Minnesota Board on Aging
State Plan

FFY 2013 - 2016

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Verification of Intent

The Minnesota Board on Aging hereby submits its State Plan on Aging for the State of Minnesota October 1, 2012 through September 30, 2016 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, when approved by the Assistant Secretary on Aging, constitutes authorization to proceed with activities under the Plan.

6/15/12
Date

Director, State Unit on Aging

6/15/12
Date

Chair

Executive Summary

Minnesota's population will undergo dramatic shifts in the next two decades. The leading edge of baby boomers started turning 60 in 2006. They are the driving force behind the aging of the state's population. With the aging of the state's population the overall need for long-term care will increase. In order to meet this demand, creative strategies to leverage a broad array of public and private resources must be deployed at the state, regional and local levels.

In 2006, the total number of family caregivers in Minnesota was estimated at 610,000, compared to a total population of 5,170,000. According to this estimate, 16% of Minnesotans age 18 and older are providing care to an adult family member. These caregivers provide 92% of all long-term care to older adults. If we are to maintain the contribution that family caregivers make to our long-term care system we must provide support that can help them maintain their own health and well-being.

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 and in response to the Olmstead decision. These efforts are guided by the principles and strategies developed by the 2001 Long-Term Care Taskforce (legislative/executive branch).

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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.

These goals have guided Minnesota's efforts for several years and considerable progress has been made.

Medical Assistance Reform

Most recently, Minnesota launched an effort to reform its Medical Assistance (Medicaid) and state-funded home and community-based services programs to continue the state's progress on rebalancing. The effort will also strengthen the state's ability to meet the needs of a growing older adult population. The key reform strategies include:

Role of the Minnesota Board on Aging

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 to oversee the effective use of Older Americans Act and state funds to support older Minnesotans. The MBA, Area Agencies on Aging and local aging service providers target Older Americans Act services to older adults (and their family caregivers) who are not eligible for the Alternative Care, Elderly Waiver or Medical Assistance programs. These individuals are at high risk of falling into the public safety net and moving into a nursing home or assisted living. They are also at high risk of hospitalizations and re-hospitalizations.

The State Plan on Aging outlines the steps that the MBA will take to support this target population and enable them to maintain their independence while receiving assistance in the ways that they prefer. The State Plan also 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.

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

Objectives

1. Fully implement the Lieutenant Governor's Senior One Stop Initiative.
2. Expand the First Contact Pilot Model Statewide.
3. Link to certified health care homes and be the source of community resources for the participating clinics .
4. Augment the MinnesotaHelp Network™ tools to increase use by consumers to plan for and understand the costs associated with long-term care and support new web tracking and support for the Money Follows the Person ADRC activities.

Goal 2: Enable older adults and family caregivers to Live Well at Home℠ by accessing proven interventions and in-home supports.

Objectives

1. Disseminate the Live Well at Home framework statewide.
2. Expand the availability of the core services statewide. The core services include: assisted transportation, caregiver support, chore, home-delivered meals and homemaker, personal emergency response and environmental modifications.

3. Increase the statewide reach of the high priority evidence-based healthy aging interventions: Chronic Disease Self-Management Program and A Matter of Balance.
4. Increase access to and efficiency of transportation alternatives through coordination with state and local agencies.
5. Work with AAAs, providers and other partners to increase the sustainability of core services and evidence-based interventions.
6. Expand the use of service models that provide more choice and control to older adults and family caregivers.
7. Increase the dementia capability of the aging services network.
8. Increase the falls prevention capability of the aging services network.
9. Undertake strategic quality assurance and improvement activities.

Goal 3: Ensure the rights of older adults and prevent their abuse, neglect and exploitation.

Objectives

1. Maintain and support the capacity of the Ombudsman for Long-Term Care Program to serve nursing home and boarding care home residents and home care consumers through advocacy, education and empowerment including prevention of adult maltreatment.
2. Expand the capacity of the Long-Term Care Ombudsman Program through use of Certified Ombudsman Volunteers (COVs).
3. Strengthen the capacity of the Adult Protection system to consistently and efficiently determine if a person is a vulnerable, the response time required, safety concerns and solutions, and to track outcomes of adult protection involvement.
4. Increase consumer and professional awareness of adult maltreatment.
5. Support low income consumer access in housing, including assisted living settings.

Goal 4: Prepare Minnesotans and their communities for the aging of the population.

Objectives

1. Implement a statewide long-term care awareness campaign to increase the number of individuals who develop a plan for meeting their long-term care needs. Market the Senior LinkAge Line® as the primary place consumers turn for comprehensive, objective long-term care options information.
2. Improve the ability of Minnesota's communities to support older adults.
3. Support statewide and community efforts to encourage older adults to continue working in both paid and volunteer roles.

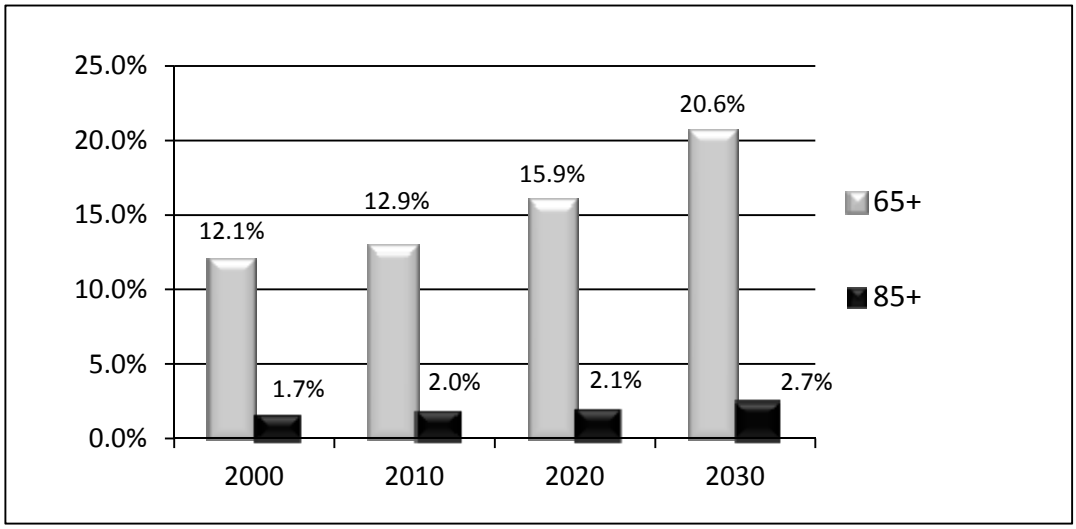
Context

Demographic Trends and Need for Long-Term Care

A. Demographic Changes[1]

Minnesota's population will undergo dramatic shifts in the next two decades. According to the 2010 Census, there are just over 683,000 Minnesotans age 65 and older. This age group is expected to nearly double by 2030 to approximately 1.3 million Minnesotans. Of this group there is estimated to be 169,000 Minnesotans age 85 and older – the most rapidly growing segment of the state's population.

