

**2009 Area Plan Outcome Form  
PSA Southwest**

<u>Administration</u>	<b>Strategies and Measure(s)</b>	<b>Supporting Activities</b>
<p><b>Outcome:</b> Minnesota's Area Agencies on Aging have sufficient capacity to meet the needs of older adults and family caregivers through the provision of high quality administration, program development and coordination, and access assistance.</p> <p><b>Rationale:</b> Over the last several years, Minnesota has undertaken significant effort to rebalance its system of long-term care. The goal of these efforts is to provide community services and supports that are more affordable and better meet the needs and preferences of older adults and their families. Increasingly, the Area Agencies on Aging and their funded providers are asked to meet these needs and preferences through their programs. It is critical that the Area Agencies on Aging have sufficient capacity to meet the needs of current older adults and prepare for the needs of an aging population.</p>	<p>AAA can annually document the following:</p> <ol style="list-style-type: none"> <li>1. Satisfactory implementation of MBA standards for administrative, program development and coordination, and access functions are met. <u>Measure:</u> Standards, assurances and description of implementation processes included in Area Plan.</li> <li>2. Administrative structures and monitoring technology are in place for collecting data on persons served with Title III-funded services. <u>Measure:</u> Successful, timely completion of required NAPIS reports.</li> <li>3. In partnership with MBA, participate in statewide or national evaluation efforts regarding Title III programs. <u>Measure:</u> Submission of regional data in evaluation reports.</li> <li>4. An updated disaster plan is on file. Demonstrated capacity to implement pandemic plan assurances. <u>Measures:</u> Satisfactory disaster plan (including reports of implementation "tests") is on file.</li> <li>5. Administrative structures and processes (including cost-sharing and reporting) are in place to support delivery of new flexible, affordable and effective service models. <u>Measure:</u> Description of administrative structures and processes included in the Area Plan.</li> </ol>	<ol style="list-style-type: none"> <li>1. Provide administrative functions, including convening advisory council on aging meetings, board meetings, etc.</li> <li>2. Develop and implement internal work plan for program development/coordination outcomes.</li> <li>3. Implement plan for provision of administrative, program development/coordination and access functions in five county area (R6W); plan includes continued allocation of Title III funding to providers, representation on MNRAAA board, hiring of SOS staff person to serve 9 county area (R6E &amp; R6W), division of PDC activities amongst PDC staff from R6E, 8 &amp; 9, exploring ACA structure, etc.</li> <li>4. Strive to build trusting and productive relationships in 5 county area (R6W) through continued conversations with key individuals, broadening involvement beyond counties, sharing results of Communities for a Lifetime survey, etc.</li> <li>5. Perform functions related to grant/contract management, including timely completion of NAPIS reports.</li> <li>6. Collaborate with other area agencies on aging to develop administrative structures and processes that support delivery of new flexible, affordable and effective service models, including cost-sharing.</li> <li>7. Work with program development staff, advisory council on aging members and other key players to develop Title III funding priorities.</li> <li>8. Analyze benefits of utilizing contracts, rather than grants, for various Title III service categories; provide analysis to Title III Grant/Contract Task Force; submit recommendations to MNRAAA Board for implementation in 2011.</li> <li>9. Collaborate with program development staff and Title III-C nutrition providers to implement re-design activities approved by MBA.</li> <li>10. Increase skill level of administrative, program development/coordination and access staff through participation in applicable training. All staff will participate in at least one training focused on relationship-building with communities of color. Access staff will attend long-term-care-options training.</li> <li>11. Monitor and evaluate MNRAAA to ensure quality of administrative, program development/coordination and access roles via monthly</li> </ol>

