funds will be

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[11] Minnesota Governor's Task Force on Broadband 2022 Annual Report, Minnesota Department of Employment and Economic Development, 2022. https://mn.gov/deed/assets/2022-broadband-task-force-report_tcm1045-557268.pdf

[12] ACL begins awarding $150M to expand the aging and disability networks' public health workforce Administration for Community Living, 2022.

used to advance efforts in the public health workforce to alleviate some of the strain our networks have experienced during the pandemic; to respond to the COVID-19 pandemic; and to prepare for future public health challenges. One theme across the three AAAs is to address those disparities by strengthening community connections and outreach to target populations, convening community conversations, and disseminating messages in multiple formats pertaining to: COVID-19 vaccinations and testing, wellness/disease prevention, social isolation, and the benefits of staying socially engaged.

In coordination with DHS led efforts, the MBA has also utilized many tools to ensure equity is in every aspect of our work.

- SLL uses an equity assessment tool to analyze new policies and procedures to enhance the equity of our services
- The MBA Dementia Grants RFP and the Live Well at Home® RFP was reviewed using the DHS Equity Analysis Toolkit
- All DHS and MBA leadership have completed the Intercultural Development Inventory (IDI)
- DHS Aging and Disability Services Division Equity Committee will be making recommendations for equity considerations
- Led and participated in a multi-year project in partnership with the University of Minnesota Center on Healthy Aging and the Minnesota Diverse Elders Coalition to understand and help close racial and ethnic disparities in home and community-based services.
- DHS Adult Protection Services (APS) will be using COVID-19 Pandemic funding (CARES Act) funding to train APS staff throughout the state on unconscious bias, and to advance work related to tribal issues and culturally specific service providers.

Advancements during COVID-19

Although remote services greatly advanced during the COVID-19 pandemic, and were allowed in both HCBS waiver programming, as well as telehealth, and in telephone reassurance with SLL, the state saw continued gaps in internet access, specifically in rural Minnesota. This raised the visibility of social isolation and the impact on older adults, especially those living in rural communities, and uncovered disparities in greater depth. As communities are finding a balance of in-person vs remote services, social isolation continues to rise to the top. Social isolation and loneliness are important, yet neglected, social determinants of the health of older people.[13]

Older Minnesotans are receiving COVID-19 vaccines:

- 94.6% of Minnesotans 65+ have had at least one vaccine dose
- 92% of Minnesotans 65+ have completed the vaccine series[14]

[13] Social Isolation and Loneliness, World Health Organization

[14] Vaccine Data: Influenza and COVID-19, Minnesota Department of Health, 2023.

Digital inclusion

Multiple AAAs pivoted to provide internet access and devices to help older adults adapt to an abrupt shift to an online world. One AAA supported an affordable housing nonprofit to purchase 50 iPads and 12 internet hotspots so that residents could participate in evidence-based health promotion programs. Another used CARES Act funding to support programs that provided older adults with tablet devices and internet service to allow them to participate in classes and stay socially connected.

Repurposing airline meals to meet nutrition needs of older adults

At the height of the COVID- 19 pandemic, many provider agencies closed, including kitchens for the congregate and home delivered meals sites. At the same time, MBA learned there was a surplus of airline meals through a vendor named AMI. AMI provided a menu of frozen meals that could be loaded onto semi-trucks or airplanes to get to the more remote areas of the state, specifically to the tribal reservations. The goal was for each elder to have a 2-week supply of frozen entrees.

Remote Services

DHS implemented permanent options to allow providers to provide several HCBS remotely, including adult day and companion services. DHS also will continue to allow annual level of care redeterminations for Medicaid HCBS to be conducted remotely, which will help to address workforce shortage and staff capacity issues at the lead agencies.

Reducing social isolation

SLL will continue working with Disability Hub MN and the Minnesota Department of Administration's System of Technology to Achieve Results (STAR) program to support and promote the Minnesota Assistive Technology Lending Library. Through this partnership, informational videos, brochures, web copy and more materials are being developed to promote this helpful and important program.

Khan Bots

AAAs have distributed over 150 robotic cats and dogs to combat social isolation. Dr. Arshia Khan at the University of Minnesota Duluth designed robots, referred to as "Khan's Bots," to help older adults with dementia in nursing homes. The robots can give reminders for medications, track a patient's movements using sensors placed on their body and in their room, and act as companions to those unable to visit loved ones, administer therapy, entertain, play games, sing dance, help with daily living activities and help improve their mood. The Khan Bots are part of a larger project Dr. Khan is working on called the "dementia-friendly living space," which uses sensors placed around the room to help improve the quality of life for those living with dementia.[15]

Long-Term Services and Supports in Minnesota

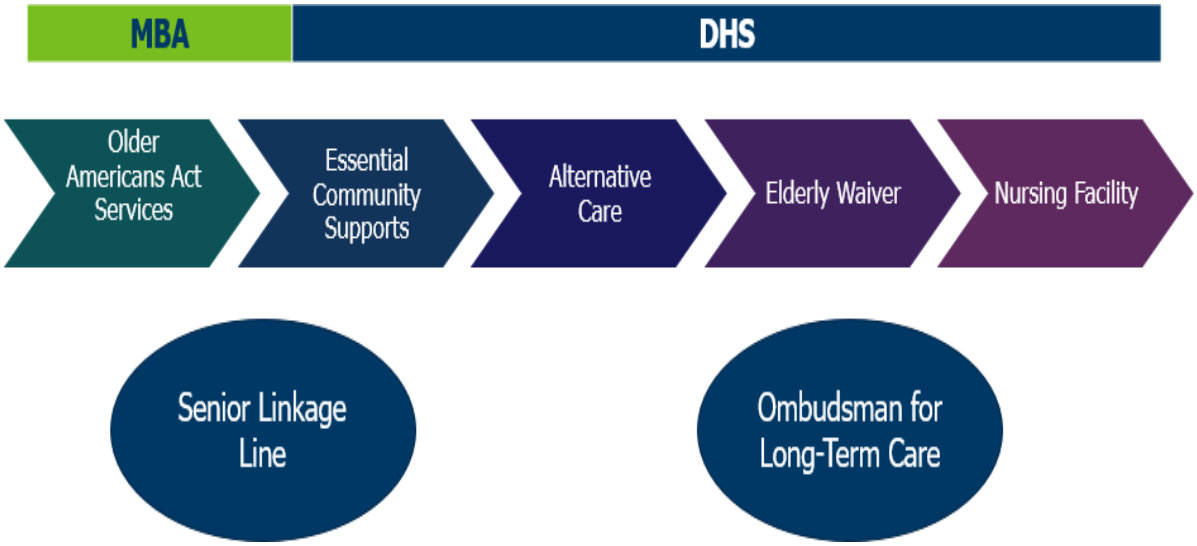
Long-term services and supports (LTSS) include the spectrum of health and social services designed to help Minnesotans with daily living tasks - across all funding

[15] Are robots the solution to understaffed nursing homes? NPR, 2022.

streams. By providing assistance across various settings, including institutional and community-based settings, LTSS allows individuals to lead meaningful lives based on their personal goals and values. Minnesota is well-known for the quality services and supports it provides to older residents. The AARP LTSS 2023 State Scorecard Report ranks Minnesota number one in the country for creating a high-quality system across five dimensions: Choice of setting and provider, quality of life, quality of care, support for family caregivers and effective transitions. This speaks to the efforts and importance DHS and MBA place on supporting our state and ensuring older adults have supports available to lead meaningful lives. Minnesota will continue to build off this success and lessons learned as we continue to experience demographic shifts that will increase demand for LTSS and require new approaches and strategies.

The range of services provided through the LTSS system in Minnesota is extensive and stretches across several areas within DHS and MBA, as seen in Figure 1. The Status of Long- Term Services and Support Legislative Report (PDF) provides an overview of collaboration and improvement efforts towards the LTSS system.

Figure 1



Home and Community Based Services

MBA and DHS oversee the spectrum of services that range from Older Americans Act (OAA) services to the means-tested programs including Elderly Waiver (EW), Alternative Care (AC) and Essential Community Supports (ECS). These programs provide home and community-based services for older adults who need a certain level of support so they can remain living in the community and experience a higher quality of life. All these programs are more cost-effective for individuals and their caregivers, as an alternative to more expensive institutional services, and align with most older adults' preference to remain in their own home for as long as possible.

DHS designs and sets the standards for the HCBS system. Lead agencies, including counties, tribal nations and managed care organizations under contract with DHS, administer the programs on a local level. It is through these partnerships with lead agencies, as well as our quality management oversight that leads us to successful outcomes.

In state fiscal year 2021:

- DHS served 32,000 individuals on EW
- DHS served 4,000 individuals on the AC program

Minnesota is a managed care state, in which older adults who are dual eligible (Medicaid and Medicare) receive coordinated care through the Minnesota Senior Health Options (MSHO) program. MSHO is recognized nationally for administering one of the most successful and longest standing integrated care programs. MSHO is managed by DHS through contracts with managed care organizations to administer MSHO and has a proven track record of improved health outcomes with high satisfaction of individuals enrolled in the program.

Minnesota conducted a study to better understand older Minnesotans' long-term care needs, experiences, and decisions leading up to Medical Assistance and EW enrollment. The Elderly Waiver Spenddown Study report describes typical trajectories that enrollees experience prior to enrolling in EW, and suggests opportunities to impact those trajectories through upstream interventions where OAA services may play a key role.

The HCBS programs overseen by MBA and DHS are growing faster than the state's population. Between 2015 and 2019, the state's total population grew by 3%, while the population of persons using HCBS grew by16%.[16] Unfortunately, rates paid to HCBS providers, who provide EW, AC, and ECS, have not kept up with the increasing cost of delivering services, as indicated in a 2019 legislative report, The Evaluation of Rate Methodology for Services Provided under Elderly Waiver and Related Programs (PDF).

DHS and MBA are working collaboratively with other state agencies on elevating and remediating the workforce shortages. Strategies include:

- Legislative action to ensure adequate rates for services delivered under the HCBS programs
- Continue to build on strategies to tap all potential "workers" to provide HCBS, such as empowering the use of volunteers, utilizing consumer directed community supports and other avenues so individuals can have choice and options for services
- DHS GEAR Division is leading a new Provider Capacity Grants Program that aims to benefit small providers who want to expand HCBS for older adults and people with disabilities from rural or underserved communities.

The Minnesota Board on Aging

The Minnesota Board on Aging (MBA) is Minnesota's federally designated State Unit on Aging. MBA's 25 members are appointed by the Governor and represent diverse backgrounds, ages, interests and communities across the state. MBA works to ensure that older Minnesotans and their families are served effectively by state and local policies and programs, so they can age well and live well.

[16] Status of Long-Term Services and Support Legislative Report, Minnesota Department of Human Services, 2019.

MBA does this through its three major roles: administrator, advisor and advocate. MBA administers federal and state funds to deliver a range of in-home and supportive services to older adults and their family caregivers.

The Older Americans Act (OAA) instructs MBA to designate a statewide network of Area Agencies on Aging (AAAs). The AAAs leverage additional local dollars and resources to ensure local input and accountability in the delivery of aging services in communities around the state. The Minnesota Indian Area Agency on Aging (MIAAA), currently administered through MBA, administers OAA funds to deliver services to Native American elders in the northern half of the state.

Through its administrator role, MBA manages two direct service programs: Senior LinkAge Line (SLL) and Office of Ombudsmen for Long-Term Care (OOLTC).

SLL and its public resource site MinnesotaHelp.info are services of MBA in partnership with AAAs. These resources provide free, objective information and assistance to help older Minnesotans and their families. SLL can help with Medicare, health insurance and long-term services and supports options, counseling, care transitions, prescription drug costs and connect Minnesotans to local services. In 2022, SLL served over 80,000 new clients. Top topics ranged from Medicare to finances to assisting caregivers. SLL works in tandem with Disability Hub MN and LinkVet to help people navigate to services, find answers and get the help they need. MinnesotaHelp.info provides access to the Nursing Home Report Card, assisted living facility licensure information and the Assisted Living Report Card (official website launching in fall of 2023).

OOLTC is responsible for providing advocacy services and interventions for individuals receiving long-term services and supports. OOLTC is committed to upholding the rights, well-being and empowerment of long-term care recipients, in line with the principles of trauma-informed care.

For more information, please refer to the 2022 Minnesota Ombudsman for Long Term Care Annual Report (PDF).

OOLTC statistics in 2022:

- OOLTC staff serve 2,000 licensed assisted living facilities, 345 licensed nursing homes, including five veterans' homes
- Certified Ombudsman Volunteer program:
    - 247 volunteer hours were donated
    - Volunteers reached 16 counties and 11 regions
    - 18 volunteers provided advocacy

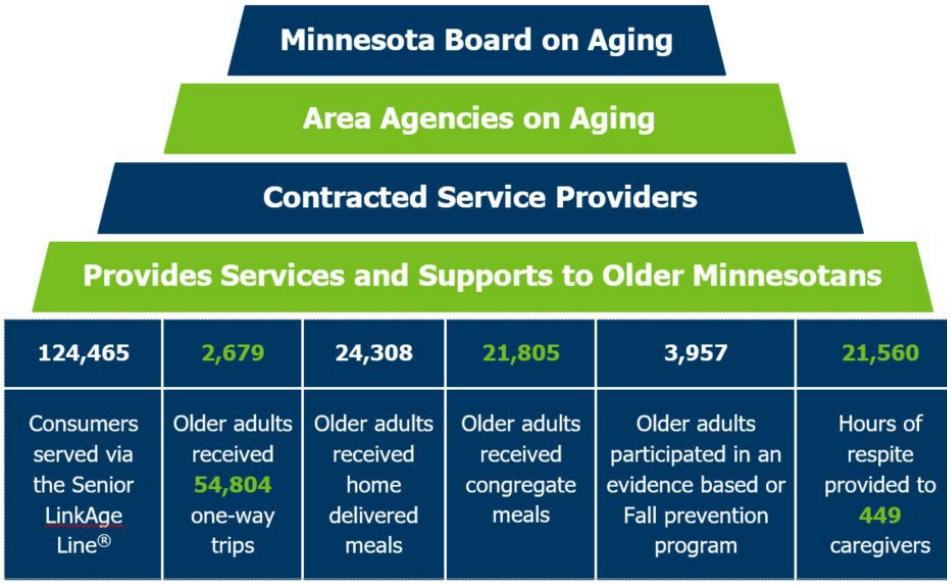
Area Agencies on Aging

In Minnesota, AAAs recruit and partner with local organizations to fill the service needs in their areas. AAAs leverage additional funds, including participant contributions and cost share, community donations, and actively apply to grants to supplement OAA dollars. As trusted community partners, AAAs play a crucial role in connecting older Minnesotans and their caregivers to local resources and services. By collaborating with a wide range of organizations, AAAs can provide targeted support and information that is tailored to the needs of each service area. This

includes essential services such as transportation, homemaker and chore assistance, nutrition programs, and caregiver support services, including respite, support groups and counseling, and information assistance. Together, these programs help ensure that individuals can age well in the community of their choice.