Population Age 65+ and 85+



The 60+ population is of particular importance to the Minnesota Board on Aging since it is the basis of eligibility for most Older Americans Act services. The leading edge of baby boomers started turning 60 in 2006 and is included in the youngest segment of this age group. They are the driving force behind the aging of the state's population.

Population Age 60+

Calendar Year	Total State Population	Total State Population 60+	State Percent 60+
2000	4,919,479	772,278	15.7%
2010	5,303,925	962,896	18.2%

[1] Unless otherwise noted, data in this section for calendar years 2000 and 2010 were taken from the U.S. Census Bureau: Demographic Characteristics 2010. Projected numbers for 2020 and 2030 taken from estimates completed by the Minnesota Demographic Center: 2004, April 2007 - 2020 & 2030 estimates based on 2000 Census data.

Minnesota's population is becoming more diverse every year. The older adult population will follow this same pattern over the next 20 years becoming more diverse as the baby boom population ages, especially in the Twin Cities metro area.

Population Estimates by Race and Ethnicity

Race categories are single race alone, except for the "two or more races" category. Individuals of Hispanic origin can be of any race.

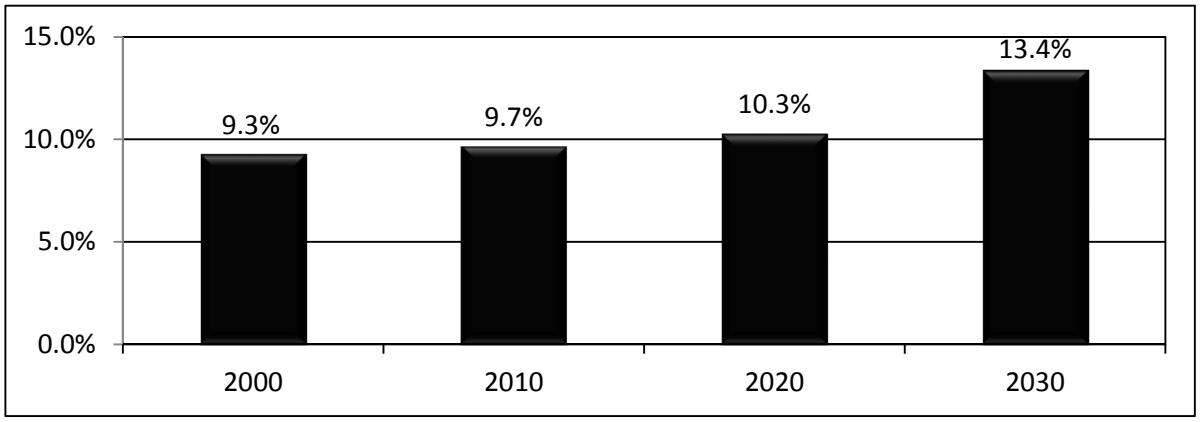
Age	Population by Age	White American	African American	American Indian	Asian American	Two or More Races	Hispanic American
60+	962,896	910,465 (94.6%)	17,486 (1.8%)	5,642 (0.6%)	15,751 (1.6%)	4,490 (0.5%)	9,565 (1.0%)
65+	683,121	654,245 (95.8%)	10,737 (1.6%)	3,392 (0.5%)	10,153 (1.5%)	2,832 (0.4%)	5,880 (0.9%)

Older adults typically experience, on average, a much lower likelihood of living at or below poverty level. However, just over 8% of this population have incomes in this category. This makes it very difficult for individuals to meet their basic needs and makes it quite difficult for them to save for potential future long-term care needs.

65+ Population Estimates by Poverty Status

Total 65+ State Population	65+ Below Poverty Level	Percent 65+ Below Poverty Level	Total State Population All Ages	All Ages Below Poverty Level	All Ages Percent Below Poverty Level
683,121	51,987	8.3%	5,119,104	542,133	10.6%

Percent of Population 65+ Living Alone



The next generations of older Minnesotans have significantly fewer children than previous cohorts—1.9 children per couple today compared to 3.2 children per couple in the 1950s. In addition, the proportion of older persons who are expected to be living alone (whether due to death of a spouse, divorce, or never having been married) is also

projected to increase significantly for the boomer generation[2]. These trends toward smaller families and smaller households will inevitably result in less family and unpaid support, and an unknown increase in demand for paid help. This trend is illustrated in the Family Caregiver Ratio chart below. Currently, there are 15 persons age 85+ for every 100 females age 45-64. By 2030 there will be 23 persons age 85+ for every 100 females age 45-64.

Family Caregiver Ratio

Family Caregiver Ratio: number of persons age 85+ per 100 females age 45-64 (who are the typical caregivers)

Calendar Year	State Ratio	State Female Population 45-64	85+ State Population
2000	16	537,163	85,601
2010	15	720,930	106,664
2020	17	753,020	125,410
2030	23	718,860	168,890

Simultaneously, the state demographer forecasts a significant reduction in the state's labor force growth: an older workforce and increasing competition for scarce younger employees. The long-term care industry depends on low-wage workers, and because of high turnover in many long-term care positions, the industry is also dependent on new workers coming on line.

B. Need for Long-Term Care

The need for long-term care in Minnesota is tied to both the demographic projections and disability rates. Today's elderly are, in general, healthier than their age peers just a generation ago. Age-specific disability rates in the United States have been decreasing at about 3 % per decade for the past several decades[3], partly due to improved public health and nutrition during this cohort's childhood (1920s and 30s), and partly due to advances in medical care, e.g., hip or knee replacements, and prescription drugs that reduce pain and allow more people to function independently. However, as noted above, the number of very old (and most likely at risk) is projected to continue to increase slowly through 2020, and then quite rapidly for the next two decades. Since the 1950s disability rates by age have generally declined.