		<p>reporting; engage board members in quarterly review process, make adjustments as warranted.</p> <ol style="list-style-type: none"><li>12. Update Emergency Preparedness Plan; share update with appropriate staff, partners and MBA.</li><li>13. Demonstrate capacity to implement pandemic plan assurances by implementing "test runs".</li><li>14. Participate in statewide or national evaluations of Title III programs, in partnership with MBA.</li><li>15. Meet MBA Standards for Administrative, Program Development and Coordination and Access Functions.</li></ol>
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<b><u>ACCESS: Direct Service</u></b>	<b>Strategies and Measure(s)</b>	<b>Supporting Activities</b>
<p><b>Outcome:</b> 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.</p> <p><b>Rationale:</b> 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®, <a href="http://www.MinnesotaHelp.info">www.MinnesotaHelp.info</a>®, and the suite of Aging and Disability Resource Center (ADRC) 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. Ongoing appraisal of the Senior LinkAge Line® service is necessary to evaluate, improve and expand the Senior LinkAge Line®.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> <li>1. Demonstrate compliance with the terms of the MinnesotaHelp Network /Senior LinkAge Line® System Standards and Assurances. <i>These standards and assurances will cover all aspects of the MinnesotaHelp Network .</i> <u>Measure:</u> Successful implementation of all Standards and Assurances demonstrated during annual site visit to AAA.</li> <li>2. Provide prescription drug expense assistance (RxConnect) to all ages. Establish a plan for increasing the number reached by a minimum of five percent (5%) in the Planning and Service Area. <u>Measures:</u> Data regarding Referral and Outreach activities reported in the Extranet calendar</li> <li>3. Increase outreach and information and assistance services to underserved individuals from diverse communities. This will include a specific focus on reaching Medicare beneficiaries with mental illness and to provide Medicare Part D Low Income Subsidy application and Part D plan selection assistance. <u>Measure:</u> Data reported in Referral and outreach activities reported in the Extranet calendar that focus on reaching underserved populations.</li> <li>4. Increased staff capacity to perform long-term care options counseling. [for definition refer to Section XIV of the 2009 Area Plan I and A Standards and Assurances] <u>Measure:</u> Number of staff participating in long-term care options training and number of counseling sessions provided reported in Referral and Extranet.</li> <li>5. Create and maintain a minimum of five (5) new</li> </ol>	<ol style="list-style-type: none"> <li>1. Develop internal work plan to ensure 2009 – 2010 “Standards and Assurances for the Senior LinkAge Line® System” and “Standards and Protocols for Prescription Drug Assistance for Minnesotans of all Ages” are implemented and met.</li> <li>2. Recruit and hire individual to provide SOS services in 9 county area (R6E &amp; R6W); access Core Body of Knowledge training, mentoring, etc.</li> <li>3. Recruit and support SLL/SHIP volunteers in 5 county area; provide quarterly training, regular updates, recognition, etc.</li> <li>4. Designate 1 person as Data Integrity Coordinator; ensure on-going integrity of resource information; participate in statewide conference calls, trainings and work groups.</li> <li>5. Designate 1 person as Volunteer Coordinator; participate in statewide conference calls, trainings and work groups.</li> <li>6. Designate 1 person as Call Center Coordinator; participate in statewide conference calls, trainings and work groups.</li> <li>7. Maintain minimum of 71 active volunteers.</li> <li>8. Ensure current volunteers receive minimum of 12 hours of training annually; include training on serving persons with mental illness and on long term care options counseling and planning.</li> <li>9. Maintain 5 specialty volunteers to assist with serving diverse populations, including minorities and dual eligibles with mental illness.</li> <li>10. Maintain Senior LinkAge Line® sites in each county within Southwest Planning and Service Area; designate volunteers and/or staff for each site.</li> <li>11. Increase outreach and information and assistance to underserved persons from diverse communities, including reaching Medicare beneficiaries with mental illness and assisting with Part D Low Income Subsidy Applications and Part D plan selection.</li> <li>12. Establish collaboratives and enhance partnerships with health care providers, counties, libraries, Centers for Independent Living, Social Security, mental health providers and others.</li> <li>13. Contact African Development Center (Mankato) and share information about Senior LinkAge Line®.</li> <li>14. Promote MinnesotaHelp network suite of tools.</li> </ol>