In FFY 2022, MBA, in partnership with AAAs and their contracted service providers, served 213,295 older Minnesotans and those caring for them through the SLL and a variety of supports. For a highlight of specific services provided, see Figure 2.

Figure 2



Older Americans Act

The Older Americans Act (OAA) of 1965 dedicates federal funding to support older adults across the United States. MBA works across various titles within the OAA such as Title III – Grants for State and Community Programs on Aging, Title VII – Allotments for Vulnerable Elder Rights Protection Activities and Title VI – Grants for Native Americans.

Title III Grants for State and Community Programs on Aging

Title III provides services and supports to older adults and family, friends and neighbors who provide caregiving. Title III consists of five core programs:

- III-B Supportive services including homemaker, transportation and chore
- III-C1 Congregate meals (meals provided in congregate settings)
- III-C2 Home delivered meals (meals delivered to the home, may be hot or frozen)
- III-D Evidence-based health promotion
- III-E National Family Caregiver Support Program

In FFY 2022, MBA and the aging network awarded over $22 million in Title III funding to support older adults and those caring for them. Table 2 lists the amount

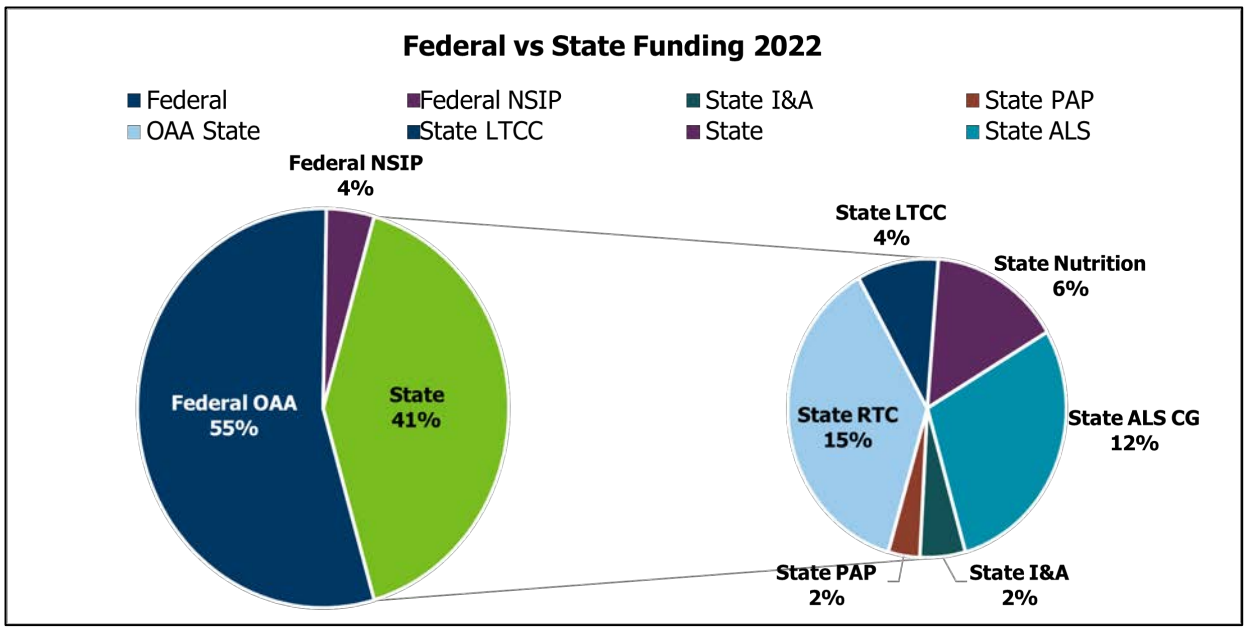
awarded per core program, the number of units provided, and the number of persons served.

Table 2

Section	Description	Amount Awarded	Units Provided	Persons Served
III-B	Supportive services including homemaker, transportation, and chore	$5,310,526	135,577	8,037
III-C1	Congregate meals	$3,191,404	644,655	20,654
III-C2	Home Delivered meals	$9,629,401	2,455,006	25,189
III-D	Evidence-based Health Promotion	$967,020	N/A	3,957
III-E	Supportive services for those caregiving	$3,462,709	56,235	2,864

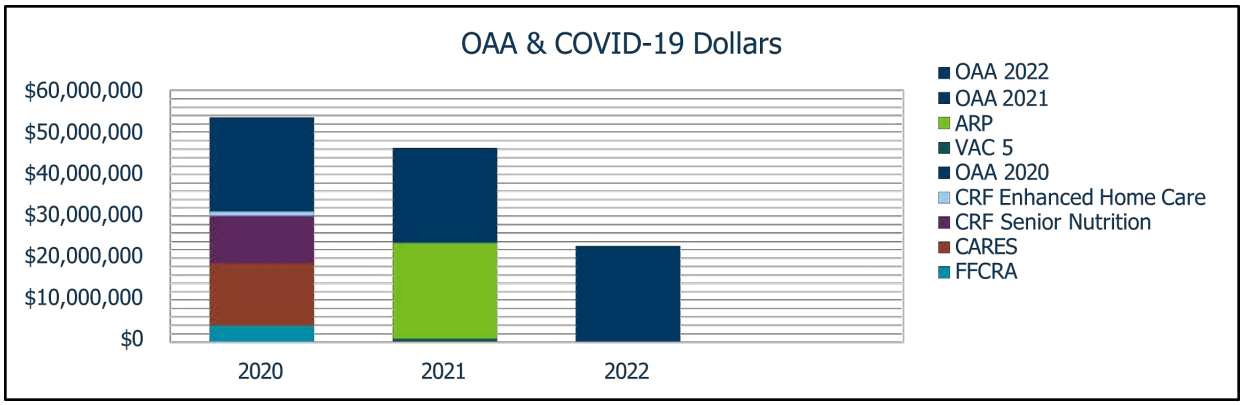
In addition to Title III funding, Minnesota also provides significant state funding to support older adults and those providing care for them. In 2022, MBA also received 1.7 million NSIP (Nutrition Services Incentive Program) dollars for a total of over $24 million in federal funding and over $17 million in state funding, including Information and Assistance (I&A), Prescription Assistance Program (PAP), Return to Community (RTC), Long Term Care Consultation (LTCC), state nutrition programs and Amyotrophic Lateral Sclerosis (ALS) caregiver support. As shown in Figure 3, state funding amounts to 41% of the funding MBA receives.

Figure 3



As a direct result of the COVID-19 pandemic, Minnesota received significant increases in funding to support older adults and those caregiving for them. As Minnesota looks towards the end of the COVID-19 pandemic and the sun-setting of COVID-19 funding, there is concern about the inevitable decline in services without additional funding. Figure 4 demonstrates the peak and now decline in available funding.

Figure 4



As the cost of services continue to rise, MBA, AAAs and partners are working together to explore strategies to fill in the gap left by the loss of additional American Rescue Plan and COVID-19 funding. Strategies include requests to the state legislature, modernizing service delivery to increase efficiencies, increasing the targeting of services, advocating for additional state funding and finding additional partners.

Nutrition

Nutrition services are one of the most critical programs provided to older adults across Minnesota. Nutrition services include home-delivered meals, congregate meals, and support of grocery delivery, food shelves and other services. Having nutritious food is critical to good health, ability to manage or prevent chronic disease and maintaining a high quality of life.

In FFY 2022:

- More than 3.5 million meals were provided through congregate and home delivered meals programs

Since the COVID-19 pandemic and in-person gathering restrictions, there was a large move from congregate dining to home delivered meals. As the COVID-19 pandemic winds down, there has been a slight shift back to congregate dining, but meals served have yet to reach pre-pandemic levels. In addition to the change in preferred service delivery, there has also been a large increase in nutrition funding available.

Minnesota values providing person-centered care, which includes offering culturally specific meals:

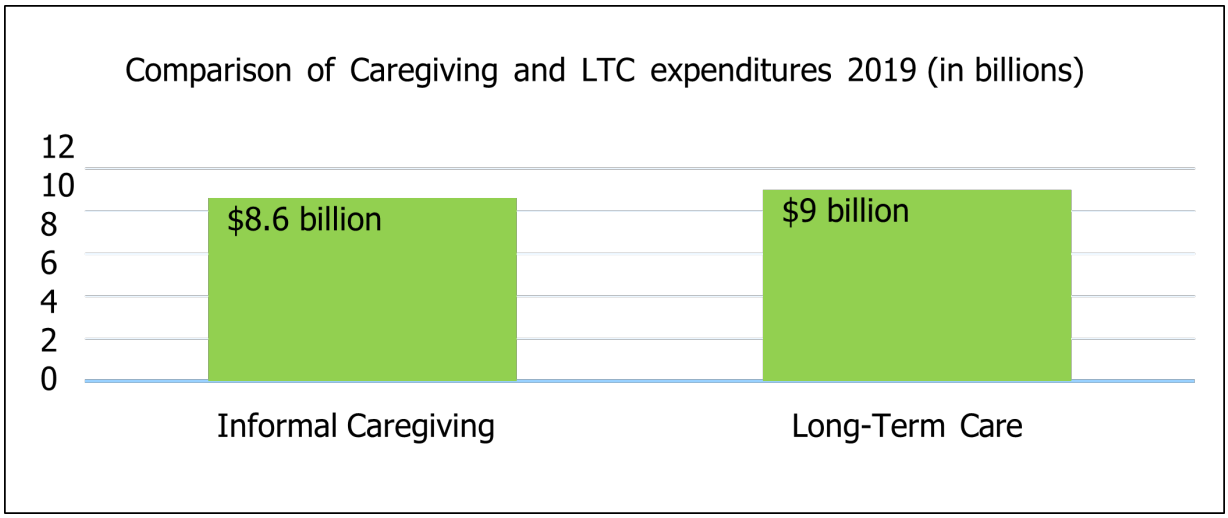
- Metro Meals on Wheels (MMOW), a FFY 2023 Live Well at Home® grantee, has expanded their website to offer meal ordering in English, Spanish, and Somali and a Latino-inspired menu. MMOW has also partnered with a local Halal restaurant and caterer to expand to the East African community
- AAAs partner with providers across Minnesota to provide meals that are Halal, Southeast Asian, Kosher, Hispanic, Laotian, Vietnamese, and Somali.

Caregiving

Caregiving (informal or unpaid) is an integral piece of Minnesota's healthcare system. MBA defines caregiving as a family member, friend or neighbor helping someone who is aging, on a regular basis, that is not paid for such work. Caregiving is a journey that's different for everyone. It varies greatly in intensity, from helping to shovel a driveway to assisting with bathing, and in duration, with care lasting from weeks to years.

Caregiving is also not a linear process; some weeks may be more intense than others. Caregiving also has financial impacts on those providing care. Figure 5 shows the value of family, friends and neighbors caregiving compared to expenditures of the Long-Term Care (LTC) system in Minnesota.[17,18]

Figure 5



As the demographics in Minnesota shift, there is a direct impact on the typical caregiving arrangement. In Minnesota, there is an increasing number of kinship caregivers, older relatives caring for children; and individuals caring for someone with Alzheimer's disease and related dementias (ADRD). Although dementia is not a normal part of aging, it is primarily a disease of age. As we live longer, the number of Minnesotans with dementia continues to rise.

Minnesota caregiving estimates:

- In 2021 approximately 530,000 family, friends and neighbors caregiving for an older adult, estimated to be worth $10 billion a year[19]
- 163,000 family, friends and neighbors caregiving for persons with Alzheimer's disease and related dementias, provided 225,000,000 hours of unpaid care estimated to be valued at close to $5.25 billion[20]

[17] Number of Family Caregivers, Hours, and Economic Value of Caregiving by State, 2017 (PDF), AARP Public Policy Institute, 2019.

[18] Minnesota Health Care Spending: 2018 and 2019 Estimates and Ten-Year Projections (PDF), Minnesota Department of Health, 2021

[19] Valuing the Invaluable: 2023 Update (PDF), AARP Public Policy Institute, 2023.

[20] Minnesota Alzheimer's Disease Facts and Figures (PDF), Alzheimer's Association, 2023

Caregiving for someone with ADRD is typically more expensive and emotionally, physically and mentally taxing than other caregiving situations. More than 50% of these family/friend dementia caregivers have been providing care for at least two years; nearly one in four provide 20 or more hours of care per week. One in four of those caring for someone with dementia are also part of Minnesota's growing "sandwich generation," caring for an older adult and a child or grandchild.[21]

As Minnesota's population continues to become more racially and culturally diverse, it will become increasingly important to develop inclusive, equitable services that reflect knowledge of and respect for these cultural differences. The return on investment is multi-faceted—among other things, greater caregiver support relieve pressure on adult protection services, delays or prevents moves into long-term care, and results in better physical and mental health of caregivers, allowing them to provide care longer. Since the last Minnesota State Plan on Aging, improvements to supporting caregivers have expanded:

- Minnesota Caregiving Coalition created in 2019
    - The Minnesota Caregiving Coalition was developed to address goal 3 in the 2019-2022 Minnesota State Plan on Aging. The coalition meets monthly and has representatives from over 20 organizations.
- Caregiver Consultation training
    - Caregiver consultation training is now available fully online. The training now includes a mechanism for evaluation as well as general updates in content.
- REST (Respite, Education, Support & Training) training and capacity expansion, since 2017:
    - More than 400 REST Companions trained
    - Over 50 Train-the-Trainers
    - 3 Statewide Trainers
    - 1 Regional trainer
- In 2022, the Minnesota legislature allocated $5 million to support ALS caregiving through the AAAs

Title VI - Serving Indian Country

Starting in June 2024, the Minnesota Indian Area Agency on Aging (MIAAA) will serve the elders of 10 of the Ojibwe and Dakota tribal governments: Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Prairie Island Indian Community, Red Lake Nation, Upper Sioux Community, and White Earth Nation.

MBA follows a government-to-government approach to seek consultation and participation by representatives of tribal governments in policy development and service program activities. With the newly expanded MIAAA we are excited to

[21] Valuing the Invaluable: 2023 Update (PDF), AARP Public Policy Institute, 2023.

leverage this opportunity and coordinate Title III and Title VI funding. Each AAA is required to address their planning and coordination efforts in their Area Plan. The Area Plan instructions have specifically required that one issue area be devoted to the explanation of how services will be provided to American Indian Tribal members and also meet the requirements for coordination between Title III and Title VI under OAA. Some successes from this coordination include:

- In 2022, Prairie Island Indian Community received assistance from Southeastern Minnesota AAA in applying for Title VI funding
- In 2022, the Minnesota River AAA successfully hired a SLL specialist who is housed within the Lower Sioux Indian Community
- In 2021, Trualta, a statewide caregiver education platform was launched, including courses specific to Indigenous Caregiving.

Beyond the Older Americans Act

Minnesota has built a robust system that stretches beyond the OAA, which includes different initiatives that support older adults across various funding streams.