Nonetheless, persons aged 85 and older have significantly higher prevalence of chronic illness and rates of disability,[4] and although Minnesota's disability rates are below the national average[5] the overall need for long-term care will increase because functional disability increases with advancing age—despite the previously mentioned slowdown in

[2] The proportion of boomers who are projected to live alone is nearly twice the rate of current elderly (86.7 % higher). Census Bureau: Projections of the Number of Households and Families in the United States 1995-2010.
[3] National Long-Term Care Survey, 2006.
[4] He *et al* (2005) *65+ in the United States: Current Population Reports*, National Institute on Aging.
[5] 2009, Thomson Reuters, Minnesota State Profile Tool: An Assessment of Minnesota's Long-Term Support System, Table 1.2 (p. 8).

the rate at which this occurs.[6] Over two-thirds of persons age 85 and older have at least one disability, and older persons are more likely to have multiple disabilities. In order to meet this demand, creative strategies to leverage a broad array of public and private resources must be deployed at the state, regional and local levels.

C. Need for Family Caregiver Support

In 2006, the total number of family caregivers in Minnesota was estimated at 610,000, compared to a total population of 5,170,000. According to this estimate, 16% of Minnesotans age 18 and older are providing care to an adult family member[7]. These caregivers provide 92% of all long-term care to older adults in Minnesota[8]. The value of this caregiving exceeds total Medical Assistance spending on health and long-term care services. If we are to maintain the contribution that family caregivers make to our long-term care system we must provide support that can help them maintain their own health and well-being.

According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS) data[9] on Minnesota's family caregivers, the majority are female, middle-aged and older (45 – 64 years old), employed, in good or excellent health, and provide less than 10 hours of care each week (68.9%). However, one in seven caregivers (14.4%) provide 21 or more hours of care per week and nearly 6% provide more than 40 hours weekly. This latter group is predominantly female, more likely to be 60 years of age or older, is caring for a spouse with memory concerns, or a child, and lives in the same household as their family member. These caregivers are also more likely to be caregiving for extended periods of time (six or more years) and are more likely to report poor or fair health status and limitations of activity due to physical, emotional and mental problems, compared to those providing fewer hours of care each week.

The most frequently reported challenges faced by all caregivers surveyed include: managing stress, finding more time for self and family, coping with finances, and balancing work and caregiving. Of particular concern are caregivers supporting family members with memory loss as this often entails some of the most intense caregiving. Minnesota caregivers who are caring for people who are reported as having memory or thinking concerns provide care for more years than caregivers caring for people without memory concerns, report greater stress and a lack of time for self and family, as well as greater limitations to their activity due to their own health problems.

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[6] Houser, Ari (2007) *Long Term Care Research Report,* AARP Public Policy Institute.
[7] AARP Public Policy Institute (2007, November). Valuing the invaluable: A new look at state estimates of the economic value of family caregiving.
[8] Survey of Older Minnesotans.
[9] The BRFSS is administered in Minnesota by the Minnesota Department of Health. To learn more, go to: www.cdc.gov/brfss/.

Home and Community-Based Services Capacity

A. Gaps Analysis

How many service providers are needed? How well are different parts of the state served? Are there "gaps" in available services in some parts of the state?[10] Since 2001 all counties in Minnesota have been asked every two years to prepare an analysis of the local capacity to meet long-term care needs of current residents, including any significant "gaps" in services or supports.[11]

The table above summarizes the top ranking service gaps across the years since 2001. In this report "service gaps" are defined as services that are rated as (a) inadequate to meet local need, (b) unavailable in the local area, or (c) available with limitations as to adequacy or quality. Note that Transportation (both Non- Medical and Medical), Chore Service, Companion Service, Respite Services (both In- Home and Out of Home), Adult Day Care and Caregiver Training & Support continue to be top aging service gap areas across the years.

The proportion of counties reporting gaps has remained constant since 2007 for Chore Service, Companion Service, In-Home Respite Care and Caregiver Training & Support. The percent of counties reporting gaps have increased since 2007 for Out of Home Respite Care (58% vs. 47%) and Adult Day Care (51% vs. 44%). Beginning with the 2009 survey, Transportation was separated into two categories: Medical Transportation and Non-Medical Transportation. Although it is difficult to compare changes in transportation given the two new categories it is important to note that the Non-Medical Transportation gap rate (66%) is slightly higher and the Medical Transportation gap rate is lower (56%) than the rate for 2007 (68%). As discussed below, the proportion of counties that have reported decreases in the supply of both Medical and Non-Medical Transportation indicate that this is an increasing gap.

[10] A more comprehensive description of the statewide LTC Gaps Survey is available on the DHS website at: www.dhs.state.mn.us/GapsAnalysis. This site provides an overview of service capacity by county and by region of the state.

[11] The Gaps Analysis survey, scheduled to be conducted in 2012, is delayed until 2013 due to legislation passed during the 2012 session. The legislation broadens the Gaps Analysis to include mental health and disability services.

Most Frequently Cited Gaps in LTC Service Capacity													
2001			**2003**			**2005**			**2007**			**2009**		
87 counties responding			72 counties responding			76 counties responding			79 counties responding			87 counties responding		
Type of service	**Rank**	**% of counties**	**Type of service**	**Rank**	**% of counties**	**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%	Transportation	1 (tie)	63%	Non-Medical Transportation	1	66%
In-Home Respite/ Caregiver Supports	2	57%	Chore Service	2	28%	Evening and Weekend Care	2	50%	Companion Service	1 (tie)	63%	Chore Service	2 (tie)	60%
Chore Service	3	48%	In-Home Respite/ Caregiver Supports	3	22%	Chore Service	3 (tie)	47%	Chore Service	3	62%	Companion Service	2 (tie)	60%
LTCC for Relocation	4	39%	Adult Day Service	4 (tie)	21%	Adult Day Service	3 (tie)	47%	Respite Care-In Home	4	51%	Respite Care-Out of Home	4	58%
Information and Assistance	5	25%	Home Delivered Meals	4 (tie)	21%	In-Home Respite/ Caregiver Supports	5	42%	Respite Care-Out of Home	5	47%	Medical Transportation	5	56%
									Caregiver/ Family Support Training	6	46%	Respite Care, In Home	6	55%
									Adult Day Care	7	44%	Adult Day Care	7	51%
												Caregiver Training & Support	8	44%

* Surveys conducted 2001-2005 included “In-Home Respite/Caregiver Supports” as a service category. This service area was expanded into 3 categories for 2007 and 2009: Caregiver/Family Support Training and In-Home Respite Services. Out-of-Home Respite Services was also added as a new service category.