	<p>Minnesotahelp Network access and outreach sites (ADRC) with partners that include counties, hospital discharge planners, health care system providers, Centers for Independent Living, Disability Linkage Line and clinics.</p> <p><u>Measure:</u> Data reported via the Extranet ADRC outreach tool.</p>	<p>15. Develop 5 additional Minnesota Network access and outreach sites with partners that include counties, hospital discharge planners, health care system providers, Centers for Independent Living, Disability Linkage Line and clinics. Monitor and maintain established sites.</p> <p>16. Increase number of persons provided with prescription drug expense assistance (RxConnect) by 5% over 2008 baseline number.</p> <p>17. Provide 25 long-term care options counseling sessions.</p>
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<b><u>PD&amp;C: Prevention and Disease Management</u></b>	<b>Strategies and Measure(s)</b>	<b>Supporting Activities</b>
<p><b>Outcome:</b> Older adults and family caregivers will be empowered to manage their own health risks and, as a result, will access fewer acute health and long-term care services.</p> <p><b>Rationale:</b> According to Transform 2010, disability rates and health problems may be on the rise as the population ages. Close to 80 percent (%) of persons over age 65 have one or more chronic conditions and 65 percent (%) have multiple chronic conditions. While many chronic conditions cannot be cured or eliminated, many of the risk factors associated with chronic conditions can be ameliorated. Falls also pose significant health concerns for older adults, 30 percent (%) of whom fall each year. Older adults' risk for falls can be reduced through evidence-based interventions that also address chronic conditions. The Area Agencies on Aging and their local partners can provide the statewide infrastructure to deliver evidence-based interventions for older adults and family caregivers that will reduce health and long-term care costs.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> <li>1. New/expanded implementation of at least one evidence-based health promotion/disease prevention intervention (focusing on falls prevention, physical activity or healthy eating). <u>Measure:</u> Number of new/expanded evidence-based intervention(s) and estimates of persons served in quarterly reports.</li> <li>2. New/expanded implementation of at least one evidence-based disease management intervention (focusing on chronic disease self-management, memory care or depression). <u>Measure:</u> Number of new/expanded evidence-based intervention(s) and estimates of persons served in quarterly reports</li> <li>3. Strengthening partnerships to <i>target</i> high-risk older adults and family caregivers and referrals to evidence-based interventions. <u>Measure:</u> Number and status of partnerships included in quarterly reports</li> <li>4. Implementation of nutrition service redesign activities. <u>Measure:</u> Nature and status of nutrition service redesign activities included in quarterly reports.</li> </ol>	<ol style="list-style-type: none"> <li>1. Provide technical assistance with development of 1 evidence-based falls prevention intervention in EDA 8.</li> <li>2. Develop additional partnerships with physical therapists to expand number of Bone Builder sites in EDA 6E.</li> <li>3. Participate in Matter of Balance training; partner with 1 community in EDA 9 to sponsor and lead classes.</li> <li>4. Disseminate information throughout 27 county area to older adults, family caregivers, Senior LinkAge Line® volunteers and providers about the Minnesota Falls Prevention Initiative; explore and/or assist with development of local initiatives.</li> <li>5. Collaborate with agencies in Sibley County to develop and implement Arthritis Exercise Program; explore development of program in Pipestone County.</li> <li>6. Monitor and provide assistance, as needed, to on-going EnhanceFitness classes in Blue Earth and Nicollet Counties.</li> <li>7. Provide continued assistance to Waseca Medical Center – Mayo Health System with implementation of New York University Caregiver Intervention targeted at caregivers of care receivers with memory loss.</li> <li>8. Provide technical assistance to Immanuel St. Joseph's Hospital – Mayo Health System, Mankato Clinic and Meeker Memorial Clinic with implementation of Alzheimer's Disease Demonstration Grant early intervention/evidence-based initiatives.</li> <li>9. Provide continued technical assistance to Redwood Area Hospital with implementation of Caregiver Coach Model.</li> <li>10. Partner with Age Well Network and continue work with staff from "Cognitive Fitness for a Lifetime of Memory Health"; explore piloting project in Minnesota.</li> <li>11. Promote prevention and disease management activities by assisting Age Well Network in bidding for 2011 Minnesota Senior Olympics.</li> <li>12. Partner with Discharge Planner Networks, ROSE Partners, public health, home care, MSHO staff, clinics, etc., to determine how to better target at-risk older adults and family caregivers and to raise awareness about</li> </ol>

