Minnesota Board on Aging
State Plan

Amendment for FFY 2010

July 1, 2009

Minnesota Board on Aging
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VERIFICATION OF INTENT

The Minnesota Board on Aging hereby submits its FFY 2010 Amendment to the State Plan on Aging for the State of Minnesota October 1, 2008 through September 30, 2012 as required under Title III of the Older Americans Act of 1965, as amended.

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

This State Plan Amendment, when approved by the Assistant Secretary on Aging, constitutes authorization to proceed with activities under the Plan.

__June 19, 2009___
Date

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Director, State Unit on Aging

__June 19, 2009___
Date

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Chair

Executive Summary

Minnesota has undertaken extensive efforts to rebalance its system of long-term care over the last several years in order to better meet the needs and preferences of current and future older adults. These efforts are guided by the principles and strategies developed by work of the Minnesota Long-Term Care Taskforce (legislative/executive branch - 2001) and strengthened through an interagency project: Transform 2010. Minnesota's goals for its long-term care system are to:

- Increase the proportion of individuals supported in the community and living as independently as possible;
- Decrease Minnesota's reliance on institutional services; and
- Increase the person-centeredness of the long-term care system.

The state has made progress toward all three of these goals. Between 1995 and 2005, the state reduced nursing home bed capacity by approximately 20%. And over 50% of older adults whose care is financed by public funds receive services in home and community-based settings. In order to continue rebalancing the long-term care system, the state is implementing a three-pronged strategy: 1) redirect public funds from institutional to community care; 2) offer more options and assistance at initiation of long-term care decision-making; and 3) expand home and community-based services capacity – and, in particular, consumer-directed service capacity.

Redirect Public Funds from Institutional to Community Care

Between 2000 and 2005, public spending for nursing home services decreased from 87.7% to 79.5% of total long-term care spending, and home and community-based services increased from 12.3% to 20.5%. In State Fiscal Year 2005, $868 million was spent through Minnesota's Medicaid Program (Medical Assistance) for nursing home care in Minnesota and $224 million for home and community-based services. In addition, we improved the linkages between health care and the community support system for persons with chronic illnesses. This occurred primarily as a result of the Elderly Waiver program shifting into managed care.

Offer More Options and Assistance at Initiation of Long-Term Care Decision-Making

Minnesota's Aging and Disability Resource Center (ADRC) program, called MinnesotaHelp Network, has focused on developing a streamlined access network through which consumers of all ages can access community services. Service information and access assistance is available through a "first contact" model of service delivery that is provided through the AAAs, under MBA supervision.

Expand Home and Community-Based Services Capacity

Targeted strategies to expand home and community-based services include OAA-funded initiatives implemented with the Area Agencies on Aging. In addition, the Community Service/Services Development (CS/SD) state grant program provides funds to develop new capacity within the home and community-based service system, and to help existing service providers redesign services to make them more cost-effective and fiscally sustainable into the future. The state's Eldercare Development Partnership program (EDPs), comprised primarily of partnerships with

Area Agencies on Aging, provides targeted technical assistance to counties, local communities and service providers. In addition, the Alternative Care (AC), Elderly Waiver (EW) and Medical Assistance (MA) programs offer in-home services to eligible individuals, including consumer-directed options.

Role of the Minnesota Board on Aging

The State Plan on Aging articulates the role of the Minnesota Board on Aging (MBA) as a partner with other state agencies within the larger, publicly-funded system of services and programs for older persons. With this State Plan, the MBA strengthens its commitment to target those older adults (and their family caregivers) who are not yet eligible for the Alternative Care program but who are at high risk of falling into the public safety net. These individuals may still be living in their own homes or in assisted living. The following Goals, Objectives and Strategies outline the steps that we will take to support this target population and enable them to maintain their independence while receiving assistance in the ways that they prefer.

Goal 1: Empower older adults and their families to make informed decisions about, and be able to easily access, home and community-based services.

Objectives

1. Expand the Aging and Disability Resource Center (ADRC) program, known as the MinnesotaHelp Network, statewide.
2. Increase capacity of MinnesotaHelp Network tools, including MinnesotaHelp.info, to support decision-making by older adults and family caregivers.
3. Expand capacity of the Aging Network to provide in-person assistance to older adults and family caregivers regarding long-term care options and resources.

Goal 2: Enable older adults and family caregivers to sustain their community living by accessing flexible, affordable and effective services.

Objectives

1. Expand collaborations among aging services, health care, faith-based and other strategic partners to identify high risk older adults and family caregivers. Strengthen referrals to in-person assistance and to modernized interventions.
2. Explore and test provision of modernized flexible, affordable and effective interventions to targeted high risk older adults and family caregivers.
3. Increase capacity to deliver flexible, affordable and effective interventions, including consumer-directed care options.

Goal 3: Empower older adults and family caregivers to manage their own health risks.

Objectives

1. Expand collaborations among aging services, health care and other strategic partners to identify high risk older adults and family caregivers. Strengthen referrals to evidence-based interventions.

2. Increase dissemination of evidence-based health promotion and disease management programs.
3. Facilitate second phase of the Senior Nutrition Task Force, as directed by the Minnesota Board on Aging in March 2009. Focus Task Force efforts on identifying new models to reach the OAA target populations.
4. Promote the use of preventive benefits available under Medicare, especially for older adults with low incomes. Coordinate with Nursing Home Diversion Project to encourage high risk older adults to maximize their preventive benefits.
5. Advocate for older adult access to improved modes of health care as mainstream health care system reform progresses in Minnesota.

Goal 4: Ensure the rights of older adults and prevent their abuse, neglect and exploitation.

Objectives

1. Expand the capacity of Long-Term Care Ombudsmen and Adult Protection to meet the needs of older adults who are increasingly choosing home and community-based service options.
2. Increase access to elder rights support and advocacy through the MinnesotaHelp Network.
3. Enhance the adult protection data system and quality infrastructure.
4. Disseminate legal education and resources to grandparent and other relative caregivers.

Goal 5: Prepare Minnesota for the aging of the population.

Objectives

1. Raise awareness of population aging and its implications for all sectors.
2. Improve the ability of Minnesota's communities to support older adults.
3. Strengthen volunteer and faith-based community programs that provide incentives for mutual support.
4. Support business and community efforts that encourage older adults to continue working in both paid and volunteer roles.
5. Expand capacity for transit alternatives through coordination with state and local transportation agencies.
6. Partner with higher education to recruit, train and maintain a larger cadre of geriatric-trained health care staff, including new types of professionals to better meet the long-term and chronic health care needs of the future.
7. Ensure inclusion of the needs of older adults in the development and implementation of emergency preparedness plans.

Context

Demographic Trends and Need for Long-Term Care

A. Demographic Changes

The older adult population in Minnesota is expected to grow by about 14% between now and 2010, while the under 65 population will grow about 10%. Then, beginning in 2011, the first wave of boomers, born between 1946 and 1964, begins to turn 65. From then and for the next 30 years, this cohort dominates the state's growth. Between 2010 and 2020, the population 65+ will grow by 40% while the under-65 population will increase by about 4%. Between 2020 and 2030, the comparable figures are 36% growth in the older group and less than one percent for the younger group.