** Evening and Week-end Care was not included as a service item in the 2007 and 2009 surveys.

*** In 2009 Transportation was separated into Medical and Non- Medical Transportation

Cultural Competency

As Minnesota's population continues to become more and more culturally diverse, it is important to assess the capacity of the State's long-term care system to provide services to older Minnesotans from diverse cultural communities. The 2009 Gaps Analysis survey asked some new questions about how prepared counties believe their provider network is to work with a few different types of cultural communities. As summarized in the chart below, only a small percent of counties believe that their providers are "very prepared" to deliver care that is culturally competent to racial and ethnic minority communities (14%), new American, immigrant and refugee communities (6%) and gay, lesbian, bisexual and transgender (GLBT) communities (12%). Most notably, 21% of counties report their provider network is "not at all prepared" to deliver care that is culturally competent to new American, immigrant and refugee communities. These results indicate that additional supports are needed in order to help prepare the long-term care provider network to provide culturally competent services to these various communities.

Capacity to Serve Culturally Diverse Communities

Community	Very Prepared	Somewhat Prepared	Not at All Prepared
Racial/ethnic minority communities	14%	80%	6%
New American/ immigrant/ refugee communities	6%	73%	21%
Gay, lesbian, bisexual and transgender communities	12%	80%	8%

Changes in Service Availability

Most counties (92%) reported that at least one home and community-based service became more available between 2007 and 2009. Interestingly the most common services that have increased in availability are not necessarily ones that were reported as top gaps in prior years. This may indicate that a lot of service development has happened in these areas in response to an increase in awareness of and/or demand for the service. In other cases, service development was driven by policy change.

Services Reported as More Available 2007-2009

Type of Service	% of Counties Expanding	Rank as Gap in 2007
Health Promotion Activities	60%	N/A[14]
Home Delivered Meals	54%	15
Fiscal Support Entities	36%	16
Personal Care Assistance	35%	N/A[12]
Homemaker Service	30%	13
Caregiver Training & Support	27%	7
Home Health Aide	23%	19
End-of-life, Hospice, Palliative Care	21%	17

Nearly four out of five (78%) counties reported a decrease in one or more services between 2007 and 2009. This is a marked increase from 2007 when only 46% of counties reported a decrease in one or more services between 2005 and 2007. No type of service had more than 19% of counties reporting a decrease. This is a marked difference from 2007 when the highest proportion of counties reporting a decrease in any service area was only 9%. These results

[12] Health Promotion Activities and Personal Care Assistance were not included as services on the 2007 survey.

indicate that while counties are experiencing expansions across many services, they are also experiencing decreases in services that they have not experienced in the past.

The most common decreases were for the services that are also many of the top gaps for 2009: Medical Transportation (19%), Chore Service (19%), Companion Service (18%), Non-Medical Transportation (17%) and Adult Day Care (16%). Transportation has been particularly affected; only one county (1%) reported that Transportation was less available in the 2007 Gaps Analysis survey.

B. Regional Survey Information

The Area Agencies on Aging conduct surveys of providers, stakeholders, community members, caregivers and older adults to gather input regarding the need for home and community-based services and the challenges older adults face in trying to remain in their own homes. The results inform the Area Agencies on Aging's decisions regarding the use of Older Americans Act Title III funds and their development efforts to increase the supply of critical services and disseminate new models of care.

Several common themes emerged across the Area Agency on Aging surveys and reinforce some of the key findings from the Gaps Analyses.

- The highest priority service needs include: transportation (including assisted transportation), homemaker, chore, caregiver support (including respite), home modifications/repairs and medication management/screening.

- The most often cited reasons why older adults cannot remain in their own homes as they experience a need for assistance include: many older adults do not have family in the area to help, people wait too long before seeking help, people are reluctant to pay for help/services and people don't know where to get help.

- It is interesting to note that in one of the surveys, a majority of providers surveyed indicated that older adults are reluctant to pay for services while a majority of the older adult respondents indicated they would be willing to pay for services. The younger cohort was more likely to indicate a willingness to pay.

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 and in response to the Olmstead decision. These efforts are guided by the principles and strategies developed by the 2001 Long-Term Care Taskforce (legislative/executive branch) and strengthened through Aging 2030. Aging 2030 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 is a key partner in these efforts.

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.

These goals have guided Minnesota's efforts for several years and considerable progress has been made. According to the 2011 AARP *State Long-Term Services and Supports Scorecard,* Minnesota ranks #1 overall in the nation across four dimensions of a high performing long-term care system including: affordability and access, choice of setting and provider, quality of life and quality of care and support for family caregivers.

Medical Assistance Reform

Most recently, Minnesota launched an effort to reform its Medical Assistance (Medicaid) and state-funded home and community-based services programs to continue the state's progress on rebalancing. The effort will also strengthen the state's ability to meet the needs of a growing older adult population. The key reform strategies include:

- Early intervention and long-term care decision support that assists individuals in making "smart" long-term care choices that can delay spend down to Medicaid
- Integration, coordination, and transition support across care settings to achieve better health outcomes and reductions in readmissions to hospitals and nursing facilities; and
- Decreased reliance on institutional-based long-term care and undertake targeted expansion of publicly-funded home and community-based service options to continuously improve programs, services, access, and choice.

The Minnesota Board on Aging, through the Home and Community-Based Services Partners Panel convened by the Minnesota Department of Human Services, has participated in many discussions with aging, disability and mental health stakeholders to develop the reform proposals. The MBA has used the opportunity to ensure that the Older Americans Act-funded initiatives are coordinated with, and complementary to, the reforms under development.

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 $12.9 million in Older Americans Act Title III funds and an additional $1.9 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 $16.1 million in local dollars and resources, ensure local input and accountability for service funding and promote local innovation in problem-solving. The Minnesota Indian 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.

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The following Goals, Objectives and Strategies outline the steps that the MBA will take to support this target population and enable them to maintain their independence while receiving assistance in the ways that they prefer. The MBA State Plan also 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.

Strategic Directions for Minnesota's Aging Network

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

Minnesota's Aging and Disability Resource Center (ADRC), the MinnesotaHelp Network™, provides streamlined service information, access assistance, health insurance and long-term care options counseling.