		<p>prevention and disease management evidence-based programs.</p> <ol style="list-style-type: none"><li>13. Meet with key individuals from 5 county area to assess and prioritize need for development of an evidence-based health promotion/disease prevention intervention or evidence-based disease management intervention; provide technical assistance with development of intervention.</li><li>14. Collaborate with administrative staff, Title III-C nutrition providers and key partners throughout 27 county area to implement re-design activities approved by MBA.</li></ol>
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<b><u>PD&amp;C: Flexible, Affordable, Effective Intervention</u></b>	<b>Strategies and Measure(s)</b>	<b>Supporting Activities</b>
<p><b>Outcome:</b> Older adults and family caregivers are able to sustain their community living by accessing services that they need and want to buy. As a result they are able to delay or avoid nursing home placement.</p> <p><b>Rationale:</b> According to Transform 2010, current service models and spending patterns are not sustainable with the aging of the population. It is critical to empower older adults and family caregivers 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 Area Agencies on Aging and their local partners connect directly with older adults and family caregivers who are at-risk for nursing home placement and Medicaid spenddown. They will play a significant role in providing a new set of services that will help them maintain their community living.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> <li>1. Development of partnerships to deliver modernized, market-driven services. <u>Measure:</u> Number of partnerships/initiatives and status of new model development included in quarterly reports.</li> <li>2. Partnerships with providers to improve targeting to high-risk older adults and family caregivers. <u>Measure:</u> Status of partnerships and targeting efforts included on quarterly reports.</li> <li>3. Develop new capacity to provide individual assistance to targeted high risk older adults and family caregivers. <u>Measure:</u> Number of AAA and/or local partner staff providing individual assistance; number of targeted individuals served.</li> <li>4. Development of capacity to leverage funding sources other than Title III (private pay, fee for service, third party payers) to provide flexible, affordable, effective interventions, including but not limited to consumer directed care options. <u>Measure:</u> Status of development process included in quarterly reports.</li> </ol>	<ol style="list-style-type: none"> <li>1. Convene and facilitate caregiver support/respite provider network meetings focused on development of modernized market-driven services.</li> <li>2. Allocate Title III-E funding for consumer-directed caregiver respite; monitor utilization, provide technical assistance as needed.</li> <li>3. Continue technical assistance to Lutheran Social Service and Coalition of African Community Services with provision of consumer choice meals for East African elders.</li> <li>4. Continue designation of State Nutrition Support Grant funding for nutrition counseling for congregate and home delivered meal participants identified to be at high nutritional risk.</li> <li>5. Partner with local food shelves and Title III-C nutrition providers to identify older adults at nutritional risk and to make appropriate referrals.</li> <li>6. Pursue development of partnership with New African Unity to develop program that would reduce isolation of elderly Somali women.</li> <li>7. Contact African Development Center (Mankato). Discuss possibility of partnering to address needs of African immigrants.</li> <li>8. Maintain partnership with West Central Integration Collaborative. Discuss methods to improve targeting to high-risk Hispanic older adults.</li> <li>9. Partner with Redwood County Volunteers, Redwood Area Hospital, Nobles County Senior Concerns and Rock County senior organizations to sponsor caregiver retreats in three counties.</li> <li>10. Partner with Bethesda Adult Day Services, Atwater LAH/BNP and LSS to target high-risk family caregivers via caregiver conference.</li> <li>11. Assist New Ulm Medical Center with delivery of CarFit, a program that determines how to adapt a vehicle to older adults changing needs; explore expansion to 1 additional site.</li> <li>12. Participate or encourage providers to participate in and utilize Powerful Tools training targeted at maintaining</li> </ol>