Today's elderly are, in general, healthier than their age peers just a generation ago. However, among persons age 85 and older the prevalence of chronic illnesses (and rates of disability) rise significantly.[1] Between 1990 and 2000, this group grew by about 25%, from 69,000 to 86,000. The number of persons over age 90 grew even faster, increasing by 28%. The 85+ group will have increased by another 25% by 2010; another 14% between 2010 and 2020; 34% between 2020 and 2030; and 58% between 2030 and 2040. By 2060, the overall numbers decline slightly because nearly all the baby boom generation will have died, and the next generation will not be as large. However, an older society will be a permanent fixture of the state's demographic profile into the foreseeable future.

B. Need for Long-Term Care

The current and forecast demand for long-term care in Minnesota is tied to both the demographic projections and disability rates. The older at–risk population (age 85+) is projected to continue to increase, more slowly through 2020, and then quite rapidly for the next two decades. At the same time, age-specific disability rates in the United States have been decreasing at the rate of 1% or more per year for the past several decades, partly due to generally improved public health standards during this cohort's early years (1920s and 30s), and partly due to advances in health and medical care widely utilized by older people.

Most current older adults want to stay in their own homes and apartments as long as possible, either with no help, with help from family or with hired help. In 2005, one of the greatest expressed concerns of older Minnesotans was that they might one day have to live in a nursing home. Fully 67% of persons aged 65 and older voiced this as a major concern for their future.[2] Surveys also show that subsequent cohorts of older Minnesotans have higher levels of education and higher per capita and household incomes, and they are expecting and demanding more choice and control over their long-term care. This trend is expected to accelerate as baby boomers, the

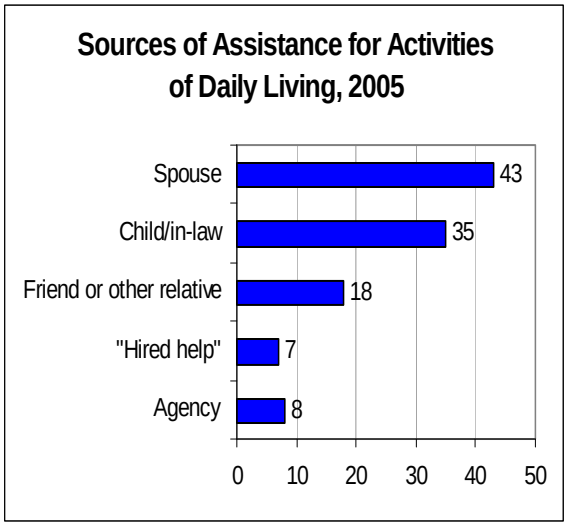
[1] He *et al* (2005) *65+ in the United States: Current Population Reports,* National Institute on Aging.
[2] Survey of Older Minnesotans, 2005 -- http://www.mnaging.org/advisor/survey.htm.

first real “consumer” generation, grow old and need care. The beginnings of this trend are already evident in the changing market for long-term care services and supports.

B. Provision of Family and “Informal” Care

Family members—mostly spouses and daughters and daughters-in-law—continue to provide the vast majority of help to older persons who need assistance with daily activities, although there have been some significant changes in the patterns of family help over the past 20 years. Through the Survey of Older Minnesotans, the state has been able to monitor the sources of help provided to older persons who require assistance on a daily basis. A standardized set of questions are used to identify need for long-term care (the Activities of Daily Living [ADL]) which includes eating, bathing, dressing, transferring (i.e., from bed to chair) and using the toilet. Among persons aged 60 and older who are living in their own homes and apartments in the community, about 2% need help from another person with one or more of these activities.

The primary sources of personal assistance–for those who need daily assistance with basic activities—continue to be family (spouse and /or child) and friends or other relatives. While the role of family members in providing basic long-term care is becoming more widely recognized, the significant role of neighbors and friends has been largely overlooked.



Over the past 10 years there has been a significant increase in the purchase of “hired help” -- whether hired by the older person or their family member -- to supplement the family’s ability to meet care needs. At the same time, there has been a decrease in the role of children and children-in-law (primarily daughters and daughters-in-law). In 1995, over 50% of persons receiving personal assistance for ADLs mentioned help from a child or child-in-law. That percentage had declined to 35% in 2005.

In the future, the number of older persons who live alone is projected to increase. Given current trends, there will be fewer elderly persons living with a spouse who can provide needed care, and the number of “children” available to help future cohorts of elderly will also decrease because of the trend toward fewer children per household – down from 3.2 children per household for today’s elderly to 1.9 children for the Boomer cohort (18% of whom are childless).

Many older Minnesotans who need long-term care also need help with regular household chores such as home maintenance, snow shoveling/yard care and other activities that are also necessary to maintain one's independence in the community. Based on the Survey of Older Minnesotans, the proportion of older persons (and their caregivers) who purchased these services has increased over the past two decades—from about 4% in 1988 to 27% in 2005—partly to meet long-term care needs and partly attributable to lifestyle changes in this "new" elderly cohort.

Rebalancing the Long-Term Care System

Minnesota has undertaken extensive efforts to rebalance its system of long-term care over the last several years in order to better meet the needs and preferences of current and future older adults. These efforts are guided by the principles and strategies developed by the 2001 Long-Term Care Taskforce (legislative/executive branch) and strengthened through Transform 2010. Transform 2010 is a cross-sector initiative to prepare Minnesota for the coming age wave of baby boomers and a permanent shift in the aging of the state's population. The Minnesota Board on Aging partnered with the Departments of Health and Human Services to launch Transform 2010 in 2006. Last year, the Transform 2010 Blueprint for Action was released. The Blueprint includes several strategies that the state and its partners will need to undertake to prepare the state, and specifically the long-term care system, for the changing population of older adults into the future.

Minnesota's goals for its long-term care system are to:

- Increase the proportion of individuals supported in the community and living as independently as possible;
- Decrease Minnesota's reliance on institutional services; and
- Increase the person-centeredness of the long-term care system.

The state has made progress toward all three of these goals. In Minnesota, consumer-directed service options now exist under programs funded by Medical Assistance (Minnesota's Medicaid program - MA), Older Americans Act Title III, the Alzheimer's Disease Demonstration Grant and state funds. Between 1995 and 2005, the state reduced nursing home bed capacity by approximately 20%. In 2005, 51% of older adults whose care was financed by public funds received services in home and community-based settings. In order to continue rebalancing the long-term care system, the state is implementing a three-pronged strategy: 1) redirect public funds from institutional to community care; 2) offer more options and assistance at initiation of long-term care decision-making; and 3) expand home and community-based services capacity – and, in particular, consumer-directed service capacity.

A. Redirect Public Funds from Institutional to Community Care

Between 2000 and 2005, public spending for nursing home services decreased from 87.7% to 79.5% of total long-term care spending, and home and community-based services increased from 12.3% to 20.5%. In State Fiscal Year 2005, $868 million was spent through the MA program for nursing home care in Minnesota and $224 million for home and community-based services.