Live Well at Home® Grants

Through Live Well at Home®, Minnesota invests in innovative, culturally responsive services that assist older Minnesotans to age in their community of choice. Since 2001 the Minnesota Legislature has committed between $6 million to $8 million each year to DHS for Live Well at Home® grants, which empower more older adults to remain living at home, delaying or preventing the need for long-term care. A special focus of Live Well at Home® is developing capacity in communities to provide more essential services, particularly in rural areas where access to care in limited.

In 2022, MBA awarded more than $7 million in grants to 57 organizations across Minnesota. Some of the latest projects include:

- Expanding caregiver support for older individuals and their families to the Red Lake Nation, White Earth Nation, Leech Lake Band of Ojibwe, Bois Forte Band of Chippewa, and Lake of the Woods County
- Funding a raised-bed vegetable and flower garden in McGregor, in rural Aitkin County, to allow equal access for people using wheelchairs and walkers
- Providing new services for American Indian elders in their homes in Minneapolis, including homemaker and chore services, home safety assessments and modifications to prevent falls.

Eldercare Development Partnership

Since 1992, Minnesota has implemented a unique and innovative grant program, the Eldercare Development Partnership, to support multi-county or statewide efforts to identify and address gaps in HCBS. These grantees bring together stakeholders in the LTSS system to expand home and community-based services (HCBS) for low-income older adults who are at risk of nursing home placement. They work in collaboration with county social service and public health agencies, AAAs, local non-profit and for profit HCBS providers, and other partners in the long-term services and supports system.

Senior Volunteer Program

The AmeriCorps Seniors volunteer program (formerly SeniorCorps) is a network of older adults who are making a difference through the three programs of the Senior Volunteer Program: the Senior Companion Program, the RSVP Program and the Foster Grandparent Program. The Senior Volunteer Program connects thousands of Minnesotans aged 55 and greater with volunteer opportunities each year. In 2021, 14,000 volunteers served 1.8 million hours across the state of Minnesota.

Statewide Dementia Efforts

According to data from the Alzheimer's Association (2022), the prevalence of Alzheimer's Disease and Related Dementias (ADRD) in Minnesota is on track to increase from the estimated 99,000 Minnesotans with an ADRD diagnosis in 2020 to 120,000 in 2025. The context becomes even more challenging when considering workforce issues; an estimated 221% increase is needed in the number of geriatricians to meet the increased demand in 2050.[22]

Minnesota has become a national leader in supporting people with ADRD. MBA, DHS and Minnesota Department of Health (MDH) lead much of the state's work related to dementia; other statewide leaders include the Alzheimer's Association of North Dakota and Minnesota and the University of Minnesota, Center for Healthy Aging and Innovation.

Alzheimer's Disease Working Group

In 2009, the Legislature tasked MBA with establishing the Alzheimer's Disease Working Group and making recommendations for policies and programs to prepare Minnesota for future increases in dementia. This cross-sector working group produced a 2011 report, Preparing Minnesota for Alzheimer's: The Budgetary, Social, and Personal Impacts (PDF), and a review and update to this report in 2019: Alzheimer's Disease Working Group Legislative Report (PDF).

MBA Dementia Grants

The MBA administers a competitive grant program focused on dementia and its impacts on caregivers. Created by the Minnesota Legislature in 2015, the legislature has appropriated $1.5 million for this program in each biennium since 2016-2017. MBA Dementia Grants support regional and local projects focused on increasing awareness of dementia, promoting cognitive testing and early diagnosis, increasing the rate of cognitive testing in the population at risk for dementias and supporting caregiving by family, friends and neighbors.

Since 2015, MBA Dementia Grantees:

- Delivered general awareness education to 60,748 persons, including community members, healthcare professionals, emergency personnel, and business owners and their employees
- Provided services, supports, and resources to 5,867 persons suspected or diagnosed with Alzheimer's or another dementia
- Supported 6,053 family, friends and neighbors caregiving.

[22] Minnesota Alzheimer's Disease Facts and Figures (PDF), Alzheimer's Association, 2023

ACT on Alzheimer's Initiative

Minnesota's successful ACT on Alzheimer's initiative, launched in 2015, is a public-private effort focused on community-level support for people with dementia. There are also almost 24,000-trained Dementia Friends throughout Minnesota. As a direct result of the availability of MBA Dementia Grants, 22 communities have become dementia friendly.

BOLD Initiative

MDH received a Building Our Largest Dementia (BOLD) Infrastructure grant to implement Alzheimer's and related dementias activities in line with the recommendations in the 2019 Alzheimer's Disease Working Group legislative report and the Healthy Brain Initiative Road Map actions.[23] MBA participates in the BOLD Action Committee, and the State Plan includes strategies that align with and support BOLD goals.

BOLD funding and strategies intend to:

- Support increased communication across the state/tribal/local jurisdiction related to Alzheimer's Disease and Related Dementias (ADRD).
- Analyze and use available data, including BRFSS, together with the state/tribal/local strategic dementia plan to set jurisdiction-wide priorities.[24]
- Promote education about the importance of including risk reduction, early diagnosis of ADRD, prevention and management of comorbidities and avoidable hospitalization, and the role of caregiving for persons with dementia.

Dementia-Friendly Airports

MBA and Age-Friendly Minnesota (AFMN) are developing a new partnership with the Minnesota-Saint Paul (MSP) International Airport's Dementia-Friendly Airports initiative. MSP is one of ten airports that are part of a Dementia-Friendly Airports working group, an international coalition of service professionals, airport staff and travel advocates working to improve air travel for people with dementia. The working group includes numerous representatives from Minnesota.

This builds on other efforts, still ongoing, to make the airport easier to navigate for people with various types of disabilities. In 2014, MSP Airport created the Travelers with Disabilities Advisory Committee, half airport personnel and half disability advocates, focused on improving equitable access for airport users. In 2020, MSP introduced the Hidden Disabilities Sunflower program, which cues airport staff and personnel to slow down and provide extra support to the person wearing the lanyard.

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[23] Alzheimer's Disease and Related Dementias: What is Dementia? Minnesota Department of Health

[24] The Behavioral Risk Factor Surveillance System (BRFSS) Centers for Disease Control and Prevention.

Cultural Experiences, Activities, and Services

Arts initiatives are proving to be an accessible and non-stigmatizing lens through which to educate community members about dementia and its impact on individuals, families and communities:

- Four dementia choruses across Minnesota have been seeded or expanded with dementia grants, with two focused on culturally adapted content and approach. The impact of this work was just documented in a peer-reviewed journal article, Finding Joy and Purpose Through Singing: Giving Voice to People Living with Dementia.
- Statewide tours of The Remember Project (supported in part by MAAA, DBA Trellis), a theatre-based effort intended to build more dementia-capable communities. Though a portfolio of one-act plays, professional actors bring real issues connected to the care, diagnosis and experience of dementia to life. Audience members take part in a facilitated conversation about the themes, metaphors and impact of memory loss depicted in the plays and often experience life-impacting insights and calls to action.

Cultural services are to key to offering support to all older Minnesotans.

- A tribal nation received Live Well at Home® funding to develop the reservation's first housing development for Tribal elders experiencing homelessness. These three, 12-unit village communities will include supportive services from across the reservation.
- A home healthcare agency received grant funding to expand their HCBS services to Hmong, Karen, and Laotian populations through translation and interpretation services.
- Arrowhead AAA is a member of the ARCHS (Arrowhead Region Consortium for Healthcare Staffing). The consortium grew out of a shared interest in working together to meet the staffing crisis in the region and has created the Indigenous HealthCare Workforce Career Camps. "Scrubs Camp" provides students the opportunity to learn about different healthcare professions from healthcare providers and educators.

Rights and Protections for older adults

Minnesota's Adult Protection Services (APS) program is responsible for investigating reported allegations of abuse, neglect, or financial exploitation of vulnerable adults referred by the state's centralized reporting system, Minnesota Adult Abuse Reporting Center (MAARC). The APS program is housed in and supervised by DHS and administered by counties and tribal nations. APS exists so that all adults who are vulnerable to abuse, neglect, or exploitation are supported to live in safety and dignity, consistent with their own culture, values, and goals, and so people concerned about them have resources for support. While APS serves adults of all ages, in 2021, there were 14,993 reports of maltreatment to Minnesotans aged 65 or older. These reports represented nearly half of the total 31,403 reports made to APS that year. The Vulnerable Adult Protection Dashboard reflects this data.

The APS 2022 Operational Plan (PDF) was informed by Minnesota's Vulnerable Adult Act (VAA) redesign which aims to improve state-wide equity and consistency in the service response provided to adults referred to APS, and to prioritize a person-

centered approach that is trauma-informed, culturally responsive, and attuned to changing demographics such as age, race, ethnicity and culture. These changes are intended to benefit all Minnesotans.

Minnesotans have the right to live with dignity, free from harm and to receive high-quality, person-centered services in the setting of their choice. OOLTC regional ombudsmen play an integral role in providing this support, through collaboration with multi-disciplinary adult protection teams, medical discharge planners and county case managers as directed by residents. In 2019, OOLTC received a legislative appropriation of 17 additional staff, greatly improving the staffing ratio of regional ombudsmen to bed capacity in Minnesota. This means more residents have access to advocacy services. At the macro level, OOLTC works collaboratively with MDH, DHS, APS, Legal Aid and other stakeholders in advocacy efforts. Whether through individual casework or systemic initiatives, OOLTC invests in building relationships that benefit those receiving long-term care services and supports.

DHS has initiatives underway to strengthen efforts that focus on safeguards and informing older adults of their choices:

- Assisted Living Licensure (ALL): As of August 1, 2021, ALL is implemented, which means residents have more rights, including stronger protections against discharge and stronger protections for persons with dementia. It will also provide for stronger oversight of these facilities by MDH.
- Medicare Fraud: SLL is Minnesota's federally designated State Health Insurance Program (SHIP) and provides comprehensive, fair and unbiased Medicare counseling. SLL is also Minnesota's federally designated Senior Medicare Patrol, which helps people fight fraud, abuse and scams.

Minnesota State Plan on Aging Goals, Objectives, Strategies and Measures

The following goals, objectives, strategies and measures outline the steps MBA will take to support older adults through the 2024-2027 State Plan on Aging.

Goal 1: Advance equity and eliminate disparities, while empowering rural and diverse communities and respecting the sovereignty of tribal nations
Short Term Outcome: Older adults from Minnesota's diverse communities, including Indian Country, will have greater access to information, resources, and services
Intermediate Outcome: The state will have stronger partnerships with Indian Country and Minnesota's diverse communities
Long-Term Outcome: Older adults from diverse communities and Indian Country will receive services they need and prefer to live well at home
Measures: • % of older adults from diverse communities who report receiving information in the language they prefer • % of older adults who report they know who to call to get the information, resources or services that they need • % of funding to diverse communities and providers

- % of diverse individuals served through the Older Americans Act
- % of diverse representation on the Minnesota Board on Aging
- % of HCBS recipients from diverse communities that express satisfaction with services

Data Sources: Peer Place, Grant Utility, Foundant, State Program Report, Board Member Self Report, National Core Indicator – Aging and Disability

Objective 1.1: Dedicate ongoing resources to advance equity for older adults who experience disparities

a. Review current informational resources, print and web, within the Aging and Adult Services Division (AASD) to analyze if groups experiencing disparities are represented
b. Collaborate with the Older Adults' Equity Collaborative (OAEC), including SAGE, to host two statewide trainings through Odyssey and other avenues focusing on cultural competency and equity
c. Establish protocols/policies to ensure linguistically and culturally appropriate OAA resources are routinely developed, such as web and print accessibility
d. Enhance the targeting of SLL, OAA and OOLTC services to improve their reach and effectiveness
e. Meet with SAGE on reviewing best practices to create inclusive services on LGBTQ+ and HIV+
f. Promote and expand digital literacy resources for older adults across the state.

Objective 1.2: Strengthen advocacy and coordination efforts in Indian Country

a. Create summary report on improving alignment between Title III and Title VI and regulatory barriers to tribal coordination
b. Complete MBA/DHS tribal consultation by 2026 and identify next steps, including addressing regulatory barriers, to implement the resulting work plan
c. Participate in AAA quarterly meetings to check in, share best practices, utilize the MBA Indian Elders Coordinator to provide support and/or
d. strategize on how to include Native American representation in all work.**

Objective 1.3: Establish and deepen relationships with diverse communities to create reciprocal partnerships

a. Utilize recent statewide needs assessment and corresponding summary report to create a collaborative workplan to address disparities in Indian Country and other underserved communities
b. Identify strategies and policy opportunities for MBA and the aging network to further work with Indian Country and other underserved communities, including ongoing consultation and feedback
c. Conduct an equity review by 2025 of local and regional aging grants to inform refinements to RFP to help boost impact in cultural and ethnic communities

Goal 2: Make aging in community truly possible for all Minnesotans

Short Term Outcome: Minnesotans will have greater awareness of community supports

Intermediate Outcome: Minnesotans will have better access to community supports

Long-Term Outcome: Minnesotans will be able to age in community longer

Measures:

- % of older adults who report being able to access the services that they need
- % increase in number of older adults served by HCBS providers who pay partially or in full for their service.

- % increase in public funds spent on HCBS vs. nursing homes
- % increase in persons served in EW in their own home vs. assisted living
- % of referrals to Return to Community that accept services
- % of referrals that come from Information & Assistance
- % of inbound calls that are successfully answered by Senior Linkage Line staff

Data Sources: National Core Indicator – Aging and Disability, HCBS Access Dashboard, Aging Data Profiles Dashboard

Objective 2.1: Support housing and transportation options that promote independence and community connection

a. Strengthen understanding of barriers to creative solutions such as intergenerational housing, cohousing, zoning laws, and accessory dwelling units (ADUs), and advocate for investments in home modifications through all possible funding sources
b. Maximize available resources to decrease older adult homelessness, including active participation in Minnesota Interagency Council on Homelessness (MICH) and Minnesota Olmstead Plan affordable housing work; partnering with Minnesota Housing Finance Agency efforts; and leveraging Live Well at Home grants
c. Support creation of innovative transportation services and models that are responsive to community needs, especially in rural Minnesota, including pilot projects through Live Well at Home grants and advocacy for volunteer driver programs
d. Participate in and advocate through statewide collaboratives to address transportation needs, such as the Minnesota Council on Transportation Access (MCOTA) work group, Regional Transportation Coordinating Councils (RTCCs), and Human Services Transportation Council
e. Invest in and scale up promising models, such as CAPABLE, that take a holistic approach to aging in community.

Objective 2.2: Grow and sustain statewide Home and Community Based Service (HCBS) capacity to serve older adults across all funding sources

a. Advocate to the legislature to increase investment in Elderly Waiver, Alternative Care, and Essential Community Supports
b. Identify and address service gaps resulting from loss of American Rescue Plan funding
c. Continue work to address system-wide barriers to access housing, workforce, transportation, and crisis, as identified in DHS' Addressing Gaps ongoing effort
d. Identify partners to address needs related to behavioral health and disparities in access to HCBS
e. Partner to advance statewide volunteer strategies to help recruit, maintain, and support volunteers, including intergenerational approaches, to address workforce issues
f. Maximize staffing capacity to answer incoming calls for people looking for resources.