The four ways in which the network distributes information includes:

- Three specialized phone lines available to assist specific populations (one of which is the Senior Linkage Line®).
- The Minnesotahelp.info (resources and decision support) web site.
- In person assistance established at local MinnesotaHelp Network™ Access sites and available through strategic initiatives such as the Senior LinkAge Line® Return to Community that will also be implementing Money Follows the Person. The Senior LinkAge Line® currently acts as the MDS Section Q Local Contact Agency (LCA).
- Finally, through print publications such as the statewide Health Care Choices publication, which has been focused on Medicare, and will be expanding to include long-term care options information.

The SLL is the designated State Health Insurance Program (SHIP) for Minnesota. Over 300 ADRC community access points exist in communities to conduct outreach and assistance. In 2010 the MinnesotaHelp Network™ reached 80,000 through the SLL; 30,000 people with disabilities through the DLL; 100,000 veterans and their families through the VLL; 500,000 unique visits through www.minnesotahelp.info; and additionally thousands of individuals with in-person forms assistance and/or referral to the appropriate lead agency for an LTCC.

The goals of Minnesota's ADRC five year plan are to strengthen the presence of long-term care options counseling through a variety of touch points in the system. These include further development of the First Contact model, integration with the Medicare Medical Home innovation strategies and implementation of new care transitions models through further development of supportive community living strategies. The plan also encompasses activities to maximize the opportunities that state and federal health care reform provide to improve care transitions for older adults and family caregivers between hospital, nursing home and home.

Currently, 93% of EW participants are served through the Minnesota Senior Health Options Program and are provided with an integrated Medicare and Medicaid package of services. In contrast, individuals who are not in a public managed care program or who are private pay are not typically provided with this level of integration across long-term services/supports and health care. This has changed with the passage in 2008 of historic state health reform legislation. One component of this legislation is to certify primary care clinics as health care homes upon meeting

certain care coordination requirements. So far, a total of 170 primary care clinics have been certified as health care homes, most located in the Twin Cities metro area.

In October 2011, through the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, the Centers for Medicare & Medicaid Services (CMS) started reimbursing certified health care homes in Minnesota and seven other states for care coordination on behalf of Medicare fee-for-service beneficiaries. The Minnesota Board on Aging received a three-year Integrated Systems Grant from the U.S. Administration on Aging in September 2011 to support MBA efforts to increase integration between health care and aging services. The focus of these efforts will be to maximize the opportunity presented by the MAPCP to build closer partnerships with health care homes and improve care coordination between clinics, hospitals and homes.

Objectives

1. Fully implement the Lieutenant Governor's Senior One Stop Initiative.
   Strategies
   - Provide government problem solving.
   - Provide volunteer matching assistance, in partnership with the Senior Corps Programs and Volunteer Centers.
   - Launch the Older Workers Counseling and Assistance component.

   Measure
   - Number of contacts in each area.
   - Consumer satisfaction levels by component.

2. Expand the First Contact Pilot Model Statewide (ADRC Statewide Plan).
   Strategies
   - Support expansion of the First Contact single point of entry pilot to include a hospital and two assisted living/nursing facility care providers in addition to the county and Central MN Council on Aging (supported by the Aging and Disability Resource Center continuation grant).
   - Facilitate Area Agency on Aging efforts to replicate the First Contact model with at least one county in their regions.
   - Increase awareness and understanding of the First Contact model with counties and other key partners.
   - Evaluate this expansion effort.

   Measures
   - Interviews with consumers as part of the evaluation indicate successful implementation and improvements in consumer decision support.
   - Number of First Contact implementation sites.

3. Link to certified health care homes and be the source of community resources for the participating clinics (ADRC Statewide Plan).
   Strategies
   - Participate in the MN Department of Health Multi-Payer Advanced Primary Care (MAPCP) Executive Committee and Resource Workgroup.

- Collaborate with MN Department of Human Services Dual Demonstration team, Stratis Health (MN's Medicare QIO), Institute for Clinical Systems Improvement (ICSI), MN Hospital Association and others to communicate the value of the MinnesotaHelp Network and the Live Well at Home approach and facilitate local partnerships.

Measures

- The number of joint trainings conducted and joint guidance documents issued through the MAPCP groups to health care homes promoting the AAA-health care home partnerships.
- The number of established partnerships between health care homes and Area Agencies on Aging.
- The number and type of referrals to the Senior Linkage Line® from the health care homes.

4. Augment the MinnesotaHelp Network tools to increase use by consumers to plan for and understand the costs associated with long-term care (ADRC Statewide Plan) and support new web tracking and support for the Money Follows the Person ADRC activities.

Strategies

- Assess and provide recommendations for modifying the Long-Term Care Navigator.
- Incorporate the Navigator into the web-based Resource House Referral database (Senior Linkage Line® client tracking system).
- Incorporate a cost calculator into the Navigator for Senior Linkage Line® staff to use while assisting consumers with long-term care options counseling.
- Update and modify the Disability Benefits 101 web site for use by the Disability Linkage Line (as supported through the AoA Integrated Systems Grant).

Measures

- Date of completion of changes to the Long-Term Care Navigator.
- Date of completion of incorporating the Navigator into Resource House.
- Date of completion of incorporating cost calculator into Navigator.
- Number of users who access the cost calculator on their own.
- Number of individuals that Senior Linkage Line® staff assist

Goal 2: Enable older adults and family caregivers to Live Well at Home℠ by accessing proven interventions and in-home supports.

The MBA and Area Agencies on Aging (AAAs) play a leadership role in building system capacity and disseminating interventions statewide. Over the last several years the focus of this work has built on the core competencies of the aging network to reach high risk older adults and family caregivers and help them maintain their safe, independent living.

The Live Well at Home (LWAH) practice framework, developed and implemented with AoA Community Living funding, provides the aging network with a common approach to identify high risk older adults and help them take action to better manage their chronic conditions and maintain their independent living. The LWAH framework is based upon the risk factors known to greatly increase the likelihood that an older adult will move permanently to a nursing home or assisted living, spend down to Medicaid eligibility, and/ or experience frequent readmissions to the hospital. These risk factors include limited functionality, injurious falls, memory concerns, lack of family/social support, living alone, stressed caregiver, and thinking of moving in order to get help. These risk factors are screened for through Minnesota's validated evidence-informed screening tool called the Live Well at Home Rapid Screen©. MBA is working with the Area Agencies on Aging, including the Senior LinkAge Line®, and local partners to disseminate statewide the risk management protocols and evidence-based interventions that address the risks identified through the LWAH Rapid Screen©.