B. Offer More Options and Assistance at Initiation of Long-Term Care Decision-Making

Minnesota's Aging and Disability Resource Center (ADRC) program, called MinnesotaHelp Network, has focused on developing a streamlined access network through which consumers of all ages can access community services. Through this network, older adults and family caregivers can access services funded through the Older Americans Act programs, Alternative Care (AC), and Elderly Waiver programs. Service information and access assistance is available through a "first contact" model of service delivery that is provided through the Area Agencies on Aging, under the supervision of the MBA. This is one of the three main roles of the AAAs in Minnesota, the other two being administration of direct service contracts and program development and coordination.

The first contact can be made through the toll-free numbers (the Senior and Disability Linkage Lines), the www.MinnesotaHelp.info website (which includes the *Long-Term Care Choices* decision support tool described below), or via in-person assistance through MN's Long-Term Care Consultation (LTCC) program. A primary strategy of the MinnesotaHelp Network is to create and implement a network of access points and outreach sites that utilize a common set of tools, including the web-based Long-Term Care Choices tool.

C. Expand Home and Community-Based Services Capacity.

Responding to a legislative requirement in 2001, all counties and Area Agencies on Aging (AAAs) in Minnesota reviewed the local capacity to meet the long-term care needs of current residents, and reported on any significant "gaps" in services or supports. Subsequent surveys in 2003 and 2005 followed roughly the same format. The table below shows the types of services that were ranked as significantly not available to meet the needs of frail elderly in 2001, 2003 and 2005.

2001 Survey 87 counties responding			2003 Survey 72 counties responding			2005 Survey 76 counties responding		
Type of service	**Rank**	**% of counties**	**Type of service**	**Rank**	**% of counties**	**Type of Service**	**Rank**	**% of counties**
Transportation	1	66	Transportation	1	42	Transportation	1	55
Respite/ Companion	2	57	Respite/ Companion	3	22	Respite/ Companion	5	42
Chore Service	3	48	Chore Service	2	28	Chore Service	3.5	47
LTCC for Relocation	4	39			**			**
Information and Assistance	5	25			**			**
			Adult Day Service	4.5	21	Adult Day Service	3.5	47
			Home Delivered Meals	4.5	21			
						Evening and Week-end Care	2	50

The highest priority "service gap" in the three successive surveys was **transportation** for frail, at-risk elderly. The next two are also consistent across all three surveys: **chore service**, such as snow shoveling and the kinds of physical chores most needed by persons who live alone in their own homes, and **respite/companionship,** to step in when family caregivers are not available or companion service for persons who live alone or have no available family.

It should also be noted that over the past five years there has been a significant increase in counties' ranking of the need for support services for families and informal caregivers. In 2005, the need for **respite/companion**, **adult day service** and **evening/week-end care** all ranked among the top five, and all three are services that support an older person's family caregivers. This highlights a growing need for effective strategies to sustain and strengthen the family and informal supports.

Targeted Strategies to Increase Home- and Community-Based Services

One of the reasons that there has been significant growth in local service capacity is because of the state and OAA-funded programs put in place to promote this development. The Area Agencies on Aging have played a critical role by using OAA funds to fill gaps in local service capacity. The Community Service/Services Development (CS/SD) state grant program was established in 2001 as an outcome of the Long-Term Care Taskforce. It provides funds to develop new capacity within the home and community-based service system, and to help existing service providers redesign services to make them more cost-effective and fiscally sustainable into the future. To date, over $40 million in grant funds have been awarded to 225 CS/SD projects in 87 counties across Minnesota. These projects have served more than 170,000 persons, developed or renovated 1,000 units of affordable housing, and increased the number of volunteers providing services by more than 39,000.

The state's Eldercare Development Partnership program (EDPs), comprised primarily of partnerships with Area Agencies on Aging, provides targeted technical assistance to counties, local communities and service providers. Through EDP technical assistance new services are created and existing services are redesigned to improve quality and sustainability. The local communities generally need assistance in two areas:

- Best practices for most effective use of existing public (and private) resources to meet emerging needs and priorities in a changing market, and
- Assistance in making needed changes—whether "business planning" expertise, convening and developing new partnerships, or direction toward state CS/SD or other grant sources.

Many of the agencies that provide these services are funded through the Minnesota Board on Aging and its network of Area Agencies on Aging (AAAs) using the federal Older Americans Act and related state funds. The AAAs are authorized by law to perform three roles that operationalize the AoA Choices for Independence initiative. These three roles are: 1) information and assistance service through the MinnesotaHelp Network, 2) administration of direct service contracts to fill critical gaps in the home and community-based service system, and 3) program development and coordination in order to establish a comprehensive and coordinated system of services for older adults and family caregivers. Nearly 316,000 older persons (unduplicated count) were served through AAA-funded programs in FFY 2007. And while these services are targeted to persons who are not eligible for other public programs, 22% of recipients had incomes below federal poverty level guidelines.

Publicly Funded Entitlement (and Low-Income) Programs

As the preference of older people for home and community-based services (HCBS) has grown, so too has the utilization of home and community-based services within other publicly funded programs. These services include those provided through the Elderly Waiver (EW), Alternative Care (AC) and Medical Assistance (MA) home care programs.

The EW program funds home and community-based services for people age 65 and older who are eligible for MA, require the level of care provided in a nursing home, and choose to reside in the community. The MN Department of Human Services (DHS) operates EW under a federal waiver to MN's MA State Plan. Lead agencies (counties, tribes and managed care organizations (MCOs)) administer the EW program. In fiscal year 2006, EW served 20,024 persons for $178 million. The average monthly cost per enrollee was $979, based upon an average monthly client population of 15,148.

The state-funded AC program was established in 1981 as a nursing home diversion program for individuals who are not financially eligible for MA but who require nursing facility level of care and need services or supports in order to remain in the community. The program pays for in-home care and community-based services for older adults who are at risk of spending down to MA eligibility

within 135 days of nursing home admission. AC participants contribute up to 30 percent of the cost of their home and community-based services, with some exemptions for very low income participants or those who opt for the consumer-directed services option. In fiscal year 2006, AC served 6,158 people and spent a total of $43.5 million. The average monthly cost per enrollee was $834, based upon an average monthly client population of 3,949.

Consumer-Directed Service Options

MN has developed a number of consumer-directed service options for all ages, and older adults are increasingly using the consumer-directed option under EW and AC. In 2004, MN was awarded a Robert Wood Johnson Foundation (RWJF) Cash and Counseling grant to bolster enrollment by older adults in consumer-directed options. MN was also one of two states awarded an innovation grant to support consumer direction under Older Americans Act (OAA)-funded services, and to fill gaps not addressed by traditional respite options. These grant funds were used to support the Aging Network's development of consumer-directed respite options under Title III-E. The greatest success with this model has been in rural areas, in tribal communities, and with traditional III-E providers who offer this option along with a range of caregiver supports.

In 2006, MN launched a statewide effort to increase consumer choice and direction in its OAA-funded nutrition program. Models developed include vouchers for culturally specific meals, bundled service packages that include two weeks of frozen meals for rural isolated older adults, and individualized meal planning, assessment and counseling for individuals with serious medical conditions upon hospital discharge.