Objective 2.3: Catalyze and support efforts to create age-friendly and dementia-friendly communities

a. Active participation in and support for AFMN, such as aiding age-friendly communities and development of the Multi Sector Blueprint for an Age-Friendly Minnesota
b. Support Minnesota communities in undertaking dementia-friendly work, including building dementia expertise in professions such as emergency responders, dental care providers, and airport personnel, etc.

c. Empower Minnesotans to support and help each other as we age and recognize family caregivers through innovative community support models such as the Village model, evidence-based health promotion programs, etc.

Objective 2.4: Improve and fortify the aging network's ability to respond to emergencies

a. Advocate for universal broadband in Minnesota as critical to preventing and reducing social isolation; emergency preparedness; access to crisis services (such as 988 Suicide and Crisis Lifeline); and rural transit service efficiency, among others, in order to meet goals outlined in the 2022 Governor's Broadband Task Force Final Report

b. Build on policy improvements and innovations learned from COVID-19 that will endure during recovery, such as meal delivery, virtual service delivery, addressing social isolation, and sustaining services during an emergency

c. Collaborate with the AFMN Council's efforts to address emergency preparedness

d. Document the expected funding reductions due the loss of American Rescue Plan Act funding. Advocate for additional dollars to offset the estimated decrease of meals and the number of persons served.

Goal 3: Support families, friends, and neighbors in sustaining their caregiving roles

Short Term Outcome: Caregivers will recognize the important role they play in our communities and system and the services that are available

Intermediate Outcome: More individuals recognize their caregiving role and access supports

Long-Term Outcome: Individuals who are caregiving are supported in their roles during critical care transitions for their older adult loved one

Measures:

- % of caregivers using the Senior Linkage Line
- % increase in caregivers served across public programs
- % increase in diverse caregivers served across public programs
- % increase in caregivers reporting that services helped them maintain their caregiving role and their own health
- % increase in older adults screened for dementia through MBA dementia grants
- Number of caregiver consultants

Data Sources: Senior Linkage Line Client Tracking System, LTSS evaluations, MnCHOICES Support Plans, Peer Place

Objective 3.1: Advance public awareness and recognition of the family, friends, and neighbors caregiving in our communities and their many contributions and challenges

a. Increase access to information and services, including self-service information, in multiple languages and formats with a goal of offering all publications in at least two languages other than English

b. Host a public awareness campaign to showcase caregiving, highlighting new data, findings, and learnings through billboards, social media, etc., inclusive of all caregiving situations, such as grandfamilies

c. Integrate caregiving into all public outreach, including as part of Older Americans Month.

Objective 3.2: Increase the flexibility of caregiving supports to respond to unique and changing needs

a. Create a toolbox with caregiver-centered tools that reduce burden and stress levels across the range of needs and stages of caregiving

b. Strengthen and scale up best practices and promising models currently being used in Minnesota, such as Caregiver Consultants, Trualta or REST, and identify additional interventions for replication

c. Support the expansion of self-directed services and options for meeting respite needs

d. Enhance the state's capacity to support caregiving situations such as grandfamilies and "sandwich" caregivers by exploring policy flexibilities, maximizing funding, and working with key partners to expand related provider and staff training

Objective 3.3: Expand the existing HCBS direct care workforce

a. Identify strategies for increasing number of professionals focused on older adults, including creating pathways that prepare and encourage high school and college students to enter the aging field

b. Increase Senior Community Service Employment Program (SCSEP) visibility through coordination with OAA programs to support efforts to strengthen the direct care workforce

c. Work on making sure the occupation codes match the standard DOL labels to identify which occupations are related to aging

Objective 3.4: Advocate for policy and investments that center caregiving as essential to broader systems and the economy

a. Implement applicable recommendations within the 2022 National Strategy to Support Family Caregivers, with particular focus on awareness and outreach; advancing partnerships and engagement; and strengthening services and supports, including respite and self-directed services options

b. Collaborate with the aging network on best practices/efforts on caregiver health and well-being through the monthly MBA-AAA caregiving workgroup and the Minnesota Caregiving Coalition meetings

c. Identify strategies for supporting caregiving related to complex conditions and illnesses, such as amyotrophic lateral sclerosis (ALS), and develop recommendations for continuation, expansion, or duplication

d. Expand strategies with businesses and employers to support their employees who are caregiving, and advocate for policies that allow working caregivers the flexibility they need to provide care

e. Develop support and training for lead agencies and providers on participation (including enrollment, licensing, and billing) in Home and Community Based Services waiver programs (Alternative Care, Essential Community Supports, Elderly Waiver) in order to increase usage of waiver caregiving services

Goal 4: Promote and support healthy aging for all Minnesotans

Short Term Outcome: Minnesotans will recognize the importance of overall health as we age

Intermediate Outcome: Minnesotans will have improved access to healthy aging supports

Long Term Outcome: Minnesota's health and social systems will be better equipped to provide person-centered care for Minnesotans as we grow older

Measures:

- % of Broadband service availability, by county
- % increase in diverse older adults served through senior nutrition program

- % increase in availability of Evidence Based Health Promotion programs, including mental health
- % increase in individuals participating in Evidence Based Health Promotion programs, including mental health

Data Sources: State Program Report, Area Plan, Peer Place

Objective 4.1: Promote access to services and programs that support overall health

a. Identify gaps and solutions for collecting data specifically for LGBTQ+ and HIV positive
b. Review data and explore solutions to address food and nutrition security, including malnutrition, through the monthly MBA-AAA work group
c. Review congregate and home delivered meal menus and adapt to address for cultural considerations and preferences and providing medically tailored meals to the maximum extent practicable
d. Explore and document barriers to offering culturally responsive, evidence-based health promotion programs
e. Scale up promising models through the AAA network to support older adults' overall health and wellbeing, such as Program to Encourage Active Rewarding Lives (PEARLs)
f. Partner with MDH on State Government Actions outlined in the Minnesota Opioid Action Plan
g. Partner with MDH to advance the Minnesota State Oral Health Plan 2020-2030, with a specific focus on Access to Oral Health Care, Health Systems Integration, and Disability, Special Care Needs, and Inclusion

Objective 4.2: Strategize and develop effective supports for solos

a. Explore expanding and creating roles to support solos, such as expansion of Caregiver Consultant and Community Health Worker services, and creation of Personal Health Decisions Assistants, including utilizing AmeriCorps Senior (especially RSVP)
b. Promote supported decision-making models that prioritize individual choice and autonomy related to issues such as financial decisions, advanced care planning, and family relationships, among others
c. Expand language (in policies, on forms, etc.) to be inclusive of solos

Objective 4.3: Champion the importance of social connection to overall health

a. Leverage recent reports on the issue of social connection, including in long-term care settings, to help quantify the impact and produce recommendations, including related to the (potential) roles of existing programs such as RSVP
b. Evaluate and raise awareness of innovative social opportunities utilized during the COVID-19 pandemic such as virtual respite, approved virtual EBHP programs, robotic companion pets, and others.
c. Partner with MDH as a member of the Minnesota Suicide Prevention Taskforce in order to further the Minnesota Suicide Prevention state plan

Objective 4.4: Strengthen Minnesota's capacity to address Alzheimer's disease and related dementias

a. Continue to work with partners to document progress on, promote, and advance recommendations from the Alzheimer's Disease Working Group's 2019 report
b. Invest in addressing infrastructural barriers to prevention, early detection and diagnosis of Alzheimer's disease and related dementias
c. Coordinate and meet on a quarterly basis with MDH to advance efforts related to Building our Largest Dementia Infrastructure (BOLD) Grant, including the updated Healthy Brain Initiative Road Map Series

Goal 5: Dismantle ageism and promote older adult rights, autonomy and protection

Short Term Outcome: Minnesotans, including those from diverse communities and Tribal nations, will have increased awareness of supports for vulnerable adults

Intermediate Outcome: Minnesotans will have access to person-centered and trauma informed care through multi-disciplinary teams

Long Term Outcome: Minnesotans have the tools to make their own decisions including access to multi-disciplinary teams

Measures:

- An Adult Protective Service public awareness campaign tailored to 1-3 diverse communities is launched
- % increase in counties showing increased maltreatment reports accepted for services
- % increase in Tribal Nations who report increased capacity for adult protective services.
- Satisfaction level individuals have with Office of Ombudsman for Long-Term Care services
- Number of trauma-informed care trainings for professionals
- Number of Ombudsman volunteers

Data Sources: Minnesota Adult Abuse Reporting Center, OOLTC data sources

Objective 5.1: Elevate aging and work toward greater integration of aging considerations into state policy

a. Advance the priorities and investments of the AFMN Council to make Minnesota's communities great places to grow up and grow old
b. Advocate for establishment of, and investments in, financing mechanisms to support Minnesotans with low to middle incomes to plan for their needs as we grow older
c. Expand access to training on working with older adults, including the impacts of ageism, for social workers, dental providers, pharmacists and similar professionals
d. Collaborate with partners to advance evidence-based, high-quality care for older adults through Age-Friendly Health Systems and Age-Friendly Public Health

Objective 5.2: Advance strategies to support individuals receiving long-term services and supports

a. Strengthen and promote the new Assisted Living licensure law through education to providers and partners; systemic advocacy for keeping resident protections in Assisted Living licensure; and pursuit of additional legislative adjustments that support those receiving long-term services and supports
b. Advance trauma-informed care at the individual, facility, and systemic levels through continued staff training on trauma-informed care and individual and systemic advocacy
c. Promote OOLTC services to LTC recipients, providers and the public through social media and other avenues
d. Strengthen advocacy efforts by enhancing partnerships with other entities (OMHDD, case managers etc.)
e. Advocate for increased transparency of facility information and disclosures
f. Increase tribal-state relations and awareness among tribes of OOLTC roles and responsibilities
g. Ensure person-centered services for all Minnesotans receiving LTSS, from home care to nursing homes, through individual and systemic advocacy for person-centered services, provision of trainings, and policy work

h. Advocate for Federal regulations that require nursing home minimum staffing requirements
Objective 5.3: Advance strategies to support vulnerable adults in the community of their choice a. Establish multi-disciplinary teams in each county to identify and support vulnerable adults and their families, especially those who are experiencing self-neglect or caregiver neglect b. Increase resources and support to county adult protective services and Tribal nations to build their capacity to identify and support adults who are vulnerable to maltreatment c. Explore program and policy options for adults who are the subject of reports to the Minnesota Adult Abuse Reporting Center (MAARC) and may benefit from services not currently offered in Minnesota, such as non-Medicaid case management d. Collaborate with counties, Tribal nations, community organizations and others to address disparities in outcomes for adults referred for adult protective services e. Launch a public awareness campaign for diverse adults who are vulnerable to maltreatment, that is consistent with culturally appropriate, person-centered messaging (Goal 5.3, APS Operational Plan)
Objective 5.4: Promote and uphold the rights of older adults and empower individual choices and values a. Expand and promote the use of Supported Decision Making, including in long-term care facilities b. Provide more education related to legal rights in a variety of circumstances; include linguistically and culturally appropriate education/resources c. Identify and work with partners, such as Southern Minnesota Legal Services, to expand and promote on-demand legal services such as the Legal Risk Detector, Justice Bus, Legal Kiosks, etc. d. Leverage caregiver funds and work with partners to update key informational resources and provide the specialized support, including legal assistance, needed by grandfamilies

Quality Management

Minnesota implements a quality assurance system across HCBS for older adults that includes data collection, analysis and continuous improvement.

The quality assurance system cuts across DHS and the MBA as we work on collaborative performance improvement to support our efforts to achieve better outcomes for people, provide the right services at the same time and sustain the overall system. The data we gather informs our decisions about how to prioritize our efforts and resources.

One of the ways the MBA is addressing quality management is through a close partnership with the AAAs. Currently, there are two ongoing MBA-AAA workgroups to address data collection and process improvement, one focused on nutrition and one focused on caregiving. There are also quarterly meetings between MBA staff and AAAs to discuss data collection and reporting, administrative functions, and other timely topics. Finally, each area plan includes a snapshot of services the corresponding AAA provided in the previous calendar year, an estimate for the current calendar year, and a goal for the next calendar year based on trends.

Using Data to Inform Decisions

DHS' Aging Data Profiles include statewide, regional and county-level demographic and service data. The profiles provide information on the variation and differences about our aging society to inform those developing programs, services and supports that help older adults live, work and engage in their communities. All data is about Minnesotans aged 65 and older.

Demographic trends can tell counties and providers about how the population of their community is changing over time and facilitate their development of services to meet those needs. These dashboards provide county level information about the demographics of HCBS programs over time.

The National Core Indicators-Aging and Disabilities (NCI-AD) initiative measures and tracks the quality of life and outcomes of older adults and adults with physical disabilities who are accessing Medicaid-funded HCBS. The goal of collecting this data is to understand how people use services and supports to help live, lean, work and enjoy life in their community. DHS, in partnership with the National Association of States United for Aging and Disabilities (NASUAD) and Human Services Research Institute (HSRI), implemented the 2018-2019 NCI-AD Adult Consumer Survey in Minnesota (PDF). Results will be used to support Minnesota's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life and outcomes of older adults and people with disabilities.

The Assisted Living Report Card, which measures and reports on the quality of individual assisted living settings for housing and services paid for privately and through public programs, is being developed for Minnesota. Once the report card is fully implemented by DHS' Aging and Adult Services Division (AASD) and MBA, results will be shared with the public through a website and will be updated over-time as new data on quality are available.

In 2022, OOLTC began collecting additional data which may lead to greater understanding and analysis of the impact of social determinants on long-term care consumers' needs and service access, as well as equity issues within the OOLTC program. Analysis of race/ethnicity, pay status, language/needs, and gender identity will guide OOLTC to develop an outreach plan to reach underserved populations and identify potential areas of unmet needs.

LTSS Performance Measures demonstrate how well the programs support people in their community while ensuring system sustainability. In general, people report they have a higher quality of life when living in the community. In addition, HCBS, on average, are also less costly than institutional services.

Analysis and Remediation of Problem Areas

Existing Methods:

- HCBS Lead Agency reviews: DHS designs and sets the standards for the HCBS system. Lead agencies, including counties, tribal nations and managed care organizations under contract with DHS administer the programs on a local level. DHS initiated the lead agency review of counties and tribes managing and administering HCBS programs in 2006 and has completed three full rounds of reviews for each lead agency. It examines all five Medicaid waiver programs and the AC program in each lead agency.
- Managed Care Organization (MCO) care plan audits: The contracts between DHS and MCOs require those organizations to annually audit a sample of care plans for all enrollees, including those who receive waiver services. The audits follow established protocols and include review of delegated administrative functions, required waiver case management tasks and person-centered planning. If MCOs use a care system model where entities

such as clinics, counties, and tribes provide care coordination for enrollees, DHS requires MCOs to audit the care systems that provide contracted services. DHS reviews and approves corrective action plans related to care plan audit findings and care system audit findings.