The Area Agencies on Aging play an equally important role in building statewide capacity to deliver a core set of supports to older adults in their homes, regardless of pay source. These supports include caregiver support, chore, homemaker, home-delivered meals, assisted transportation, personal emergency response system and environmental modifications. In 2009, five of these supports (caregiver support, homemaker, chore, personal emergency response system and home-delivered meals) were found to be the most used by participants in the Alternative Care (AC) and Elderly Waiver (EW) Programs. These supports will be made available to EW participants who will no longer meet the nursing facility level of care criteria when the 2009 legislatively authorized changes are implemented, through the new state-funded Essential Community Supports Program. The MBA will be working with the AAAs to ensure statewide availability of these supports to high risk individuals regardless of pay source. Older Americans Act funds will support the delivery of these services to high risk individuals who are not yet eligible for Alternative Care or EW on a sliding fee scale basis.

Objectives

1. Disseminate the Live Well at Home framework statewide, as supported through the AoA Integrated Systems Grant.
   Strategies

- Fully integrate the training, communication, marketing and outreach activities for all relevant programs under the Live Well at Home framework.
- Engage state partners to identify their role within the Live Well at Home framework and support their local members' implementation.
- Strengthen the connections between the Senior Linkage Line® and the organizations who implement one or more of the interventions and services that are a part of Live Well at Home.
- Offer the Live Well at Home approach, evidence-based interventions and core supports to health care homes and hospitals as the set of community resources that can most effectively help high risk older adults mitigate their risks, manage their health and maintain their independent living.

Measures

- Number of individuals reached with integrated LWAH communications.
- Number of state partner organizations who are engaged in implementing one or more components of the Live Well at Home framework.
- Number of local partners that are engaged in implementing one or more components of the Live Well at Home framework.
- Number and percent of health care partners who refer high risk older adults to the aging services network.

2. Expand the availability of the core services statewide. The core services include: assisted transportation, caregiver support, chore, home-delivered meals and homemaker, personal emergency response and environmental modifications.

   Strategies

   - Maximize available Older Americans Act funds to support these services.
   - Through the Eldercare Development Partnerships, implement strategic technical assistance efforts with providers that can address specific service gaps, with priority on reaching minority elders and rural isolated older adults.
   - Through the Eldercare Development Partnerships, facilitate provider efforts to bill and receive reimbursement from public and private sources.
   - Strengthen the state's Lifespan Respite Coalition to expand the availability of respite options for family caregivers of people of all ages and abilities.

   Measures

   - Proportion of available OAA funds, by OAA Title III Section, that are used to support one or more core service.
   - Number of organizations working with the Eldercare Development Partnerships to address specific gaps.
   - Proportion of specific service gaps that are addressed, by county and region.
   - Ranking of core services gaps as reported in the bi-annual county Gaps Analysis Survey.
   - Number of organizations participating in Lifespan Respite Coalition, by population represented.

3. Increase the statewide reach of the high priority evidence-based healthy aging interventions: Chronic Disease Self-Management Program (Living Well with Chronic Conditions) and A Matter of Balance.

   Strategies

- Maximize Older Americans Act III-D funds to support these interventions, with a priority on reaching minority elders and rural isolated older adults.
- As supported through the AoA Integrated Systems Grant, partner with the Minnesota Department of Health, Institute for Clinical Systems Improvement, Stratis Health, and others to facilitate health care provider referrals and other connections as a part of the AAA-health care home partnerships.
- Support implementation of these programs through Wisdom Steps, the Native Elders health promotion program, in part through the AoA Integrated Systems Grant.

Measures

- Proportion of OAA III-D funds that are used to support each program.
- Proportion of health care homes that are referring/connecting older adults to one or both programs.
- Number of Native Elders who participate in each program.

4. Increase access to and efficiency of transportation alternatives through coordination with state and local agencies.

Strategies

- Continue to support information sharing among providers and consumers i.e. implementation of Veterans Transportation Community Living Initiative.
- Leverage federal transportation funds by supporting assisted transportation with Older Americans Act funds, a critical gap in transportation services for older adults.
- Support local human service transit coordination plans:
    - Support the targeting of 5310 Transportation for Elderly Persons and Person with Disabilities, Job Access Reverse Commute (JARC), New Freedom and Community Service/Community Services Development (CS/SD) funding to explore and test new transportation models identified in plans
    - Support the broader application of technology to schedule, track, and bill for transportation services.
    - Ensure inclusion of Older Americans Act-funded transportation services and the needs of older adults in Local Human Service Transit Coordination Plans.

Measures

- Number of discussions facilitated between transportation agencies to improve coordination and application of technology.
- Proportion of Older Americans Act funds supporting assisted transportation.
- Number of Local Human Service Transit Coordination Plans that include Older Americans Act-funded services and the needs of older adults.
- Number of proposals funded that are coordinating Department of Human Services, Board on Aging and Department of Transportation dollars.

5. Work with AAAs, providers and other partners to increase the sustainability of core services and evidence-based interventions that are supported, in part, by Older Americans Act funds.

Strategies

- Expand the implementation of cost sharing to all allowable Older Americans Act services.
- Increase number of private pay individuals served by Older Americans Act providers.
- Develop business plans for the healthy aging interventions and the New York University Caregiver Intervention.
- Engage state partners, including potential funders, to support one or more service/intervention.

Measures

- Proportion of Older Americans Act providers to implement cost sharing for allowable services.
- Proportion of program income generated by Older Americans Act providers that is cost share revenue.
- Proportion of persons served by Older Americans Act providers that are private pay.
- Number of business plans completed, by evidence-based intervention.
- Number of other funders supporting evidence-based interventions.

6. Expand the use of service models that provide more choice and control to older adults and family caregivers.

Strategies

- Expand the Veterans Directed – Home and Community-Based Services program statewide.
- Increase the availability of the self-directed service option supported with Older Americans Act funds.
- Explore and test the use of alternative contracting models that provide more consumer choice without individual budgets.

Measures

- Number of Area Agency on Aging regions offering the Veterans Directed – Home and Community-Based Services program statewide.
- Proportion of available Older Americans Act funds that are allocated to self-directed service options.

7. Increase the dementia capability of the aging services network, as supported through the AoA Integrated Systems Grant.