Role of the Minnesota Board on Aging

The Minnesota Board on Aging (MBA) is the designated State Unit on Aging for Minnesota. The MBA administers more than $17.8 million in Older Americans Act Title III funds and an additional $6.8 million in state funds annually. The Older Americans Act stipulates that the MBA designate a statewide network of multi-county Area Agencies on Aging (AAAs). These local AAAs leverage an additional $16.9 million in local dollars and resources, ensure local input and accountability for service funding and promote local innovation in problem-solving. The Minnesota Chippewa Tribe Area Agency on Aging administers Older Americans Act Title III and Title VI funds to deliver services to tribal elders in the northern half of the state. In addition, the MBA has oversight responsibilities for the Office of Ombudsman for Long-Term Care. This program provides direct, one-to-one advocacy and problem-solving for nursing home residents, older persons receiving services in the community and their families.

The **mission** of the Minnesota Board on Aging is to *ensure that older Minnesotans and their families are effectively served by state and local policies and programs -- in order to age well and live well.*

In its advocacy role, the MBA promotes policies to the State Legislature, the Governor and State Agencies that fairly reflect the needs and interests of older Minnesotans. In its advisory role, the MBA provides objective information and promotes public education on ways to meet the changing needs of Minnesota's older population to age well and live well. In its administrator role, the MBA partners with the Area Agencies on Aging and others to oversee the effective use of Older Americans Act and state funds to support older Minnesotans.

Strategic Directions for Minnesota's Aging Network

The MBA State Plan articulates the role of the MBA as a partner with other state agencies within the larger, publicly-funded system of services and programs for older persons. The goals, strategies and outcomes in this plan, therefore, represent both the federal expectations for the MBA's work as the designated State Unit on Aging as well as state priorities and issues identified through the input provided by the Area Agencies on Aging, their local partners, older adults and family caregivers.

A. Transform 2010: Preparing Minnesota for the Age Wave

The Minnesota Board on Aging partnered with the Minnesota Department of Human Services, 14 other state agencies, and numerous public and private organizations to host community forums around the state. The forums were held to gather input on the resulting 2010 Blueprint for Action. Over 1,000 citizens from around the state participated in the forum. The Blueprint for Action strategies identified under each theme below relate specifically to the unique role of the Minnesota Board on Aging, the Area Agencies on Aging and our local aging service partners in operationalizing the Transform 2010 vision.

Redefining Work and Retirement**:** Minnesotans will work, "retire," and volunteer, and contribute to the state's economic vitality and quality of life.

- Engage Minnesotans in vital aging opportunities as they age.
- Encourage individuals to plan and "self-invest" in financial planning for a lifetime.
- Expand the options available to individuals to pay for long-term care costs.

Supporting Caregivers of All Ages: Caregivers of all ages and for all ages will get the support they need to provide care to family members, friends and neighbors.

- Transform Minnesota's workplaces into "eldercare friendly" environments for workers who are also caregivers.
- Increase supply and types of caregiver supports as well as public awareness of the services that help caregivers.
- Activate the networks of neighbors and faith communities to support individuals who do not have family or other social support.
- Create web-based tools to provide caregivers with planning and purchasing options.
- Ensure that grandparents raising grandchildren have access to existing programs intended to help families with children.

Fostering Communities for a Lifetime**:** All of Minnesota's communities will be vital and supportive environments for their residents of all ages.

- Foster social connections that build "community" among residents and nurture a sense of responsibility across generations.
- Expand range of products and services that help residents stay engaged and independent as they age.
- Support assessment and planning efforts to develop healthy communities for a lifetime.
- Establish Aging and Disability Resource Center outreach sites and access points in critical pathways through Minnesota communities.

Improving Health and Long-Term Care: All Minnesotans will lead healthy lives, and have access to an integrated health and long-term care system that is consumer-centered, affordable and provides effective chronic care management.

- Transform long-term care to increase consumer control over the where, who and how of service provision.
- Provide individuals with the information they need to make good decisions about lifestyle and health habits.
- Develop and demonstrate new models of good chronic care to serve Minnesota's Medicare population.
- Incorporate consumer feedback into all quality improvement efforts in health and long-term care.
- Strengthen Minnesota's adult protection and advocacy systems to serve a doubling in numbers of frail elders in the future.

Maximizing Use of Technology: Technology will be utilized to transform systems, provide more efficient services, and improve the quality of life for individuals and society as they age.

- Expand knowledge about and use of technology that helps people help themselves, e.g., home modifications, assistive devices, safety systems.
- Utilize information technology, e.g., the internet, to expand access to information about resources for consumers and families.

In January and February 2008, the MBA held public hearings in 14 communities across the state to elicit public comment regarding the state's Planning and Services Areas, and any changes needed to better meet the needs of older Minnesotans. Over 150 people attended the hearings. The participants indicated that the changes to the PSA structure in 2005 have led to more coordination and less duplication among service providers. However, they also noted challenges related to delivering services to a growing number of older adults living in increasingly rural areas with fixed levels of funding. Additional challenges noted at the forums include the quest for sustainability, the difficulty in targeting and serving the hard to reach populations, and the difficulty in making changes to programs and systems even though there is consensus that changes are needed.

Every quarter, the MBA receives quantitative and narrative reports from the AAAs regarding their program development activities. These reports provide a statewide picture of the status of long-term care systems change efforts and the needs of older Minnesotans. In 2007, the AAAs documented their efforts to expand consumer directed and consumer choice models in the caregiver support and nutrition programs. The AAAs also reported providing technical assistance to over 450 community organizations regarding the development of Communities for a Lifetime. These efforts involved collecting input from local residents, assessing the livability of the community as it relates to supporting aging in place, and developing plans to increase the livability of the community. Through these efforts, the AAAs are able to gather a great deal of input and ideas from communities in their region regarding the current status of the long-term care system and ways to improve in-home and community-based supports.

In January and March 2008, the MBA and AAAs held two retreats to jointly develop the new Area Plan and State Plan Outcomes. The Area Agencies on Aging based their input in the retreats on the feedback and input they have received from their subcontractors, other local partners, and the consumers that they serve. These joint planning sessions identified specific challenges associated with implementing the outcomes as well as opportunities for coordinating across state programs and between state and AAA staff.

A significant focus of the retreats was the role of the Aging Network in Minnesota's long-term care system into the future. Participants agreed that the Aging Network needs to use Title III and related state funds in the most strategic way possible in order to have an impact on the overall system and to produce significant outcomes for the people that we serve. As a result, the Board on Aging has strengthened its commitment to target those older adults (and their family caregivers) whose income and resources make them ineligible for entitlement programs or other significant public assistance (Alternative Care) but who are at high risk of falling into the safety net. These individuals may still be living in their own homes or in assisted living. We may know them as a result of providing initial services to them, such as home delivered meals, chore or transportation. Or we may know of them through our community partners in the health care, financial planning or other sectors. The following Goals, Objectives and Strategies outline the steps that we will take to support this target population and enable them to maintain their independence while receiving assistance in the ways that they prefer.

Goal 1: Empower older adults and their families to make informed decisions about, and be able to easily access, home and community-based services.