Establishing Performance Measures

New performance measures are being developed for AAA area plans and the Minnesota State Plan.

- In spring 2022, MBA contracted with Public Sector Consultants (PSC), utilizing COVID-19 pandemic funds (Consolidation Appropriations Act and VAC5 administrative funding), to establish performance measures for the AAAs based on the Minnesota State Plan goals. This process included several rounds of interviews with stakeholders, data exploration, and an environmental scan of performance measures used in other states. Beginning with the 2025 AAA area plans, MBA will begin to monitor the 10 identified performance measures as identified in the PSC Performance Measures Report.
- New in FFY 2024, the MBA will begin monitoring statewide performance measures, corresponding to each Minnesota State Plan goal.

Continuous Improvement

Satisfaction Surveys

MBA gathers feedback from the public through two satisfaction surveys:

- SLL offers a post-call survey to every person who calls into the 1-800 number. The survey allows the person to mark yes or no to the following three questions: 1) if they have received the information needed; 2) whether the staff person was knowledgeable and helpful; and 3) whether they would recommend SLL. SLL has received positive feedback with 97% of responses marked yes.
- Since 2005, MBA, in partnership with AAAs and their providers, have administered a survey to caregivers receiving Title III services. The survey collects general demographic information, ratings of the services received, and if the services helped them provide care longer. The Title III caregiver services consistently receive ratings between four and five, with five being the highest rating possible.

MBA will continue to build upon these initiatives, which will better inform strategies to strengthen our service delivery.

Appendices

Appendix A: State Plan Guidance

State Plan Assurances and Required Activities

Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low- income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy,

and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—...

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older

individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to

designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)

(i)

(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low- income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

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

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

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

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

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will

include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

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

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

(C) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families; if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals

with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) 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, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, 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;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

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

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

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

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

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

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

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

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

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b) (1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals aged 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d) (1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f) (1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(11) contracts with health care payers;

(12) consumer private pay programs; or

(13) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to

provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in- home services will be directly provided by the state agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the state agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such state agency or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the state agency or area agency on aging is already providing case management

services (as of the date of submission of the plan) under a state program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the state agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the state agency pursuant to section 712 shall be used to supplement and not supplant other federal, state, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title,

including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) 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

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English- speaking ability, then the State will

require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

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

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 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.

(19) The plan shall include the assurances and description required by section 705(a)

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways

in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in childcare, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self- directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals aged 85 and older in the State is expected to affect the need for supportive services.

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

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(ii) receipt of reports of elder abuse;

(iii) 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 if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order...

6/29/23

Signature and Title of Authorized Official

Date

Appendix B: Information Requirements

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State Plan;

RESPONSE: Area Agencies on Aging are required to sign assurances that preference will be given to providing services to older individuals with the characteristics described. In addition, the Area Agencies on Aging must submit, as a component of their annual Area Plan on Aging, a chart that estimates the number of older individuals from each population group that will be served, by section of Title III funding. MBA staff monitor actual participants served and their characteristics throughout the Area Plan year and work with the Area Agencies on Aging to remediate any issues, as needed.

Section 306(a)(6)(I)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE: The Senior LinkAge Line will continue working with the Disability Hub and the Minnesota Department of Administration's System of Technology to Achieve Results (STAR) program to support and promote the Minnesota Assistive Technology Lending Library. Together, we are working to develop informational videos, brochures, web copy and more to promote this helpful and important program that benefits older adults and people with disabilities across the state.

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

RESPONSE: Area Agencies on Aging are required to sign assurances that they have an emergency preparedness plan in place for the services that are deemed critical. Currently this includes home delivered meals. The assurances include the requirement for the plans to be coordinated with other efforts and organizations. The MBA reviews the Area Plans and requires modifications before final approval is given to address any gaps in information provided.

Section 307(a)(2)

The plan shall provide that the State agency will —...

> (C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306

(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). (Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)

RESPONSE:

Access: minimum of 5% of III-B allocation In-Home: minimum of 5% of III-B allocation

Legal Assistance: minimum of 10% of III-B allocation

Together, the expenditure on these three categories of services must be at least 40% of the Area Agencies on Aging's new obligational authority of III-B.

Section 307(a)(3)

The plan shall—

...

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:

- FFY2023: $10,916,360
- FFY2024: $10,916,360
- FFY2025: $10,916,360
- FFY2026: $10,916,360

In FFY 2023, the Area Agencies on Aging signed assurances that preference will be given to providing services to older individuals in rural areas. In addition, the Area Agencies on Aging submitted, as a component of their annual Area Plan on Aging, a chart that estimated the number of older individuals from each population group that will be served, by section of Title III funding. MBA staff monitored actual participants served and their characteristics throughout the Area Plan year and worked with the Area Agencies on Aging to remediate any issues, as needed.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

RESPONSE:

Within each of the services funded, the Area Agencies on Aging are required to work with their providers to identify and serve older individuals in need of the service who live in rural areas. As a result, the Area Agencies on Aging have facilitated the development of creative models to reach these older individuals in the most cost-effective manner. One example is the delivery of frozen home delivered meals once a week or once every two weeks to older individuals who live in very isolated areas. In addition to the meals, volunteers also bring other items that are needed by the older individuals. Funds are allocated for this purpose according to Minnesota's Intrastate Funding Formula (IFF).

Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

> (A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and
>
> (B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

RESPONSE: There are 14,995 low-income minority older individuals in Minnesota. An estimated 5,429 are limited English proficient. Much of the low-income older adult population (including those with limited English proficiency) in Minnesota resides in the Twin Cities metro area. MAAA contracts with thirteen culturally-specific community organizations to serve their elders. Across Minnesota, Area Agencies on Aging contract with 15 agencies to provide Special Access Programs which provide information and referral, outreach, advocacy, translation/interpretation and short-term case management services to help minority and non-English speaking elders access services they need. Some of the special access providers are also receive additional III-B and III-D funds to offer assisted transportation and evidence-based health promotion programs.

Across Minnesota there are at least 4 providers offering culturally specific meals. These meals include Halal, Southeast Asian, Kosher, Hispanic, Laotian, Vietnamese, and Somali. In addition, through various COVID-19 funded partnerships culturally specific food was distributed to Native American communities including frozen soups and smoothies.

The Minnesota Indian Area Agency on Aging (MIAAA), administered by the Minnesota Board on Aging, continues to bring culturally specific assistance to elders on four reservations, including legal services, nutrition services, caregiver services, transportation, information and assistance and access. Other developments include bringing legal services to American Indians who live outside the service area of the one legal services (civil) provider with a contract with MIAAA; forming a relationship between the northwestern AAA, a caregiver provider and a "closed" tribal reservation that is not affiliated with the MIAAA; and other ongoing work to reach other under-represented, hard-to-reach older individuals across the state.

Section 307(a)(21)

The plan shall —

. . .

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

RESPONSE: The Minnesota Board on Aging employs a full-time Indian Elders Coordinator staff person to be the liaison for the tribes regarding aging services and to ensure that Native American elders have full access to all programs and services. In addition, the MBA participates in ongoing Tribal Consultation. Since the last State Plan submission, the Senior LinkAge Line has also hired staff to work directly from Tribal offices. Recently, MBA has revised framework language regarding MBA membership to include Tribal representation. In addition, MBA just completed development of the DEIA Strategic Directive and is now implementing the DEIA Strategic Directive, including additional targeting factors in the IFF

The staff to the Minnesota Board on Aging have attended government-to-government training developed by the 13 tribal governments and the University of Minnesota-Duluth to ground state staff in the principles of sovereignty, ethics, law, management, budget and leadership.

The curriculum included information on federal Indian policy and the legal background between the tribes and the states.

Section 307(a)(27)

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals aged 85 and older in the State is expected to affect the need for supportive services

RESPONSE: As part of the AFMN Council, MBA participated in a statewide needs assessment. This needs assessment directly informed the State Plan on Aging.

Additionally, in partnership with The SCAN Foundation, West Health, and the May and Stanley Smith Charitable Trust, the Center for Health Care Strategies (CHCS), AFMN Council is participating in a multi-state learning collaborative to advance Master Plans for Aging (MPAs).

Section 307(a)(28)

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE: The Area Agencies on Aging, as part of their Area Plan submission, each sign an assurance related to emergency preparedness. The Minnesota Board on Aging is part of the Minnesota Emergency Preparedness Plan in which Home Delivered meals have been classified as a priority 1 service. The AFMN Council has adopted emergency preparedness as one of its key priorities. An emergency planning report will be released soon, highlighting highlight numerous state agencies' immediate priorities and strategies at the outset COVID-19, especially related to older adults. The report will identify common themes and challenges and discuss what the state and Minnesota communities have learned from the pandemic.

Section 307(a)(29)

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE: Designated MBA staff participate fully in the development of the state

government-wide continuity of operations plan process, ensures the inclusion of older adults in the plan and develops the aging services specific plan. MBA staff work with the Area Agencies on Aging to support their plan development efforts and coordinates regional and local communications between the Area Agencies on Aging and the relevant organizations.

Section 705(a) ELIGIBILITY —

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—. . .

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).

(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of

grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) 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 if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.

RESPONSE: The Minnesota Board on Aging requires, through the annual Area Plans, that Area Agencies on Aging gather public input regarding their programs and services, establish and work through their local advisory boards to make funding decisions on programs and services, ensure access to their programs and benefits, and protect the rights of vulnerable elders through provision of legal education and legal assistance,

MBA administers the OOLTC program and in partnership with DHS, the Adult Protection Program (which is managed locally by the counties) to protect elders' rights. OOLTC staff are state employees and are located in each region of the state.

Appendix C: Intrastate Funding Formula (IFF)

Updated Formula effective 1/1/2025:

This attachment reflects the updated Intrastate Funding Formula (IFF) for the State Plan on Aging 2024-2027. This revised formula is the result of an extensive and inclusive effort to engage key partners, particularly AAAs. This effort sought to build consensus on key priorities and address opportunities to improve the previous version. To have successful engagement, MBA created an IFF subcommittee comprised of MBA board members and MBA leadership.

The IFF subcommittee:

- Convened more than a dozen meetings during 2022 and early 2023, to explore options for improving and adjusting the formula.
- Focused on ensuring the formula aligned with shared principles related to equity, collaboration, transparency, accountability, and data-driven decision making.
- Met regularly with AAAs (including directors, staff, and advisory council members) to share updates on progress and solicit feedback. AAAs provided extensive verbal and written feedback on iterative drafts before a draft was approved for public comment by MBA in February 2023.
- Analyzed and implemented the extensive number of public comments.

The resulting final formula intends to address public comments that seek greater emphasis and parity in minority and rural populations. Lastly, the IFF subcommittee added a targeted base allocation to ensure that the smallest region received adequate administrative funds. This final version of the IFF was approved by MBA on June 30, 2023. Refer to Exhibit 1 for factor, weights, and data source. MBA will distribute OAA and related federal and state funds by means of the revised IFF described in this appendix.[25]

MBA is committed to using the most recent and best available data. U.S. Census Bureau data is used to produce population counts for each factor. More specifically, the U.S. Census Bureau's American Community Survey (ACS) five-year estimates from 2018-2022 are used for all factors, except for the "persons aged 60 and over who live in nonurban areas," which leverages the U.S. Census Bureau's Decennial Census. In some cases, the MBA will use ACS data provided by the Administration for Community Living's Aging, Independence, and Disability Program data portal. In accordance with OAA Section 305 (a)(2)(c). The IFF data will be updated on the state plan cycle, or when best available data is acquirable.

Each IFF factor, weights and data sources are described in Exhibit 1. Using each IFF factor data source, the number of individuals in a Planning and Service Area (PSA) is divided by the total number of individuals in the state for the corresponding factor. Then that percentage is multiplied by the corresponding weight. This method is used for each region across all the factors and weights included in Exhibit 1. The

[25] The development of the IFF took place prior to the implementation of the Final Rule. The MBA will come into compliance with Final Rule by October 1, 2025.

sum of a PSA share of each factor determines the total share of available funds that PSA region will receive.

Exhibit 1 Factors, Weights, and Data Source

Factor	Factor Description	Weight	Data Source
Population 60+	Number of individuals aged 60 and over	40%	ACS five- year estimates
Low-income 60+	Number of individuals aged 60 and over with income below the federal poverty level	20%	ACS five-year estimates
Minority 60+	Number of individuals aged 60 and over who are not counted as “white alone” in ACS data	20%	ACS five-year estimates
Rural 60+	Number of individuals aged 60 and over who live in nonurban areas	15%	ACS five-year estimates and U.S. 2020 Census data
Population density ratio 60+	The population density of individuals aged 60 and over in each PSA region as a ratio compared to the statewide average population density of individuals aged 60 and over[26]	5%	ACS five-year estimates

Distribution of funds

Note: Descriptive statements are requirements identified in the OAA section 305(d)

Step 1. State Agency Administration

MBA shall use 5% of total allocation for state agency administration, as allowed under section 308(b).

Step 2. Area Plan Administration

After application of amounts used under section 308(b) for state agency administration, MBA shall take 10% of its combined allotments for supportive services (III B), congregate nutrition services (III C-1), home delivered meal services (III C-2), and family caregiver (III E) funds for area plan administration using the IFF. Funds from disease prevention and health promotion services (D) are not applied to this section. After applying IFF, any PSA region that would receive less than $100,000 for area plan administration will receive additional funds to meet a $100,000 minimum funding level using the process described in the mathematical statement section and Exhibit 2 Calculation of Administrative Allocation per PSA. The formula and calculation method used ensures that the total amount calculated is not greater than 10% of the total award.

Step 3. Ombudsman for Long Term Care

After application of amounts used under section 308(b) for state agency administration and area plan administration, MBA shall provide funding from Title

[26] Population density is calculated by taking the total number of people aged 60 and above per square mile for the entire state as the numerator, and the average population density of the people aged 60 and above for the PSA region as the denominator. For example, an Area Agency on Aging PSA has a density of 18.85, and the state as a whole is 15.26. The fraction 15.26/18.85 results in a “Population Density Ratio 60+” of 0.85.

III-B to OOLTC an amount that is no less than the amount expended by the MBA with funds received under Title III for federal fiscal year 2019. MBA shall distribute the remaining funds according to the factors and weights outlined in Exhibit 1.

Step 4. Title III-B Supportive Services

After subtracting calculation for state agency administration, area agency administration, and OOLTC, MBA shall distribute the remaining funds according to the factors in Exhibit 1. Funds available to AAAs for program development and coordination activities shall be taken from the direct service allocation. AAA program development and coordination requests for specific amounts will be considered as part of the area plan and budget approval process.

Step 5. Titles III-C1 and III-C2 Nutrition Services

After subtracting amounts for state agency administration and AAA administration, MBA shall distribute the remaining funds according to the factors in Exhibit 1.