		<p>well-being of caregivers.</p> <ol style="list-style-type: none"><li>13. Explore provision of flexible case management services for private pay persons age 60+.</li><li>14. Hold discussions with providers and counties regarding contracting for caregiver coach services.</li><li>15. Research funding options other than Title III-C for provision of home delivered meals in rural areas.</li><li>16. Explore transitioning Sibley County FIA program to fee-for-service model, including home management services.</li><li>17. Continue data collection of key elements of Waseca Medical Center – Mayo Health System Caregiver Coach model.</li><li>18. Pilot Working Caregiver Resource Guide/Employee Brochure with 5 employers.</li></ol>
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<b><u>PD&amp;C: Transform 2010 - Preparing for an Aging Population</u></b>	<b>Strategies and Measure(s)</b>	<b>Supporting Activities</b>
<p><b>Outcome:</b> Minnesota’s communities are good places to grow up and grow old, and offer physical, social and service features for their residents of all ages.</p> <p><b>Rationale:</b> Most boomers and current older people want to remain in their own homes and communities as long as possible and age in place there. They are more likely to be able to do so if communities provide physical, social and service supports needed by residents of all ages and abilities. In order to prepare for the aging of the population, we must work with a broad range of partners to fulfill the vision of Transform 2010. Minnesota’s Area Agencies on Aging play a critical leadership role in convening partners to address community-wide issues related to the aging of the population.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> <li>1. Education about Transform 2010 provided to community groups or organizations. <u>Measure:</u> Number of presentations conducted, by community and organization, included in quarterly reports.</li> <li>2. Provision of information on Transform 2010-related promising practices provided to community groups and organizations. <u>Measure:</u> Number of groups/organizations that received information included in quarterly reports.</li> <li>3. Technical assistance on applying for CS/SD and other grants provided to community groups or organizations. <u>Measure:</u> Number of groups/organizations that received technical assistance regarding grant applications included in quarterly reports.</li> </ol>	<ol style="list-style-type: none"> <li>1. Analyze results of 2008 “Communities for a Lifetime” (CFL) survey conducted with municipalities located throughout SW Planning and Service Area.</li> <li>2. Raise awareness about aging of the population by providing presentations related to Transform 2010 and survey results of CFL. Target communities*, organizations and employers. Partner with local Regional Development Commissions, ElderCare Development Partnership and other agencies. Provide 16 presentations to 5 communities, 9 organizations, and 2 employers.</li> <li>3. Assist 4 communities and 2 organizations in addressing needs of current and future older adults; needs potential to be addressed could include transportation, housing, and physical, service and social infrastructures. Assistance may include providing information about best practices related to Transform 2010, connecting to resources, and identifying partners.</li> <li>4. Develop and implement standardized process to be used for evaluation of CS/SD grant proposals.</li> <li>5. Promote availability of CS/SD funding and provide technical assistance to communities and organizations to ensure development of strong CS/SD or other grant applications. Assistance may include identifying partners, developing budgets, reviewing proposal, etc.</li> <li>6. Explore expansion of transportation rider companion model in EDA 8 and promote volunteer driver training.</li> <li>7. Continue to partner with providers in Sibley County to resolve transportation issues.</li> <li>8. Strengthen community-based organizations by assisting them to generate revenue and community support; encourage participation in on-line sustainability training developed by Southeast Metro SAIL/EDP.</li> <li>9. Promote utilization of home-and-community-based services by maintaining 2 market-based Discharge Planner Networks.</li> <li>10. Assist Country View Assisted Living with implementation of wireless monitoring system.</li> </ol> <p>* "Communities" may include townships, cities, counties, neighborhoods, market areas and/or cultural/ethnic clusters.</p>