Federal and state policies stress the importance of accurate and timely information made available to help older persons and their families (as well as all persons with disabilities) to know their choices and options in regards to community services and supports. The Senior LinkAge Line®, www.MinnesotaHelp.info®, and the suite of MinnesotaHelp Network information

tools are critical to helping Minnesotans understand and utilize services and resources. Information should also be available to help people to prepare in advance for their own aging and retirement, to understand tools for using their own resources (e.g., reverse mortgages) and to find solutions for problems that are unanticipated.

As part of the MinnesotaHelp Network, Minnesota's Area Agencies on Aging will expand and improve the Senior LinkAge Line® information and assistance service by making the service accessible, high quality, unbiased, accurate, comprehensive and available in order to meet the demands in each Planning and Service Area. The Area Agencies on Aging are also committed to growing their capacity to provide in-person assistance to older adults and family caregivers regarding their long-term care options and resources. Community partners, such as libraries, banks, stores, and others, can be important sources of connection to the MinnesotaHelp Network of tools and resources. These tools and resources can assist older adults and family caregivers make decisions regarding long-term care. Timely access to the MinnesotaHelp Network is especially critical for those older adults at risk of nursing home placement and thus are a particular focus of these efforts.

Objectives

1. Expand the Aging and Disability Resource Center (ADRC) program, known as the MinnesotaHelp Network, statewide.
   Strategies
   - Develop new MinnesotaHelp Network access and outreach sites in each Area Agency on Aging region with partners that include counties, hospital discharge planners, health care system providers, Centers for Independent Living, Disability Linkage Line, and clinics.
   - Develop new or expanded partnerships with community entities, including libraries, banks, stores, etc. to engage them as "connectors" to the MinnesotaHelp Network.
   - Develop new or expanded collaborations with health care providers and other strategic partners as power users of MinnesotaHelp Network tools.

   Measure
   - In each AAA region, development and maintenance of five MinnesotaHelp Network access and outreach sites. Status updates reported in extranet ADRC outreach tool.

2. Increase capacity of MinnesotaHelp Network tools, including MinnesotaHelp.info, to support decision-making by older adults and family caregivers.
   Strategies
   - Collaborate with Minnesota's Long-Term Care Partnership Program to provide tools to help individuals plan ahead for their long-term care needs.

- Incorporate new technologies to provide consumers with a range of tools to help them make informed decisions, such as a Live Chat feature added to MinnesotaHelp.info.

Measures

- Number of presentations conducted regarding Partnership Program that include information on how to access MinnesotaHelp Network tools.
- Date at which Live Chat becomes operational on MinnesotaHelp.info.

3. Expand capacity of the Aging Network to provide in-person assistance to older adults and family caregivers regarding long-term care options and resources.

Strategies

- Strengthen capacity of LinkAge Line staff to conduct long-term care options counseling.
- Develop capacity to provide support planner function (including uniform targeted risk management and service plan implementation) to targeted high risk older adults and family caregivers. Test alternative methods of providing this service, including different roles for the Area Agencies on Aging, through the Nursing Home Diversion Grant.
- Continue to provide evidence-based caregiver coach training to aging service providers who work directly with family caregivers, with a particular emphasis on reaching providers who work in very rural areas.

Measures

- Number of LinkAge Line staff participating in long-term care options counseling training.
- Status of development efforts to provide support planner function included in AAA quarterly narrative reports.
- Number of aging service provider staff participating in caregiver coach training.

Goal 2: Enable older adults and family caregivers to sustain their community living by accessing flexible, affordable and effective services.

Current service models and spending patterns are not sustainable with the aging of the population. Older adults and family caregivers must be empowered to make informed decisions and to better conserve and extend their own resources using in-home options, including those that are consumer-directed, for support in the community. Minnesota's Aging Network is well-positioned to provide flexible, affordable and effective services to older adults and family caregivers who are at-risk for nursing home placement and Medicaid spenddown.

Objectives

1. Expand collaborations with aging services, health care, faith-based and other strategic partners to identify high risk older adults and family caregivers. Strengthen referrals to in-person assistance and to flexible, affordable, effective interventions.

Strategies

- Test high risk triage tool with strategic partners, through the Nursing Home Diversion Grant.
- Through the Nursing Home Diversion Grant, track referral processes and patterns to identify the most effective ways to connect high risk people with the services that they need.
- Through the Alzheimer's Demonstration Grant, continue to build community and medical system care delivery mechanisms tracking outcomes demonstrating the impact on caregivers, care receivers, physicians/clinics and community service providers.

Measure

- Include status of development efforts, including persons served and engaged partners, in semi-annual and annual progress reports to AoA.

2. Explore and test provision of modernized flexible, affordable and effective interventions to targeted high risk older adults and family caregivers.

Strategies

- Continue to develop models of consumer-directed services in the nutrition and caregiver support programs. Track implementation efforts and outcomes, share learnings statewide.
- Through the Nursing Home Diversion Grant, test models of diversion support services that focus on in-person assistance as well as those that focus on innovative in-home service packages.

Measures

- Include update on status of development efforts in AAA quarterly narrative reports.
- Track Nursing Home Diversion Grant effort through progress reports to AoA.

3. Increase capacity to deliver flexible, affordable and effective interventions, including consumer directed care options.

Strategies

- Support Area Agency on Aging efforts to develop capacity and processes to leverage funding sources other than Title III (private pay, fee for service, third party payors) to provide modernized interventions, including but not limited to consumer-directed options.

Measures

- Number of trainings conducted, and AAA staff participating, regarding consumer direction and other new business models.
- Date at which online sustainability training modules for aging services providers is available. Number of individuals accessing the modules. Number of trainings conducted by AAA development staff using the modules.

Goal 3: Empower older adults and family caregivers to manage their own health risks.

Disability rates and health problems may be on the rise as the population ages. Close to 80% of persons over age 65 have one or more chronic conditions and 65% have multiple chronic conditions. Health care costs rise exponentially with the number of chronic conditions, especially if one is dementia. While many

chronic conditions cannot be cured or eliminated, many of the risk factors associated with chronic conditions can be ameliorated through community-based interventions to improve diet and encourage exercise. Falls also pose significant health concerns for older adults, 30% of whom fall each year. Older adults' risk for falls can be reduced through evidence-based interventions that also address chronic conditions. The Aging Network provides the statewide infrastructure to deliver evidence-based interventions to older adults and family caregivers that will reduce health and long-term care costs.

Objectives

1. Expand collaborations with aging services, health care, and other strategic partners to identify high risk older adults and family caregivers. Strengthen referrals to evidence-based interventions.

   Strategies

   - Continue to implement the Minnesota Memory Care Initiative, with particular focus on the development of physician champions, clinic capacity and early identification and referral to appropriate services. Continue to gather learnings from these efforts to inform broader systems change efforts.
   - Expand the Minnesota Falls Prevention Initiative to new partners who can implement the quick screening and assessment processes outlined in the American Geriatrics Society guidelines. Continue to support quality improvement efforts of the statewide associations of home care agencies and hospitals.
   - Continue implementation of the professional training plan to support and guide these efforts. Emphasize referral processes for health care providers to connect patients to falls prevention interventions, including evidence-based programs.
   - Develop healthy aging website that will provide information about evidence-based interventions and an up-to-date listing of class locations (that we ensure are maintaining fidelity to original models) to serve as a quick reference for community partners. Work directly with the health plans, with a focus on the diverse population of dual eligibles, to implement referral processes to these programs.