Step 6. Title III-D Disease Prevention and Health Promotion

After subtracting calculations for state agency administration, MBA shall distribute the balance of funds according to the factors in Exhibit 1.

Step 7. Title III-E Caregiver Services

After subtracting calculations for state agency administration and AAA administration, MBA shall distribute the remaining funds according to the factors in Exhibit 1.

Hold Harmless Description and Calculation

To protect AAAs from experiencing large changes in funding as the new formulas are implemented, the financial plan applies “hold harmless” provisions. These will ensure that no AAA’s allocation from any Title III part decreases by more than five percent from year to year. These provisions will restrain annual losses for the State Plan on Aging 2024-2027. Hold harmless will be in effect until each AAA receives at least 95% of their previous year allocation. If this extends beyond the time of the 2024-2027 State Plan on Aging, the SUA will reassess at the next State Plan on Aging submission. Implementation of the updated IFF will begin January 1, 2025, with the 95% Hold Harmless policy, as outlined in the AAA Operations Manual. To determine the outcomes of the Hold Harmless Policy the following steps must be completed:

1. Determine AAA administrative allocations and Hold Harmless Policy. Using the area plan administration amount determined in Step 2 in Distribution of Funds, follow Exhibit 2 Calculation of Administrative Allocation per PSA and Hold Harmless calculation.
2. Determine AAA direct service allocations and Hold Harmless Policy. Using the area plan direct service amounts determined in Steps 4-7 in Distribution of Funds, follow Exhibit 3 Calculation of Direct Service Allocation per PSA and Hold Harmless calculation.

Mathematical Statements for IFF

Any region that would receive less than $100,000 for area plan administration based on their IFF share, will receive additional area plan administration funds needed to

meet a $100,000 minimum funding level using proportional distributions from other PSA administration allocations described in the mathematical description below. If there are insufficient area plan administration funds, MBA will supplement funds through state dollars.

Exhibit 1 Factors and weights for calculations

To obtain the PSA cumulative total calculate each of the following 5 factors, then take the sum.

Formula: Factor 1 + Factor 2 + Factor 3 + Factor 4 + Factor 5 = PSA cumulative total

Factor 1: PSA 60+ population divided by Total MN population x 40%

Factor 2: PSA Low-Income 60+ population divided by MN Low-income population total x 20%

Factor 3: PSA Minority 60+ population divided by MN minority 60+ population total x 20%

Factor 4: PSA Rural 60+ population divided by MN rural 60+population total x 15%

Factor 5: PSA 60+ population density ratio divided by MN 60+ population density ratio x 5%

Mathematical Symbol Definitions

/ means the number on the left of the symbol is divided by the number on the right.

X means the number on the left of the symbol is multiplied by the number on the right.

+ means the number on the left of the symbol is added to the number on the right, unless it immediately follows the number 60 (as in “60+”), in which case, it serves as an abbreviation for “Age 60 and above".

< means that the item on the left is less than the item on the right.

> means that the item on the left is greater than the item on the right.

() these items, parentheses, mean that the items within them are calculated with one another before they are either multiplied, divided, added, or subtracted to any other item on that specific line.

Exhibit 2 Calculation of Administrative Allocation Floor and Hold Harmless

Administrative allocations are calculated based on the IFF, using weighted factors to distribute funds as shown in Figure 6. The formula and calculation method ensures that the total amount calculated is no greater than 10% of the remaining award (see Step 2 in Distribution of Funds). The IFF functions as described below:

Administrative Allocation Floor Calculation

1. After determining the amount from Step 2 in Distribution of Funds
2. PSAs that receive less than $100,000 are identified.
3. The amount needed by identified PSAs to reach $100,000 is determined.

4. The amount determined in #3 is ran through the IFF minus the PSA(s) identified in #2 to determine the administration amount contributed by AAAs above the $100,000 floor.
5. The administration amount contributed by each PSA above the $100,000 floor is subtracted from the original administration allocations determined in #1.

Hold Harmless (HH) Calculation*

1. Determine the percentage of the previous year's allocation the PSA would receive for administration without a HH policy.
2. Determine administration floor calculation for current year (see instructions above).
3. AFTER determining administration floor, reassess allocation changes from #1 to determine which PSAs fall below the 95% HH.
4. For PSAs who receive more than 95% of the previous year's allocation, determine the maximum they can contribute for administration to remain above the floor, before falling below the HH; AND determine the proportional amount the PSA should contribute based on the IFF.
5. Collect administration funds for PSAs who fall below the 95% HH. Begin with proportional amounts, then draw from the maximum.
6. Redistribute funds and calculate final allocations. Each PSA should receive at least 95% of the previous year's funding for administration service.

*Hold Harmless calculation must occur after the floor calculation.

Exhibit 3 Calculation of Direct Service Allocations – per PSA

All direct service allocations to the PSAs will be determined based on the IFF, using weighted factors to distribute funds as shown in Figure 6. The IFF functions as described below:

Direct Service Calculation

1. Calculate the total Title III (B, C, D, E) direct service allocations using steps 4-7 from Distribution of Funds section.
2. Use the PSA cumulative percentage to determine allocations for direct service.

Hold Harmless (HH) Calculation*

1. Determine the percentage of the previous year's allocation the PSA would receive for direct service without a HH policy.
2. AFTER determining direct service allocations, reassess allocation changes to determine which PSAs fall below the 95% HH.
3. For PSAs who receive more than 95% of the previous year's allocation, determine the maximum they can contribute for direct service, before falling below the HH; and determine the proportional amount the PSA should contribute based on the IFF.

4. Collect direct service funds for PSAs who fall below the 95% HH. Begin with proportional amounts, then draw from the maximum.
5. Redistribute funds and calculate final allocations. Each PSA should receive at least 95% of the previous year's funding for direct service.

*Hold Harmless calculation must occur after the direct service calculation.

Planning and Service Area

MBA has designated a AAA to serve each designated Planning and Service Area (PSA).

Area Agency on Aging	Region	Counties and Tribal Nations Served
Arrowhead Area Agency on Aging (AAAA)	Northeast	Aitkin, Carlton, Cook, Itasca, Koochiching, Lake, and St. Louis
Central Minnesota Council on Aging (CMCOA)	Central	Benton, Cass, Chisago, Crow Wing, Isanti, Kanabec, Mille Lacs, Morrison, Pine, Sherburne, Stearns, Todd, Wadena, and Wright
Dancing Sky Area Agency on Aging (DSAAA)	Northwest	Becker, Beltrami, Clay, Clearwater, Douglas, Grant, Hubbard, Kittson, Lake of the Woods, Mahnomen, Marshall, Norman, Otter Tail, Pennington, Polk, Pope, Red Lake, Roseau, Stevens, Traverse, and Wilkin
Metropolitan Area Agency on Aging (MAAA) DBA Trellis	Twin Cities Metro Area	Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington
Minnesota Indian Area Agency on Aging (MIAAA)	Tribal Nations	Bois Forte Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, Grand Portage Band of Lake Superior Chippewa, Leech Lake Band of Ojibwe, Lower Sioux Indian Community, Mille Lacs Band of Ojibwe, Prairie Island Indian Community, Red Lake Nation, Upper Sioux Community, and White Earth Nation.
Minnesota River Area Agency on Aging (MNRAAA)	Southwest	Big Stone, Blue Earth, Brown, Chippewa, Cottonwood, Faribault, Jackson, Kandiyohi, Lac qui Parle, Le Sueur, Lincoln, Lyon, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Pipestone, Redwood, Renville, Rock, Sibley, Swift, Waseca, Watonwan, and Yellow Medicine
Southeastern Minnesota Area Agency on Aging (SEMAAA)	Southeast	Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona

Factors, Weights, and PSA Cumulative Percentage

Figure 1. Fund Allocation by PSA Region: Population 60+ (Weighted 40%)[27]

PSA Region	Pop. 60+	% of Pop.	Factor
DSAAA	110,771	8.38%	3.35%
AAAA	97,143	7.35%	2.94%
CMCOA	181,940	13.76%	5.50%
MNRAAA	136,885	10.35%	4.14%
SEMAAA	127,370	9.63%	3.85%
MAAA	658,709	49.82%	19.93%
MIAAA	9,336	0.71%	0.28%
Totals	1,322,154	100%	40%

Figure 2. Fund Allocation by PSA Region: Low-income 60+ (Weighted 20%)

PSA Region	Low-income 60+	% of Pop.	Factor
DSAAA	9,737	9.40%	1.88%
AAAA	9,228	8.91%	1.78%
CMCOA	14,996	14.47%	2.89%
MNRAAA	11,149	10.76%	2.15%
SEMAAA	9,572	9.24%	1.85%
MAAA	47,712	46.05%	9.21%
MIAAA	1,212	1.17%	0.23%
Totals	103,06	100%	20%

Figure 3. Fund Allocation by PSA Region: Minority 60+ (Weighted 20%)

PSA Region	Min. 60+	% of Pop.	Factor
DSAAA	5,065	4.84%	0.97%
AAAA	3,977	3.80%	0.76%
CMCOA	6,371	6.09%	1.22%
MNRAAA	4,854	4.64%	0.93%

[27] Population aged 60+ by Area Agency on Aging: 2020 US Census, Table DECENNIALDHC2020.H2, "Population by Age by Census Tract."

SEMAAA	5,604	5.36%	1.07%
MAAA	76,165	72.79%	14.56%
MIAAA	2,594	2.48%	0.50%
Totals	104,630	100%	20%

Figure 4. Fund Allocation by PSA Region: Rural 60+ (Weighted 15%)[28]

PSA Region	Rural 60+	% of Pop.	Factor
DSAAA	77,046	17.19%	2.58%
AAAA	58,800	13.12%	1.97%
CMCOA	115,970	25.88%	3.88%
MNRAAA	88,878	19.83%	2.98%
SEMAAA	53,759	12.00%	1.80%
MAAA	44,307	9.89%	1.48%
MIAAA	9,336	2.08%	0.31%
Totals	448,096	100%	15%

Figure 5. Fund Allocation by PSA Region: Population Density (Weighted 5%)

PSA Region	Sq. Miles	Pop. Density Ratio	% of Ratio	Factor
DSAAA	22,798	4.86	20.27%	1.01%
AAAA	18,265	5.32	18.51%	0.93%
CMCOA	11,828	15.38	6.40%	0.32%
MNRAAA	17,195	7.96	12.37%	0.62%
SEMAAA	6,756	18.85	5.22%	0.26%
MAAA	2,786	236.46	0.42%	0.02%
MIAAA	3,842	2.68	36.81%	1.84%
Totals	83,469	NA	100%	5%

[28] Rural Population aged 60+ by Area Agency on Aging: 2022 American Community Survey, Table ACSST5Y2022.S0101, “Population by Age by Urban or Rural Status by Census Tract, 2022 5-Year ACS.”

Figure 6. Fund Allocation by PSA Region: Total Share/PSA Cumulative Percentage

PSA Region	All Factors
DSAAA	9.79%
AAAA	8.37%
CMCOA	13.82%
MNRAAA	10.81%
SEMAAA	8.83%
MAAA	45.20%
MIAAA	3.17%
Totals	100%

Exhibit 7. Preliminary Funding Allocations based on FFY23 area plan allocations (as of 02/2023) by PSA by Category

PSA	III-3A	III-B	III-C1	III-C2	III-D	III-E	Title III Subtotal	NSIP*
DSAAA	247,744	500,874	776,915	534,818	43,130	281,100	2,384,581	284,182
AAAA	197,104	398,492	618,109	425,499	34,314	223,642	1,897,160	180,414
CMCOA	306,242	620,553	962,552	662,609	53,435	348,267	2,953,658	288,411
MNRAAA	291,618	589,574	914,500	629,530	50,768	330,881	2,806,871	287,330
SEMAAA	230,063	465,128	721,470	496,650	40,052	261,039	2,214,402	158,199
MAAA	985,092	2,029,792	3,148,449	2,167,351	174,782	1,139,157	9,644,623	425,021
MIAAA	100,000	142,136	220,470	151,769	12,239	79,770	706,384	70,228
Totals by Fund	2,357,863	4,746,549	7,362,465	5,068,226	408,720	2,663,856	22,607,679	1,693,785

*NSIP—Nutrition Services Incentive Program

Nutrition Services Incentive Program (NSIP) Funds Distribution

MBA distributes the total NSIP allocation to AAAs based on the number of NSIP meals reported in the annual FFY 2019 State Program Report/Older Americans Act Performance System, per ACL COVID-19 Response: NSIP Guidance 2021.

Exhibit 8. NSIP Allocations Based on 2019 NSIP Meals

PSA	C1 Meal Counts	C2 Meal Counts	Total Meal counts	% Allocated
DSAAA	205,689	190,188	395,877	17%
AAAA	156,316	95,010	251,326	11%
CMCOA	213,551	188,218	401,769	17%
MNRAAA	221,773	178,490	400,263	17%

PSA	C1 Meal Counts	C2 Meal Counts	Total Meal counts	% Allocated
SEMAAA	149,760	70,619	220,379	9%
MAAA	316,791	275,285	592,076	25%
MIAAA	27,476	70,355	97,831	4%
2019 Meal Count Total	1,291,356	1,068,165	2,359,521	100%

Appendix D: Age-Friendly Minnesota Status Checks

These eight issue briefs were developed in 2021 to inform the Multisector Blueprint for Aging and other age-friendly work across the state:

Age-Friendly Status Check – Age-Friendly Integration

Age-Friendly Status Check – Caregiving and Dementia

Age-Friendly Status Check – Emergency Preparedness

Age-Friendly Status Check – Health & Well-Being

Age-Friendly Status Check – Inclusion & Equity

Age-Friendly Status Check – Individual Rights & Protections

Age-Friendly Status Check – Life at Home and in the Neighborhood

Age-Friendly Status Check – Social and Community Connections

Appendix E: Why Solos Matter to Minnesota (and Elsewhere…)

A white paper by Linda J. Camp: Why Solos Matter to Minnesota (and Elsewhere…)

Appendix F: Statewide Needs Assessment on Aging Summary

Statewide Needs Assessment on Aging

Minnesota's State Plan on Aging goals grew out of needs and opportunities identified in several ways. We gathered our own data and consulted findings from our core partners' work. This section provides an overview of those efforts and highlights some key findings.

DHS, MBA, AFMN Council

Beginning in 2021 Minnesota conducted a multi-stage needs assessment focused on the state's older residents. The assessment was to inform plans and priorities of DHS, MBA, and the AFMN Council. It also represented a key step in the AARP Network of Age-Friendly States and Communities, which Minnesota joined in January 2022. Network members commit to following a five-year process that begins with identifying community needs.

Status Check Briefs

DHS engaged a consultant to develop a set of "status check" briefs exploring the approaches and impact of the aging network over the previous one to two years. The briefs served as a basis for a series of structured discussions with AAAs and MBA staff over the course of several months to elicit priority needs and opportunities related to the development of this state plan.