Strategies

- Develop and implement a dementia capability training program for Senior Linkage Line and other frontline aging services network professionals.
- Develop and implement a dementia capability training program for caregiver consultants.
- Increase the ease of use of www.minnesotahelp.info and the Long-Term Care Navigator by caregivers of people with dementia.
- Regionalize the availability of the New York University Caregiver Intervention (NYUCI).

Measures

- Number and percent of individuals trained who indicate an increase in understanding about dementia and how to effectively communicate with an individual with dementia.
- Proportion of feedback from caregivers who have used www.minnesotahelp.info and/or the Long-Term Care Navigator indicating that the tools are easy to use.

- Proportion of Area Agency on Aging regions currently implementing NYUCI that have developed sufficient regional capacity.

8. Increase the falls prevention capability of the aging services network, as supported through the AoA Integrated Systems Grant.

   Strategies

   - Re-engage state and local partners in MN's Fall Prevention Call to Action objectives and strategies.
   - Conduct trainings and presentations on falls data and prevention methods.
   - Coordinate public awareness and education activities for the annual First Day of Fall. Secure Governor's Proclamation for the day.
   - Facilitate partnerships between local organizations who have a role to play in preventing falls in order to apply a multi-factorial approach in a specific community.

   Measures

   - Number of state and local partners engaged in falls prevention.
   - Number of presentations conducted.
   - Number of First Day of Fall events. Number of older adults, professionals and community members reached.

9. Undertake strategic quality assurance and improvement activities focused on the Older Americans Act-funded services.

   Strategies

   - Maintain currency in research related to evidence-based interventions and best practices in home and community-based services to identify potential new service models or improvements that can be implemented in Minnesota.
   - Update and refine state and regional quality assurance plans that encompass all Older Americans Act-funded services. Incorporate national best practices.
   - Implement a core set of common participant experience measures across home and community-based services programs and settings.
   - As supported through the AoA Integrated Systems Grant, explore the use of common participant experience and outcome measures with health care homes.

   Measures

   - Dates of completion of state and regional quality assurance plans.
   - Number and type of common participant experience measures implemented across settings. Implementation date.
   - Number and type of common participant experience and outcome measures implemented with health care partners.

Goal 3: Ensure the rights of older adults and prevent their abuse, neglect and exploitation.

Office of Ombudsman for Long-Term Care

The mission of the Long-Term Care Ombudsman Program is to enhance the quality of life and services for consumers and to protect the health, safety, welfare and rights of consumers through advocacy, education and empowerment. The Ombudsman Program promotes person-directed living which respects individual values and preferences and preserves individual rights. To accomplish the elder advocacy and protection mission of the program under the Older Americans Act, the Office continues to assist individual consumers with problem-solving, make regular visits to long-term care settings, provide information consultation to consumers and their families and offer community education.

Ombudsman volunteers play a key role in the program's mission. Volunteers are assigned to visit a local nursing home or housing with services setting weekly or bi-weekly. This regular presence is essential to consumer problem-solving, education and empowerment and bridges collaboration with service providers in consumer protection and well-being.

Consumer problem solving issues include quality of services, rights violations, access to services and termination of services or discharge from housing. Information consultation includes consumer rights and protection, service and funding options, regulation of services. Education includes consumer rights, safeguards under Minnesota's Adult Protection Act and guardianship and conservatorship law and the role of the LTC Ombudsman Program.

Finally, systemic advocacy occurs as a result of the program's day to day work as outlined above. Knowing the consumer experience through advocacy and educational efforts mobilizes the program to partner with other consumer groups, public agencies, policy makers, service providers and citizens to enhance the well-being of older and disabled Minnesotans. Systemic advocacy in the most recent years has been responsible for passage of several new laws ensuring more protection for vulnerable seniors, including: 1) a bill of rights for wards under guardianship/conservatorship. MN is the only state in the country with this protection, and the Office testified in Congress in 2012 about this. 2) felony deprivation (neglect) was passed in 2012, ensuring that the consequences for severe intentional neglect will now be at the increased level of a felony.
The MN Vulnerable Adult Act was recently strengthened to include more protection for people at risk of financial exploitation.

The Ombudsman Office and the Adult Protection Program are critical components of the MN Vulnerable Adult Justice Project – a collaboration of county adult protection staff and country attorneys, consumer advocates, elder law attorneys, professional guardians and conservators, community social workers and state agencies. This group consistently moves forward with protections needed – in a unanimous manner, and has passed several laws with bi-partisan, unanimous support.

Systemic advocacy also impacts citizens across the country especially as we fulfill the purpose of the Elder Justice Act and support other federal initiatives impacting our constituents.

Adult Protection Program

The Adult Protection Program provides training and consultation about the Minnesota Vulnerable Adults Act. Identifying maltreatment in vulnerable adults can be challenging because the adult may not be able to communicate what happened or may be considered an unreliable witness. For example, an elderly man with dementia has a bruise on his arm. Is the bruise the result of caregiver abuse or did he accidentally bump into the wall?

Eighty-seven counties have their own adult protection units which are responsible for investigating county complaints and providing protective services. State agencies investigate complaints in regulated industries, such as nursing facilities or group homes. Law enforcement units coordinate with state and local vulnerable adult units to investigate maltreatment reports made and investigated.
.
The Adult Protection Program is a consultant for Minnesota's Vulnerable Adult Act. In addition to educating the public about maltreatment of vulnerable adults, the Adult Protective Program consults with local agencies, including counties and law enforcement agencies.

Objectives

1. Maintain and support the capacity of the Ombudsman for Long-Term Care Program to serve nursing home and boarding care home residents and home care consumers through advocacy, education and empowerment including prevention of adult maltreatment.
    Strategy
        - Continue the key functions of individual consumer advocacy; information consultation and education and systemic advocacy.
    Measures
        - Number of complaints handled.
        - Number of cases closed.
        - Number of information consultations.
        - Number of educational sessions
        - Specific work on systemic issues.

2. Expand the capacity of the Long-Term Care Ombudsman Program through use of Certified Ombudsman Volunteers (COVs). (This objective meets a criterion of the Elder Justice Act.)
    Strategies
        - Increase the number and diversification of volunteers assigned to local long-term care settings through local and statewide recruitment.
        - Implement a training curriculum comparable to ombudsman training to prepare COVs to fulfill the program’s mission.

Measures

- Number and diversity of volunteers recruited and assigned.
- Training sessions completed and evaluated.