   Measures

   - Status of development efforts included in AAA quarterly narrative reports.
   - Number of communications to professionals regarding falls prevention guidelines. Number of professionals reached with communications. Track health care professionals as a sub-set.
   - Results of follow-up surveys to health care and other professionals regarding falls prevention activities.
   - Date at which healthy aging website goes live. Number of hits. Number of program referrals that originate from website.

2. Increase dissemination of evidence-based health promotion and disease management programs.

   Strategies

   - Through the Evidence-Based Disease Prevention Grant, continue to disseminate EnhanceFitness, Matter of Balance and the Chronic Disease Self-Management Programs in the three targeted regions, under the leadership of the Area Agencies on Aging. Provide in-state master trainings for each program for interested partners statewide.
   - Coordinate dissemination and sustainability of Matter of Balance, under the leadership of the MN Chippewa Tribe AAA, and the Wisdom Steps preventive health program that is supported by all of the tribes.
   - Through a grant from USDA Extension, support dissemination of the Healthy Eating for Successful Living program, with a particular focus on rural areas.
   - Through a grant from CDC, continue dissemination of the Arthritis Exercise Programs and the Arthritis Self-Management Program. Support broad implementation of these programs through three targeted senior housing and health care provider networks.
   - Through the Alzheimer's Demonstration Project Evidence-Based Grant, continue to translate New York University Caregiver Intervention in the four targeted regions. Provide training to interested and capable caregiver coaches statewide.

   Measures

   - Dates at which in-state master trainings are conducted for EnhanceFitness, Matter of Balance and CDSMP.
   - Number of organizations implementing the evidence-based models. Track health care provider organizations as a sub-set.
   - Number of participants in each of the models.
   - Number of trainings conducted on NYUCI for caregiver coaches. Number of caregiver coaches participating in the training.

3. Facilitate second phase of the Senior Nutrition Task Force, as directed by the Minnesota Board on Aging in March 2009. Focus Task Force efforts on identifying new models to reach the OAA target populations.

   Strategies

   - Identify new partners to participate in visioning process, including those involved in addressing hunger, experts in nutrition and chronic disease, and Transform 2010 partners.
   - Identify models from other states that would enable Minnesota's nutrition providers to reach the target populations outlined in the OAA, with emphasis given to those at risk for institutionalization.
   - Continue implementation of approved steps to improve the contracting and data processes of the Senior Nutrition Program.

   Measures

   - Completion of the second phase Task Force process and development of final recommendations, provided to the Board in December 2009.
   - Board approval of Phase II Report and Recommendations.
   - Status of implementation efforts as reported to the Board on quarterly basis.

4. Promote the use of preventive benefits available under Medicare, especially for older adults with low incomes. Coordinate with Nursing Home Diversion Project to encourage high risk older adults to maximize their preventive benefits.

   Strategies

   - Train Link Age Line staff to refer older adults and family caregivers to the tools available on MyMedicare.gov.
   - Participate in "My Health. My Medicare" campaign to raise awareness of Medicare preventive benefits.
   - Train Special Access Projects and tribal outreach staff, who work with older adults from diverse populations, about Medicare preventive benefits.

   Measures

   - Number of trainings conducted on Medicare outreach tools and information for LinkAge Line staff. Number of staff participating.
   - Number of trainings conducted on Medicare preventive benefits for Special Access Project staff. Number of staff participating.

5. Advocate for older adult access to improved modes of health care as mainstream health care system reform progresses in Minnesota.

   Strategies

   - Educate older adults and their family members about health care clinics through MinnesotaHelp Network.
   - Encourage older adult participation in statewide, population-based health promotion strategies focused on obesity and tobacco cessation.

   Measures

   - Number of older adults and family caregivers accessing health care clinic information on MinnesotaHelp.info.
   - Number of older adults participating in health promotion efforts stemming from health care reform initiatives.

Goal 4: Ensure the rights of older adults and prevent their abuse, neglect and exploitation.

State success in rebalancing long-term care has resulted in an increasing proportion of frail individuals who are now supported in their own homes in the community. Because of this shift, the state's current nursing home-focused infrastructure for long-term care accountability must also be "rebalanced" to better serve frail and sometimes vulnerable persons in decentralized locations in the community. The federal Older Americans Act requires states to create a comprehensive system to both advocate on behalf of residents and other vulnerable elderly and to identify and address instances of abuse, neglect or exploitation. The MBA will redesign the Ombudsman and Adult Protection programs to better meet the changing needs of frail and vulnerable persons. See Appendix B for more information on MN's Office of Ombudsman for Long-Term Care.

In addition, the MBA and Area Agencies on Aging are continuing to witness a growing number of grandparent and other relatives performing the role of primary

caregiver to children. The Minnesota Chippewa Tribe Area Agency on Aging, through its work with the tribal communities, has seen the most dramatic increase in the number of grandparents raising grandchildren. As a result, there is a significant need for legal education and resources that specifically addresses the challenges and concerns of grandparent caregivers.

Objectives

1. Expand the capacity of Long-Term Care Ombudsmen and Adult Protection to meet the needs of older adults who are increasingly choosing home and community-based service options (including assisted living).
   Strategies
   - Increase the number of Ombudsman in all long-term care settings as well as the range of tasks that they are trained to complete.
   - Work with the Minnesota ElderCare Rights Alliance to measure and report on the capacity of the current system to ensure protection of frail and vulnerable elderly receiving in-home care in their own homes and apartments.
   - Launch online training module for mandated reporters regarding elder maltreatment and how to report it.

   Measures
   - Number of Ombudsman in long-term care settings. Range of tasks that they have been trained to complete.
   - Completion of report on current adult protection capacity.
   - Date at which online training module is available for mandated reporters.

2. Increase access to elder rights support and advocacy through the MinnesotaHelp Network.
   Strategies
   - Train Linkage Line staff and volunteers to identify individuals who may need assistance from the Long-Term Care Ombudsman or Adult Protection.
   - Strengthen referral protocols and tracking between Linkage Line and the Ombudsman and Adult Protection entry points.

   Measures
   - Number of trainings conducted for Linkage Line staff. Number of staff participating.
   - Number of referrals to Ombudsman and Adult Protection by Linkage Line staff.

3. Enhance the adult protection data system and quality infrastructure.
   Strategies
   - Link the databases managed by the regulatory and investigative units within Adult Protection.
   - Create accessible and timely reports of system and provider performance and consumer feedback.
   - Promote and expand the development of effective accountability mechanisms (including consumer feedback) for services provided in community and residential settings.

Measures

- Date at which databases are linked.
- Date(s) at which reports are created.
- Status of development efforts included in annual reports.