Priority concerns that emerged from this process included:

- Need for more equitable and culturally responsive services
- Quality, caring workforce to serve older residents and support caregivers
- More transportation options and affordable, equitable, appropriate housing
- Recognition and treatment of social connection as essential
- Increased access to broadband and technology

Targeted Phone Interviews

DHS contracted with Rainbow Research to develop an interview guide and conduct phone interviews with older adults from historically underserved groups, such as BIPOC (Black, Indigenous, and People of Color), LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, and Queer), low-income, rural, veterans, or who have a disability, among others.

Interviews were conducted with 95 individuals ages 60 and over; 62 of whom were Black, Native American, Asian American and Latiné/Hispanic; 34 of whom identified as having a disability; and 10 identified as veterans.

Priority concerns that emerged from these interviews included:

- Social isolation
- Awareness and use of services was low (e.g., 46% were not aware of SLL)
- Affordable housing, employment opportunities, and mental health services were the least available things overall, and they were least available to BIPOC communities.
- White respondents reported the highest community satisfaction and degree to which essential needs are being met.

While the sample size was relatively small, important knowledge was gained related to key gaps and needs, particularly among older adults from communities of color and other underserved groups.

Statewide Survey and Focus Groups

DHS built on Rainbow Research's work and developed a longer survey organized into ten sections. For several months in 2021, this survey was promoted broadly throughout the state, primarily online.

Rainbow Research and two cultural navigators were contracted to boost participation among groups whose voices are often missed during such engagement.

The survey received 913 responses, of which 741 were 55 years old or older. 77% were women, and 6% identified as part of the LGBTQ+ community. 3% were Black, 4% were African (such as Somali or Ethiopian), 2% were Asian American, 1% were Latine/Hispanic, 1% were Native American, and 82% were White.

In addition, DHS contracted with the National Resource Center on Native American Aging (NRCNAA) to engage American Indian tribal and urban elders in the survey to ensure their voices were heard and included. During spring 2022, this effort resulted in 301 survey responses from adults ages 55 and above. 77% were women and 10% identified as members of the LGBTQ community.

With strong support from the state's six regional AAAs and other partners, Minnesota also conducted forty-eight focus groups throughout the state using questions organized by the same domains used in the survey.

The key survey findings discussed below tie to the goals, objectives and strategies at the center of this state plan. However, in-depth analysis of this data is forthcoming over the course of the plan and will be tied to work happening as part of the Multi-Sector Blueprint for an Age-Friendly Minnesota.

Key Survey Findings

Initial analysis of survey data reveals numerous commonalities as well as some striking differences between statewide and tribal respondents.

- Statewide survey respondents generally reported more concern about social isolation, whereas tribal survey respondents generally reported more concern about transportation.
- The greatest difference in the responses between the two sets of respondents was that 38% of statewide survey respondents said they have enough family, friends or neighbors nearby to help care for them if their needs change, compared to 72% of tribal survey respondents.

The following table presents additional highlights from the two surveys. Respondents for both datasets were 55 years old or older.

Key Survey Findings by Domain

Domain / question	Response	Statewide Survey	American Indian & Urban Tribal Elder Survey
Demographics	Have children under 18 living in their household	9%	37%
	Regularly help an aging family member or friend take care of themselves	35%	48%
Built environment: Housing and outdoor spaces and buildings	Need modifications or significant repairs to their current residence to remain safely living at home	49%	53%
	Say their community does not have appropriate, affordable housing options should they need to move out of their current residence	32%	23%
	Say they have enough family, friends or neighbors nearby to help care for them if their needs change	38%	72%
Transportation	Say lack of transportation "negatively impacts my life"	20%	36%
	Reported fair or poor availability of	32%	30%

Domain / question	Response	Statewide Survey	American Indian & Urban Tribal Elder Survey
Community Support and health services	mental health services		
	Reported poor availability of affordable home care services	19%	14%
	Don't know who or where to call for assistance with finding or accessing services	20%	20%
Communication and information **The sources most respondents would turn to for information:**	Family and friends	87%	90%
	The internet	82%	80%
	Doctor/health care professional	80%	81%
	Senior LinkAge Line	67%	61%
	Say it is extremely important or very important to have broadband service at home	93%	79%
Social participation and inclusion **Respondents said they often or sometimes:**	Lack companionship	44%	36%
	Feel left out	38%	26%
	Feel isolated in their community	35%	29%
Safety, basic needs and affordable housing **Respondents often or sometimes go without:**	Food	3%	15%
	Mental health care	15%	19%
	Legal assistance	18%	27%
	Of those who go without needed services, financial challenges are the most common barrier.	21%	30%
Work and Civic Engagement	Are or have been employed while also doing significant caregiving for an aging family member or friend	58%	31%
	Say their community has very good or good availability of volunteering opportunities	74%	45%
Emergency Preparedness	Do not have friends or family who could help them at any time of the day or night	17%	9%
	Rely on friends and/or family to help with daily tasks	18%	48%
	Are very concerned about a public health emergency affecting their	22%	31%

Domain / question	Response	Statewide Survey	American Indian & Urban Tribal Elder Survey
	home or community		

Regional Comparison

Some notable differences, discussed below, stood out across the state's six AAA geographic regions: Central (Central Minnesota Council on Aging), Metro (Trellis), Northeast (Arrowhead AAA), Northwest (Dancing Sky AAA), Southeast (Southeast AAA), and Southwest (Minnesota River AAA).

Built Environment: Housing and Outdoor Spaces & Buildings

The fewest Metro respondents (79%) say their housing is "affordable or appropriate for my needs," compared to in 95% in the Southwest and 86% overall.

33% of Central respondents said they have enough family and friends nearby to help care for them should their needs change, compared to 42% in the Southwest and 38% overall.

The highest proportion of Northeast (58%) and Southwest (60%) respondents say their homes need major repairs to enable them to stay there long as possible, compared to 41% in Southeast and 49% overall.

Transportation

Transportation is most problematic for Metro respondents and least so for respondents in the Southwest and Southeast regions. For example, 24% of Metro respondents say lack of transportation negatively impacts my life, compared to less than 10% among Southeast respondents.

Community Support & Health Services

Access to low-cost yardwork or home repair services is highest in the Southeast (23% say good or very good), and least available in Central (4.2% say good or very good).

Northeast (18%) and Northwest (16%) regions reported poor access to healthcare within 15 minutes of home, compared to 9% overall.

Communication & Information

25% of Metro respondents do not know who or where to call to find or access services, compared to 12% in Southwest Minnesota, and 20% overall.

More than 10% of Northwest respondents do not feel safe using the internet, compared to 6% overall.

Social Participation and Inclusion

Metro and Central regions had the highest percentages of respondents who answered that they often lack companionship, feel left out, and feel isolated in their communities. For example, 67% of Northwest respondents said they never lack companionship, compared to 51% in the metro region and 56% overall.

Work & Civic Engagement

Northwest has the highest percentage of respondents (71%) who are or have been employed while also doing significant caregiving for an aging family member or friend, compared to 58% overall. 95% of Southeast respondents say their communities have good or very good volunteer opportunities, compared to 74% overall.

Safety, Basic Needs and Affording Aging

Metro respondents are most likely to go without needs such as health care, mental health care, transportation, and social connection. For example, 16% often or sometimes go without needed health care, compared to 4% in Southeast and 11% overall.

Barriers to meeting these needs vary across regions: in the Northeast, the most common challenge is lack of internet access; in Northwest, services or staff are not culturally appropriate; in Central, the most common challenge is financial; in Metro, it is language; and in Southwest and Southeast, it is lack of technological devices.

Emergency Preparedness

Northeast respondents report the lowest rates of having broadband service at home (74%), compared to 85% overall.

Metro respondents are least likely (78%) to have friends or family who can help them at any time of the day or night, compared to 91% in Southeast and 83% overall.

Appendix G: Minnesota Board on Aging Performance Measures Report

Executive Summary

Background

MBA engaged Public Sector Consultants (PSC) to review the current data reporting environment in the state's aging network, investigate the use of national performance measures, and use that knowledge to develop performance measures to include in the MBA's upcoming federal fiscal year (FFY) 2024–2027 State Plan on Aging. MBA plans to use this information to support its staff and members in gaining a comprehensive view of information that is currently gathered and identifying how it can be used to measure the performance of the state's AAAs and the services they provide.

These activities provided a strong foundation and detailed information that helped to generate a set of performance measures, descriptions, and calculations.

PSC's process involved:

- Reviewing Minnesota's aging network
- Scanning measures used in other states and at the federal level
- Conducting focused conversations with groups of key partners in the effort
- Identifying and mapping existing data sources within the network.

Performance Measures Development and Methodology

Based on the information gathered from the focused conversations and MBA interviews, PSC mapped existing data to provide a foundation for developing Minnesota-specific performance measures. PSC created an extensive list of potential data elements and their respective sources that could be used to support performance measures based on state plan goals. PSC utilized the SMARTIE Method, making sure goals were specific, measurable, attainable, realistic, timely, inclusive, and equitable, to incorporate equity and inclusion.

State Plan Goals

- Goal one: Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations
- Goal two: Make aging in community truly possible for more Minnesotans
- Goal three: Support families, friends, and neighbors in sustaining their caregiving roles
- Goal four: Promote and support healthy aging for all Minnesotans
- Goal five: Dismantle ageism and promote older adult rights, autonomy, and protection

Performance Measures

Ten performance measures align to four of the State Plan on Aging's five stated goals. No measures are recommended for goal five due to a lack of currently existing data.

State Plan Goal	Measure Name	Unit of Measure
Goal one	1A. Individuals served in targeted populations	Percentage
Goal one	1B. AAA Advisory Committee representation	Count
Goal two	2A. Return to Community referrals that accept services	Percentage
Goal two	2B. Return to Community from a nursing facility	Count
Goal two	2C. Return to Community to remain in their community	Count
Goal three	3A. Caregivers served by Title III-E services	Count
Goal three	3B. Satisfaction of caregivers with caregiving services	Percentage
Goal three	3C. Outcomes of caregivers who complete caregiver survey	Percentage
Goal four	4A. Number of meals per person per month	Average
Goal four	4B. Persons served who are at high nutritional risk	Percentage

Performance Measure Specification Manual

PSC developed a measure specification manual during the performance measure development process. The measure specification manual provides the technical components of each measure for MBA staff to be able to generate the developed performance measures.

- Performance measure name
- Performance measure description
- Data source and elements
- Processes for measure construction
- Data quality considerations
- Targets and baseline
- Reporting frequency
- File date

Roadmap to Performance Measure Implementation

The recommendations provided are laid out as a roadmap to enable the MBA to continue working on the performance measures and take them from their current state to full implementation.

- Step one: Quality assurance and quality control
- Step two: Measure specification refinement
- Step three: Measure reporting
- Step four: Adoption and implementation
- Step five: Data warehousing

Introduction and Background

In January 2022, MBA engaged Public Sector Consultants to review the current data reporting environment in the state's aging network, investigate the use of national performance measures, and use that knowledge to develop performance measures to include in the MBA's upcoming federal fiscal year (FFY) 2024–2027 State Plan on Aging. MBA plans to use this information to support its staff and members in gaining a comprehensive view of information that is currently gathered and identifying how it can be used to measure the performance of the state's AAAs and the services they provide.

Performance measures can support resource allocation and other policy decisions to improve service delivery, program effectiveness, accountability, and equity of public services based on quantifiable data and empirical evidence. Performance measures can also help identify processes that are or are not working.

PSC's process involved reviewing Minnesota's aging network, scanning measures used in other states and at the federal level, speaking with groups of key partners in the effort, and identifying and mapping existing data sources within the network. These activities provided a foundation for developing an initial set of performance measures, which were then vetted and revised as needed.

In addition, PSC worked to adopt a common definition for performance measures to ensure a mutual understanding among partners involved in the measure development process. MBA used the following definition of performance measurement from the Administration for Community Living (ACL):

Performance measurement is the systematic measuring of a program's activities, outputs, and outcomes and their relationship to the agency's or program's objectives. (ACL 2020)

MBA staff and AAAs collaborated for the performance measure development process. PSC and MBA staff met regularly through biweekly project management meetings and monthly team meetings. During the monthly team meetings, MBA staff provided direction and feedback on the requirements and considerations for performance measures as they were created. Discussions regarding specific data elements and sources used in the development and application of performance measures gave MBA staff an opportunity to provide feedback on the proposed data elements and sources, identify specific challenges or limitations with the data as it is currently collected, and offer alternative data elements if needed. These conversations also provided PSC with detailed information that helped to generate and clarify performance measure names, descriptions, and calculations so that every component of the performance measure appropriately matched the data being used.

Once the measures were developed, PSC prepared specifications for each performance measure, generated the performance measures using real data, and held a final presentation webinar. The specification document is a companion to this report that the

MBA can operationalize and expand on each performance measure. The webinar clarified measure specifications and allowed partners an opportunity to ask questions.

This report concludes with recommendations made by AAAs and MBA staff for future measure development and enhancements.

The Aging Network in Minnesota

A fundamental understanding of the regulatory and funding structures that govern service provision is key to developing effective performance measures. The framework for the oversight and provision of aging services nationwide begins with the OAA, the sentinel legislation providing for the needs of older adults. The provisions of that legislation are handled by several federal and state agencies, including the U.S. Department of Health and Human Services (DHHS) and ACL, state units on aging, AAAs, and local aging services providers. It is helpful to understand how these various elements interact to appreciate the value of well-crafted performance measurements.

The Older Americans Act

OAA was signed into law in 1965 to provide comprehensive support services to older adults. It established authority for grants to states to deliver social and nutritional care to this population and their family caregivers through a national network of state agencies on aging, local AAAs, and tribal organizations. Subsequent reauthorizations of the act have promoted specific operational priorities aimed at improving the experience of participants and the effectiveness of service delivery (ACL 2021). As a primary source of funding for these vital services, the act provides a central source of guidance and regulation. It sets many of the governing rules with which the delivery of OAA Title III services must comply. OAA Title III services account for the largest portion of OAA funding, supporting a comprehensive national network of federal, state, and local agencies (ACL 2021).

Administration for Community Living

ACL was established in 2012 within DHHS to promote the principle that older adults and people with disabilities should be able to live where they choose and be able to participate fully in their communities. By funding services and supports and providing resources and guidance to agencies that provide these services, ACL is a primary source of information in the field.

Minnesota Board on Aging

MBA oversees over $25 million in funding allocated through the OAA, which is distributed among seven AAAs throughout the state to provide services to older Minnesotans. Every four years, the MBA submits a State Plan on Aging to ACL that outlines how it will spend OAA and related funding it receives to support older adults and caregiving family and friends. The State Plan on Aging provides the priorities and parameters for the area plans that are submitted by the AAAs to the MBA each calendar year. The area plans are discussed in greater detail further in this report. MBA, which serves as administrator, adviser, and advocate, then administers the State Plan on Aging, setting out goals and objectives for the aging network statewide.