3. Strengthen the capacity of the Adult Protection system to consistently and efficiently determine if a person is a vulnerable, the response time required, safety concerns and solutions, and to track outcomes of adult protection involvement.

Strategy

- Implement the Structured Decision Making tool for Adult Protection.

Measures

- Launch date of Structured Decision Making tool.
- Training sessions for county social workers completed and evaluated.
- Percentage of adult protection responses within mandated timelines.

4. Increase consumer and professional awareness of adult maltreatment. (This objective meets a criterion of the Elder Justice Act.)

Strategies

- Conduct statewide elder rights videoconferences and conference presentations for social service professionals, including adult protection workers.
- Convene the annual World Elder Abuse Awareness Day conference at the William Mitchell College of Law and the Elder's Abuse Awareness Conference in partnership with the Minnesota Chippewa Tribe.
- Train the trainer: train ombudsmen and volunteers with an Ombudsman developed training tool called "Stand Up for Yourself."
- Ombudsmen and volunteers will educate local nursing home residents about recognizing abuse and neglect and advocating for oneself and other residents.

Measures

- Number of adult protection workers trained.
- Number of social service professionals trained.
- Number of ombudsmen and volunteers trained.
- Number of residents educated about abuse and neglect.
- Number of attendees of elder abuse awareness events, including the number of older adults and community members.

5. Support low income consumer access in housing, including assisted living settings (systemic advocacy.)

Strategies

- Implement the state legislative mandate to hold a work group to examine the public funding barriers and disparities for low income consumers wanting to move into housing with services settings.
- Collaborate with key stakeholders to improve access to public programs for low income consumers in housing with services.

Measures

- Report due to the Minnesota legislature January 2013.
- Implement recommendations of the report, be they changes in state or county practices or policies, consumer and provider education or legislative changes.

Goal 4: Prepare Minnesotans and their communities 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. The need to plan for one's future long-term care is a challenge we all must face. Public-private partnerships are critical to addressing the gap between the proportion of individuals who have a long-term care plan and the proportion of individuals who will need some form of long-term care.

Communities for a lifetime are good places to grow up and grow old. Community members work together – across generations – to improve the quality of life by identifying and delivering physical, social and service supports to residents of all ages and abilities. Such communities enable older adults to age in place and maintain their independence while receiving support from family, friends and neighbors.

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 processes to make communities more livable for all ages.

Objectives

1. Implement a statewide long-term care awareness campaign to increase the number of individuals who develop a plan for meeting their long-term care needs. Market the Senior LinkAge Line® as the primary place consumers turn for comprehensive, objective long-term care options information.

   Strategies

   - Implement the Own Your Future Campaign, in partnership with the Department of Human Services. Key activities of this effort include:
     - Pilots in three areas in Minnesota to test different outreach methods (mailed letter vs. internet ads).
     - Introduce the campaign through PSAs on radio and TV (Aug-Sept 2012).
     - Launch the campaign through methods informed by the pilots (Labor Day – Dec 2012).
     - Continue statewide publicity and ongoing education and awareness activities by employers and grassroots organizations (mid-2012 through 2013).
   - Continue public awareness and education efforts related to long-term care planning after the Own Your Future Campaign. Inform these efforts by lessons learned through Own Your Future.

   Measures

   - Pilot results regarding effectiveness of different outreach methods.
   - Number of hits to webpages and other social media that provide information about Own Your Future and long-term care planning.
   - Number of local Own Your Future forums held and number of participants.

2. Improve the ability of Minnesota's communities to support older adults.
   Strategies
   - Conduct Aging 2030 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.
   - 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.

   Measures
   - Number of presentations conducted by state staff and AAAs.
   - Number of local development plans that address the needs of older adults.
   - Number of technical assistance "sessions" conducted with communities by state staff and AAAs.

3. Support statewide and community efforts to encourage older adults to continue working in both paid and volunteer roles.
   Strategies
   - Continue to partner with the Invisible Force, an informal collaboration of organizations working together to more effectively tap the resource of older adults who want to contribute to their communities. Build on the momentum resulting from the 2011 Volunteer Summit to realize the vision of the Lieutenant Governor.
   - Encourage CS/SD applications for projects that will develop and embed processes that facilitate mutual support among community members of all ages.
   - Partner with the Department of Human Services and Department of Employment and Economic Development to address employment options for older adults.

   Measures
   - Number of new state and local partnerships to recruit, refer, retain and fully utilize older adult volunteers.
   - Number of trainings and technical assistance "sessions" provided to potential CS/SD applicants.
   - Date of Older Worker Summit, tentatively scheduled for January 2013.
   - Number and type of policy or program changes resulting from state partnership on older workers.

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. <u>Area Plan Administration - Title III-3A</u>

   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	60+ POP	% POP	FACTOR	65+ LOW INCOME	% LOW INCOME	FACTOR	60+ MIN	% 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%			
LDSAAA	90,614	9.41%	5.18%	6,006	11.58%	2.32%	2,984	5.64%	0.56%	72,483	17.55%	1.75%	22,776	3.98	1.55%	11.36%
AAAA	77,703	8.07%	4.44%	3,947	7.61%	1.52%	2,007	3.79%	0.38%	51,282	12.41%	1.24%	18,222	4.26	1.45%	9.03%
CMCOA	131,738	13.68%	7.52%	8,590	16.56%	3.31%	2,912	5.50%	0.55%	85,676	20.74%	2.07%	11,835	11.13	0.57%	14.03%
MNRAAA	114,195	11.86%	6.52%	7,617	14.68%	2.94%	2,069	3.91%	0.39%	106,195	25.71%	2.57%	17,201	6.64	0.94%	13.36%
SEMAAA	98,399	10.22%	5.62%	5,922	11.41%	2.28%	2,888	5.46%	0.55%	68,123	16.49%	1.65%	6,770	14.53	0.45%	10.54%
MAAA	450,247	46.76%	25.72%	19,805	38.17%	7.63%	40,069	75.70%	7.57%	29,349	7.10%	0.71%	2,813	160.06	0.04%	41.67%
TOTALS	962,896	100.00%		51,887	100.00%		52,929	100.00%		413,108	100.00%		79,617	12.0941		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 60+ below Federal Poverty Guidelines
Minnesota 2010

Race/Ethnicity	Number of persons
Asian	1,307
Black	1,451
American Indian/Alaskan Native	468
Native Hawaiian/Pacific Islander	12
Other race	358
Hispanic/Latino	794
Total	4,390

Source: 2010 U.S. Census