5. Disseminate legal education and resources to grandparent and other relative caregivers.

   Strategies

   - Purchase and disseminate legal education DVDs and manuals to legal and aging services professionals. Provide training on the use of the materials.
   - Enhance availability of legal education and resources on the internet. Link key internet sites to increase accessibility.
   - Compile information on family law attorneys who could work with grandparent and other relative caregivers.

   Measures

   - Number of trainings conducted for legal and aging services professionals. Number of individuals participating.
   - Date of completion of website enhancements; number of unique visitors to the website and site use (number of hits).

Goal 5: Prepare Minnesota for the aging of the population.

The age wave of baby boomers will represent a permanent shift in the age of Minnesota's population and will bring with it both challenges and opportunities. Through the Transform 2010 community forums, Minnesotans shared concerns about labor shortages, the future of Social Security and Medicare, the capacity of our health and long-term care systems, and the ability of families to continue their high levels of eldercare. At the same time, there is a growing number of providers and leaders who are committed to reinventing the way we do business and to address our community needs in the context of an aging population. The MBA and the Area Agencies on Aging play a key role in helping individuals take more personal responsibility for their long-term care, facilitating systems change efforts and supporting community-wide processes to become more livable for all ages.

Objectives

1. Raise awareness of population aging and its implications for all sectors.

   Strategies

   - Conduct Transform 2010 presentations for community leaders.
   - Work with city and county officials to include the needs of current and future older adults in development plans related to housing, transportation and other physical infrastructure.

   Measures

   - Number of presentations conducted by state staff and AAAs.
   - Number of local development plans that address the needs of older adults.

2. Improve the ability of Minnesota's communities to support older adults.
   Strategies
   - Connect communities with resources and technical assistance regarding housing options that support aging in place.
   - Connect communities with resources and technical assistance regarding changes that they can make to their physical, service and social infrastructures to support a growing older adult population.
   - Continue to work with tribal communities to increase the accessibility of Medicaid and state-funded home and community-based services.

   Measure
   - Number of technical assistance "sessions" conducted with communities by state staff and AAAs.

3. Strengthen volunteer and faith-based community programs that provide incentives for mutual support.
   Strategies
   - Encourage CS/SD applications for projects that will develop and embed processes that facilitate mutual support among community members of all ages.
   - Identify models from other states and communities. Share learnings with AAAs and EDP staff.
   - Provide leader/coach training to faith-based, special access and tribal organizations to deliver the Chronic Disease Self-Management Program, Matter of Balance and other evidence-based health promotion programs.

   Measures
   - Number of trainings and technical assistance "sessions" provided to potential CS/SD applicants.
   - Number of communications to AAAs and EDP staff with information regarding other state and community models.
   - Number of faith-based organization staff and volunteers that participate in and complete leader or coach trainings. Number of classes implemented by these organizations.

4. Support business and community efforts that encourage older adults to continue working in both paid and volunteer roles.
   Strategies
   - Provide technical assistance to businesses about how to implement flexible work hours and menu-based benefit options.
   - Support statewide implementation of the Vital Aging Network and other "third age" endeavors in order to maximize the contributions of older adults.

   Measure
   - Number of technical assistance "sessions" provided to businesses.

5. Expand capacity for transit alternatives through coordination with state and local transportation agencies.

   Strategies

   - Explore new transportation models. Support CS/SD proposals to test new models.
   - Support the broader application of technology to schedule, track, and bill for transportation services.

   Measures

   - Number of trainings and technical assistance "sessions" provided to potential CS/SD applicants.
   - Number of discussions facilitated between transportation agencies to improve coordination and application of technology.

6. Partner with higher education to recruit, train and maintain a larger cadre of geriatric-trained health care staff, including new types of professionals to better meet the long-term and chronic health care needs of the future.

   Strategies

   - Assist in developing a one-stop website as a resource for job seekers and employers that includes information on educational, training and employment opportunities.

   Measures

   - Date at which one-stop website goes live.
   - Number of unique visits to the website.

7. Ensure inclusion of the needs of older adults in the development and implementation of emergency preparedness plans.

   Strategies

   - Continue to represent the Aging and Adults Services Division and the MBA in the development and refinement of the Department of Human Services' Continuing Care Administration continuity of operations plan. See Appendix C for more information.
   - Partner with state, regional and county lead agencies in order to participate in the development or update of emergency preparedness plans.
   - Encourage participation by local aging service providers in community-wide "tests" of emergency response plans.

   Measures

   - Number of emergency preparedness plans that address the needs of older adults.
   - Satisfactory disaster plan (including reports of implementation tests) on file at AAA level.

APPENDIX A: INTRASTATE FUNDING FORMULA

(Submitted 7/1/2004)

The Minnesota Board on Aging shall designate an Area Agency on Aging to serve each designated Planning and Service Area. Older Americans Act and State of Minnesota funds are distributed by means of an allocation formula.

A. Formula Goals and Assumptions

1. Goals of the intrastate funding formula are to

- allocate federal and state funds equitably throughout the state;
- meet the requirements of the Older Americans Act for the allocation of funds;
- reflect the proportionate distribution of persons age 60 and over in each planning and service area; and
- give preference to populations over age 60 with greatest social and economic need, as defined in the Older Americans Act, with special attention to low income minority populations.

2. Assumptions on which the intrastate funding formula is based are that

- particular attention should be given to the needs of Older Native Americans living on reservations;
- the distribution of direct service funds should reflect the needs and circumstances unique to providing services to and administering programs for older persons in rural and less populated areas of the state;
- the distribution of administrative funds should allow designated area agencies on aging to meet the minimum requirements of MBA standards and guidelines;

B. Statement of Funding Formula

1. Area Plan Administration - Title III-3A

After application of amounts used under section 308(b) for state agency administration, the Minnesota Board on Aging shall take 10% of its combined allotments for supportive services, congregate nutrition services, home delivered meal services, disease prevention and health promotion services, and family caregiver funds for Area Plan administration. Funds shall be taken in the same proportion as each fund contributes to the total remaining, with the exception of funds for family caregivers and disease prevention and health promotion and set-aside amounts for the

Indian Area Agency on Aging. Remaining funds shall be distributed according to the factors of:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

2. Direct Service - Title III-B funds for Supportive Services

After deleting amounts for state agency administration, operation of the long term care ombudsman program, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance funds according to the factors of:

a. population 60+ (55%);
b. low income 65+ (20%);
a. minority 60+ (10%);
b. persons age 65+ in non-urbanized (rural) areas (10%); and
c. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

Funds available to area agencies on aging for program development and coordination activities shall be taken from the direct service allocation. Area agency on aging requests for specific amounts will be considered as part of the area plan and budget approval process.

3. Direct Service - Titles III-C1 and III-C2 and State of Minnesota funds for Nutrition Services

After deleting amounts for state agency administration, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the factors of:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

4. Direct Service - Title III-D funds for Disease Prevention and Health Promotion Services

After deleting amounts for the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the following factors:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

5. Direct Service - Title III-E funds for Family Caregiver Support Services

After deleting amounts for state agency administration, area agency administration and the Indian Area Agency on Aging, the Minnesota Board on Aging shall distribute the balance of funds according to the following factors:

a. population 60+ (55%);
b. low income 65+ (20%);
c. minority 60+ (10%);
d. persons age 65+ in non-urbanized (rural) areas (10%); and
e. population density of persons age 60+ in each planning and service area as a ratio compared to the statewide average population density of persons age 60+ (5%).