Minnesota Area Agencies on Aging

There are seven AAAs, six of which serve geographical regions of the state, and the Minnesota Indian AAA, which serves four tribal reservations in the northern half of the

state. The AAAs are sources of services and information to older adults, their families and communities, and caregivers. The seven AAAs are:

- Arrowhead AAA
- Central Minnesota Council on Aging
- Dancing Sky AAA
- Metropolitan AAA (dba Trellis)
- Minnesota Indian AAA
- Minnesota River AAA
- Southeastern Minnesota AAA

AAAs create and submit annual area plans to MBA describing how they will use their funds to perform their roles in administration, access, development, and advocacy. Each agency submits utilization reports about their services throughout the year through multiple data reporting vehicles. MBA staff then analyze the information based on program and service requirements as part of their process to align the regional reports to the state report.

National Practices on Performance Measures

Lessons from Federal and National Partners

To understand how performance measures are developed and used, the project began by investigating materials already tested and available from many national and state partners. Notable among these sources is ACL's performance measure guidance published by their Office of Performance Evaluation in September 2020. This guidance provides valuable information on the elements and benefits of good performance evaluation, instructions on how to develop and evaluate effective measures, and resources and templates to accomplish the task.

PSC also looked to many of the materials made available by ADvancing States, a national association that supports system innovation and national policies that support LTSS for older adults and people with disabilities. Many of their papers, publications, conference presentations and materials and other resources have been pertinent to the work of this project. Additionally, their National Core Indicators – Aging and Disabilities initiative is a unique effort to develop standardized data to assess the outcomes of services in a host of states.

In July 2022, the CMS released their first set of quality measures for HCBS. This standardized set of quality measures for Medicaid-funded HCBS is intended to promote common and consistent measures, create opportunities for comparing data across states, improve quality of care and outcomes for persons receiving services, and support state efforts to promote equity within HCBS programs. The HCBS Quality Measure Set was reviewed for its possible applicability to the measures needed in Minnesota.

Lessons from Other States

In addition to the national sources of information on quality and performance measurement, PSC interviewed staff from selected states, that were recommended based on their work at the state level. Given the limited time frame of this project, it

was not feasible to attempt a comprehensive state-by-state review, so focus was given to Ohio and Michigan, two states with demonstrated success.

States vary widely in how aging services are organized, funded, and delivered. Approaches that are highly successful in another state do not necessarily translate well to Minnesotan circumstances and expectations. Therefore, the most important lessons gleaned in this research were from the conversations and materials obtained from Minnesota staff and organizations.

Ohio

In May 2022, representatives from the MBA and PSC met with staff from the Ohio Department of Aging to learn of their experience in developing and applying measures designed to evaluate their aging programs. The discussion provided insights into the process Ohio used to construct their Strategic Action Plan, which helped define the measurability of their State Plan. Topics included how to adequately define outputs and provide working definitions, special challenges the department faced in their process for developing performance measures, and their strategies to address equity considerations. Additionally, they mentioned an inclusive advisory committee was crucial to their work to garner necessary input and feedback on their measures.

Michigan

PSC reviewed the Michigan State Plan on Aging for Federal Fiscal Years 2021–2023, which is notable for the extensive efforts of the Aging and Adult Services Agency and Commission on Services to the Aging, to define and prioritize a succinct set of performance measures aimed at the agency and commission's four articulated goals. PSC's review found that the plan demonstrates the value of stakeholder input into the development process and proves the value of simplicity. Crafting measures that are on target and straightforward can greatly increase the chances that they will be successfully implemented.

Focused Conversations

An initial step in the process to develop measures was a set of focused conversations held with key partners. These sessions included meetings with representatives from AAAs and MBA staff. Prior to the focused conversations, PSC worked with the lead MBA project staff to identify factors that should be considered during the measure creation process. One theme that emerged from MBA staff was the desire for performance measures to help program staff determine how well services are being provided. They noted that performance is currently measured anecdotally, and at this time it is not possible to gain a consistent understanding of service delivery models, outputs and effective practices at the AAA level.

Generally, among focused conversation participants, there was strong consensus on the importance of developing performance measures with a specific goal. Staff did note that the development of robust performance measures over time would allow them to identify gaps in services and how well services are being delivered to older adults.

Conversation participants noted that most of the data currently collected represents inputs and outputs (e.g., number of clients served, number of volunteers, etc.), rather than demonstrating outcomes or impacts. For example, some staff mentioned wanting measures that focused on the cost per unit of services, but others suggested that measures related to the cost of services may have unintended consequences on service

delivery and quality. Overall, participants shared the desire to generate performance measures that would inform them of the impact of their work.

Data Mapping

MBA Staff Interviews

PSC met with MBA staff responsible for the data sources PSC reviewed. During these conversations, MBA staff provided PSC with demonstrations of existing data collection platforms and repositories, including PeerPlace, Grant Utility, SLL's client tracking system, and ACL's State Program Report.

The demonstrations allowed PSC to better understand the data MBA currently uses, from data collection through reporting, and created a visual, interactive learning opportunity that provided a complete overview of each data source. The demonstrations also helped:

- Identify and understand the full breadth of the data being collected, including data not in reports
- Identify potential data elements for performance measures
- Clearly define what each data point measures and its parameters
- Highlight potential data limitations
- Answer any questions about the data.

Based on the information gathered from the focused conversations and MBA interviews, PSC mapped existing data to provide a foundation for developing Minnesota-specific performance measures. PSC reviewed data and collection methods from AAAs and MBA staff to identify alignment between data that is currently being collected and the Minnesota State Plan on Aging goals. PSC used this information to develop a methodology for assessing each group's data and collection methods to provide a systematic review and identify and organize relevant information.

MBA staff supported this effort by providing a data resource spreadsheet that cataloged relevant data by:

- Program
- Platform where data is collected
- Data collected
- How data is reported
- Frequency of collection
- Staff who oversee data collection and reporting

MBA staff also provided PSC examples of data spreadsheets and relevant reports for each piece of data to better understand data collection and utilization.

AAA Area Plans

PSC also reviewed each of the 2022 AAA Area Plans on Aging to understand the roles of the AAAs, the services they provide, and the data they collect and report to the MBA. The plans relay a wide variety of information, including:

- Information on program development and coordination

- Population profiles and demographics, including targeted populations and services provided
- A summary of all services provided by or through the AAA, including indirectly through contracts with community partners
- Specific metrics identified by the AAA that relate to state plan goals and objectives and how they relate to each of the AAAs' service roles (i.e., administration, advocacy, access, and development)

An overview of the sources reviewed during the data mapping exercise is outlined in the table below.

Exhibit 2. Data Sources Reviewed

Data Source	Description	Data Owners
Area plans	Annual workplan and budget submitted by the AAAs to MBA that describe priorities and plans for their service area for the following calendar year	AAAs and MBA
Caregiver survey	Survey conducted annually for family, friend, and neighbors' caregiving that gathers information, including demographics, satisfaction with services and supports, and caregiver outcomes	Resource Development (RD) team
Client Tracking System	Data reporting system that tracks client- level data for anyone seeking or receiving information and assistance from the SLL	SLL
Grant Utility	Data reporting system that tracks funding expenditures for Title III programs and services	RD team
Peer Place	Data reporting system that tracks client- level data for those receiving services under Title III programming	RD team
State Program Report	Report ACL uses to monitor performance on OAA programs. Report provides annual data on program participants, services, and expenditures for Title III, VI, and VII programs	RD team
Trualta	Online platform that provides information, training, and resources for family and friend caregivers	RD team

With this catalog of data, PSC was able to create an extensive list of potential data elements and their respective sources that could be used to support performance measures based on state plan goals and objectives.

Performance Measures Development and Methodology

Performance measures are a concrete way to drive results, but without an explicit equity and inclusion component, measures will not produce better outcomes for marginalized communities or address disparities. By incorporating equity and inclusion into the SMARTIE methodology, MBA's commitment to equity and inclusion is anchored by tangible and actionable steps.

The SMARTIE acronym was used as a checklist for each measure:

- Specific: linked to a specific goal, e.g., the state plan goals
- Measurable: a quantifiable way to track progress or success
- Attainable: action oriented
- Realistic: benchmarks must be achievable
- Timely: appropriate deadline for achieving goal
- Inclusive: incorporates traditionally marginalized communities by stratifying measures
- Equitable: includes elements of fairness or justice that seek to address systematic justice, equity, and oppression

Performance measures developed during the initial phase will not meet all components of SMARTIE objectives; however, the checklist should be used as a final validity check for the performance measures in the future.

Alignment with State Plan Goals and AAA Roles

The process for developing performance measures was not a linear one. It required multiple strategies and iterations to develop the final framework and measures. One consistent aspect of measure development was the requirement to link the measures to the state plan goals. MBA also sought measures to monitor AAAs' success in carrying out their primary roles of administration, advocacy, access, and development.

State Plan Goals

MBA is currently in the process of finalizing their goals for the FFY 2024–2027 State Plan on Aging. At the time this report was written, the state plan goals were not yet finalized. Below are the drafted goals expected to be finalized in February 2023.

- Goal one: Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations
- Goal two: Make aging in community truly possible for more Minnesotans
- Goal three: Support families, friends, and neighbors in sustaining their caregiving roles
- Goal four: Promote and support healthy aging for all Minnesotans
- Goal five: Dismantle ageism and promote older adult rights, autonomy and protection

AAA Roles

The AAAs have four roles. Though it was not feasible during this initial phase to develop measures that would cover each of the roles, measures were developed for outputs from teams that work toward filling these AAA roles.

- Administration: Maximize quality and effectiveness AAAs create and maintain high-quality internal processes, standards and systems. AAAs achieve this through effective fiscal management, well-qualified staff, building strong partnerships, using data to strengthen services, and understanding the resources and needs in their planning and service areas.
- Advocacy: Promote policies that reflect the needs and interests of older Minnesotans. AAAs advocate for policies that fairly reflect the needs and interests of older Minnesotans to ensure that older people and their families are well served. AAAs provide one-to-one advocacy, systems advocacy, and policy advocacy. They engage in the legislative process, provide information and assistance to individuals, and draw attention to critical issues, especially by providing data on key trends.
- Access: Link people to information from AAAs to provide access to high-quality assistance for older adults, their families and caregivers, the organizations serving them, and their communities. This includes directly providing older adults and their families with the resources they need to make informed choices.
- Service development: Promote statewide availability of key community-level supports. AAAs promote local availability of core home and community-based services and supports. AAAs form partnerships and work to create sustainable, person-centered, and evidence-based systems and services to pursue these goals. AAAs promote local availability of core HCBS.

Recommended Performance Measures

PSC developed the following performance measures to measure outcomes of the drafted state plan goals and meet components of the SMARTIE criteria above. PSC also created specifications, which include data sources, data elements, etc., to operationalize the performance measures developed.

Specifications for each of the performance measures are in Appendix A.

Exhibit 3. Recommended Performance Measures by State Plan Goal

Goal one: Advance equity and address disparities, through empowering cultural and ethnic communities, and respecting the sovereignty of Tribal Nations

Measure Name	Measure Definition
1A. Individuals served in targeted populations	Percentage of individuals served in targeted populations as defined by OAA Section 206 compared to percent of total population

1B. AAA Advisory Committee representation	Individuals serving on the AAA Advisory Committee reflect the communities they serve

Goal two: Make aging in community truly possible for more Minnesotans

Measure Name	Measure Definition
2A. Return to Community referrals that accept services	Percentage of referrals to Return to Community that accept services
2B. Return to Community from a nursing facility	Number of persons Return to Community helps discharge from a nursing facility
2C. Return to Community to remain in their community	Number of persons currently living in the community and using Return to Community to remain in their community

Goal three: Support families, friends, and neighbors in sustaining their caregiving roles

Measure Name	Measure Definition
3A. Caregivers served by Title III-E services	Total number of caregivers served by Title III-E services
3B. Satisfaction of caregivers with caregiving services	The level of satisfaction of caregivers with caregiving supportive services that they have received
3C. Outcomes of caregivers who complete caregiver survey	Self-reported outcomes of caregivers who have received caregiving supportive services

Goal four: Promote and support healthy aging for all Minnesotans

Measure Name	Measure Definition
4A. Number of meals per person per month	Number of meals per person per month
4B. Persons served who are at high nutritional risk	Percentage of persons served who are at high nutritional risk

Key Staff Feedback

In November 2022, PSC presented the newly developed performance measures to MBA staff and the AAAs to offer them the opportunity to provide feedback. MBA staff prepared an FAQ to respond to AAA questions asked during the second round of focused conversations. The feedback document is included in Appendix C.

Recommended Next Steps

This report provides an overview of the process MBA and PSC took to develop the initial set of performance measures. The recommendations provided are laid out as a roadmap to enable MBA to continue working on the performance measures and take them from their current state to full implementation. Implementation of additional performance measures will provide MBA the ability to assess and evaluate their programs' performance. Additionally, fully implemented performance measures can be used to support MBA in decision making.

Roadmap to Performance Measure Implementation

- Step one: Quality assurance and quality control
- Step two: Measure specification refinement
- Step three: Measure reporting
- Step four: Adoption and implementation
- Step five: Data warehousing

Step One: Quality Assurance and Quality Control

MBA should establish a performance measure workgroup or leverage existing spaces to continue the work to strengthen and develop new performance measures.

Step Two: Measure Specification Refinement

The measure specifications must be recognized as a living document. As quality assurance and control get underway, the performance measures must be updated according to findings.

MBA staff should utilize the SMARTIE checklist to support the creation of inclusive and equitable measures while keeping measures relevant, applicable, focused, and quantifiable.

PSC provided a master specification template to support this process and recommends that MBA staff develop standard operating procedures and document how and when to update measure specifications.

Step Three: Measure Reporting

As measures are refined and finalized, MBA leadership must determine the best way to regularly report performance measures. For example, staff can generate a performance monitoring report or dashboard to share outcomes. A dashboard would require MBA to develop and maintain a user interface, while reports can be distributed through email and via the website. Both are appropriate means for reporting measure results. The benefits of the dashboards over reports are that they tend to have more capabilities in displaying, filtering, and sharing data. MBA should examine its capacity and determine which reporting method meets their needs. Once a reporting mechanism has been determined, staff training on system programming to generate and stratify measures will be essential.

Step Four: Adoption and Implementation

Once performance measures have been vetted, refined, and operationalized, MBA can utilize performance measure results to assist in decision-making processes. The performance measures will become a tool to help inform whether program objectives are being met and identify areas needing additional work. The measures will have limitations, as they are only able to provide information about certain components of the program and therefore should be applied with other information to make strategic decisions. Nonetheless, evaluating measure results in regularly scheduled decision-making meetings will support program goals and objectives.

Step Five: Data Warehousing

MBA staff will need to develop a plan to strengthen data collection processes and systems for generating current and future measures. This planning includes building a

data warehouse, which would integrate data from different systems into a single source, thus accelerating the process of generating measures by enabling the user to query any data needed. It also streamlines data availability through automated live feeds and can help decrease user error by reducing the need to manually transfer and use the data.

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