6. "Set aside amounts" for the Indian Area Agency on Aging utilize the previous year's allocation levels plus or minus a percentage amount equal to changes in statewide totals available for distribution for each fund.

7. No planning and service area shall receive a total allocation of direct service funds that is less than 95% of the previous year's allocation of direct service funds. Should additional funds be necessary to maintain the 95% funding level for any planning and service area, they shall first be taken proportionately from the State of Minnesota direct service funds allocated to other planning and service areas, and then proportionately from federal funds allocated to other planning and service areas.

8. No planning and service area shall receive an allocation of administrative funds that is less than 95% of the previous year's allocation of administrative funds. Should additional funds be necessary to maintain the 95% funding level for any planning and service area, they shall be taken proportionately from the federal

administrative funds allocated to other planning and service areas.

9. Paragraphs 7 and 8 shall not apply beginning in Area Plan Year 2008.

10. The Minnesota Board on Aging shall use the data from the most recent Census for the factors of 1) population 60+, 2) low income 65+, 3) minority 60+, 4) population 65+ in non-urbanized areas and 5) density for the 60+ population.

    A demonstration of the allocation of funds, pursuant to the proposed funding formula, is as follows:

DATA BY PLANNING AND SERVICE AREA

PSA	POP 60+	% of POP	FACTOR	65+ LOW INCOME	% of LOW INCOME	FACTOR	60+ MIN	% of MIN	FACTOR	65+ NON URBAN	% NON URBAN	FACTOR	SQUARE MILES	DENSITY RATIO	FACTOR	FINAL FACTOR
	WEIGHTED 55%			WEIGHTED 20%			WEIGHTED 10%			WEIGHTED 10%			WEIGHTED 5%			
NW	79,114	10.24%	5.63%	6,407	14.11%	2.82%	1,839	6.72%	0.67%	72,483	17.55%	1.75%	22,776	3.47	1.40%	12.34%
ARROW	68,350	8.85%	4.87%	4,545	10.01%	2.00%	1,292	4.72%	0.47%	51,282	12.41%	1.24%	18,222	3.75	1.29%	9.93%
CENTRAL	97,658	12.65%	6.95%	7,341	16.17%	3.23%	1,501	5.48%	0.55%	85,676	20.74%	2.07%	11,835	8.25	0.59%	13.47%
SW	106,195	13.75%	7.56%	7,616	16.77%	3.35%	1,109	4.05%	0.41%	106,195	25.71%	2.57%	17,201	6.17	0.79%	14.75%
SE	81,787	10.59%	5.82%	5,305	11.68%	2.34%	1,349	4.93%	0.49%	68,123	16.49%	1.65%	6,770	12.08	0.40%	10.76%
METRO	339,174	43.92%	24.16%	14,191	31.25%	6.25%	20,288	74.10%	7.41%	29,349	7.10%	0.71%	2,813	120.57	0.04%	38.76%
TOTALS	772,278	100.00%		45,405	100.00%		27,378	100.00%		413,108	100.00%		79,617	9.699913		100.00%

Identification of Low-Income Minority Older Persons

In accordance with Section 307 (a) (15) (a) with respect to the fiscal year preceding the fiscal year for which this plan is prepared, the number of low-income minority older individuals in Minnesota is identified below:

Persons Age 65+ below Federal Poverty Guidelines
Minnesota 2000

Race/Ethnicity	Number of persons
Asian	971
Black	913
American Indian/Alaskan Native	430
Native Hawaiian/Pacific Islander	0
Other race	518
Hispanic/Latino	454
Total	3,286

Source: 2000 U.S. Census

APPENDIX B: Office of Ombudsman for Long-Term Care

Background: The Office of Ombudsman for Older Minnesotans was established in state statute within the Minnesota Board on Aging in 1987. The mission of the office is to enhance the quality of care and quality of life of older adults by promoting the rights of long-term care residents, home-care consumers and Medicare beneficiaries through: advocacy, education and empowerment.

Operations: Fourteen regional ombudsmen deliver service to older adults throughout the State. Their work is leveraged by the commitment of over 100 volunteer advocates. Regional ombudsmen are required by statute to complete 60 hours of continuing education each year; the volunteer advocates they supervise are mandated to complete 12 hours annually.

Key roles of regional ombudsmen and volunteer advocates are to:

- Receive complaints and questions
- Gather relevant information
- Evaluate claims objectively and advocate for change/relief when the facts support the claim
- Develop, evaluate and discuss options
- Facilitate, negotiate, educate and mediate
- Resolve issues in a timely manner at the most appropriate level of the entity
- Identify complaint patterns and trends

In addition to regional ombudsmen, other state office staff include an ombudsman supervisor, two ombudsman specialists and an office administrator. The State Ombudsman oversees the work of ombudsman staff and volunteers and issues reports to the Minnesota Board on Aging. The State Ombudsman is authorized to represent the interests of older adults to state agencies, Minnesota policy makers, and in administrative, judicial and legislative forums when the facts warrant.

APPENDIX C: DHS Aging and Adult Services Division Continuity of Operations Plan

The purpose of the continuity of operations plan is to minimize disruption to the primary business of Aging and Adult Services Division should a business interruption occur at 444 Lafayette Road, St. Paul, MN 55155 and 540 Cedar, St. Paul, MN 55101. This objective can only be accomplished by pre-planning and by taking steps to limit any potential disruption to a predictable, acceptable period of time. The Aging and Adult Services Division's continuity of operations plan is based on a "worst case scenario" of total loss of the building and its contents. The plan or sub-set of the plan can be modified and used in the event of a less significant incident. The continuity of operations plan is designed to recover time-sensitive services.

In the event of a business interruption, the normal organization of the Aging and Adult Services Division will work to continue the on-going, day-to-day operations of the agency. The Aging and Adult Services Division's focus will shift from the current structure and function of "business as usual" to the structure and function of an organization working towards survival and the recovery of time-sensitive services.

The plan will be executed in phases. Each phase assumes that the alternate location(s) and business infrastructure necessary to support recovery, resumption, and restoration processes are in place.

- Response: This phase involves the reaction to an incident or emergency. The goals of this phase focus on life-safety issues. It covers the period of time from the incident to the declaration of an emergency.
- Recovery: This phase involves recovery of the services that support the most time-sensitive agency services. It covers the period from the time of emergency declaration up to 10 days. During this period of time only pre-determined resources are restored.
- Resumption: This phase involves the continuation of time-sensitive business processes. It covers a period from 10 days to 30 days. Non-time sensitive business processes will not be restored.
- Restoration: During this phase, all transferred business and computer processing operations will be migrated from the alternate location(s) to the restored primary site or relocated to a new structure. Normal business operations and services will be re-established at the primary site and post-recovery operations will be completed.

Each Area Agency on Aging in Minnesota has developed a separate continuity of operations plan. The MBA has copies of each plan and continues to work with each AAA on improving and updating their plans.