

**2010 Area Plan Outcome Form
PSA Southwest**

<u>ACCESS: Direct Service</u>	Strategies and Measure(s)	Supporting Activities
<p>Outcome: 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. Throughout each Planning and Service Area, the service will be available by phone, in person and via internet (chat).</p> <p>Rationale: Federal and state policies stress the importance of accurate and timely information made available to help older persons and their families (as well as all persons with disabilities) to know their choices and options in regards to community services and supports. The Senior LinkAge Line®, www.MinnesotaHelp.info®, and the suite of MinnesotaHelp Network™ information tools are critical to helping Minnesotans understand and utilize services and resources. Information should also be available to help people to prepare in advance for their own aging and retirement, to understand tools for using their own resources (e.g., reverse mortgages, long-term care partnership) 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"> 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. 2. Provide prescription drug expense assistance (RxConnect™) to all ages. Establish a plan for increasing the number reached by a minimum of three percent (3%) in the Planning and Service Area. <u>Measure:</u> Data in Web Referral and Outreach activities reported in the Extranet calendar demonstrate an increase in serving persons of all ages with RxConnect™ assistance. 3. Increase outreach and information and assistance services by a minimum of 5% to underserved individuals from diverse communities. This will include a specific outreach focus and 5% of SHIP funding dedicated to supporting activities to reach dual eligible Medicare beneficiaries with mental illness. Increased application assistance provided in all Planning and Services Areas with Medicare Part D Low Income Subsidy and Medicare Savings Programs as well as Part D plan selection assistance. <u>Measure:</u> Data reported in Web Referral and outreach activities reported in the Extranet calendar that focus on reaching underserved populations with the activities. 4. Increase staff capacity to perform long-term care options counseling and nursing home conversion work. <u>Measure:</u> Number of staff participating in long-term care options and nursing home conversion trainings and number of counseling sessions provided reported in Web Referral and Extranet. 5. Maintain current MinnesotaHelp Network™ sites and look at expansion opportunities that might exist with partners such as; 	<ol style="list-style-type: none"> 1. Develop and implement internal work plan to ensure 2010 – 2011 MinnesotaHelp Network™ / Senior LinkAge Line® System Standards and Assurances are implemented and met. <i>Demonstrate successful implementation during MBA site visit.</i> 2. Maintain Contact Center, Volunteer, and Data Integrity Coordinators’ positions; participate in statewide conference calls, trainings and work groups. <i>Document activities.</i> 3. Maintain minimum of 71 active volunteers. <i>Document number.</i> 4. Maintain 5 specialty volunteers to assist with serving diverse populations, including minorities and dual eligibles with mental illness. <i>Document number of volunteers.</i> 5. Develop and implement training policy for staff and volunteers. <i>Document date of implementation and progress made toward meeting training standards defined in policy.</i> 6. Implement volunteer risk management plan developed by volunteer coordinators and approved by MBA. <i>Document date of implementation.</i> 7. Maintain Senior LinkAge Line® sites in each county within Southwest Planning and Service Area; designate volunteers and/or staff for each site. <i>Document location of sites.</i> 8. Develop and implement plan for local and regional promotion, publicity and public information activities. <i>Document date of implementation and progress made toward completion of activities.</i> 9. Increase outreach and information and assistance services by minimum of 5% to underserved individuals from diverse communities; include specific outreach focus and 5% of SHIP funding

	<p>counties, hospital discharge planners, libraries, health care system providers, assisted living facilities, Centers for Independent Living, Disability Linkage Line® and clinics. <u>Measure:</u> Data reported via the Extranet MinnesotaHelp Network™ Kiosk Management tool.</p> <p>6. Provide phone based assistance to Transitional Consultation callers of all ages. <u>Measure:</u> Data reported In Web Referral including utilizing the risk management tool and the follow up components.</p>	<p>dedicated to supporting activities to reach dual eligible Medicare beneficiaries with mental illness. Increase application assistance provided with Medicare Part D Low Income Subsidy, Medicare Savings Programs and Part D plan selection. <i>Data reported via Web Referral and outreach activities in Extranet calendar that focus on reaching underserved populations.</i></p> <p>10. Provide 20 Senior Surf days. <i>Document number and location of Senior Surf Days.</i></p> <p>11. Provide 90 community education events. <i>Document that 85% of individuals who attend “What’s New in Medicare for 2010” presentation and respond to survey, indicate presentation answered questions they had on what was new in Medicare for 2010.</i></p> <p>12. Establish collaboratives and enhance partnerships with health care providers, counties, libraries, Centers for Independent Living, Social Security, pharmacies, mental health providers and others. <i>Document name of collaboratives established and partnerships enhanced.</i></p> <p>13. Maintain current MinnesotaHelp Network™ sites; explore opportunities for expansion with partners such as counties, hospital discharge planners, libraries, health care system providers, assisted living facilities, Centers for Independent Living, Disability Linkage Line and clinics. <i>Report via the Extranet MinnesotaHelp Network™ Kiosk Management tool.</i></p> <p>14. Establish plan to increase number of persons of all ages provided with prescription drug expense assistance (RxConnect) by 3% over 2009 baseline number. <i>Document 2009 baseline number and number served in 2010.</i></p> <p>15. Increase staff capacity to perform long-term care options counseling and nursing home conversion</p>
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<u>PD&C: Prevention and Disease Management</u>	Strategies and Measure(s)	Supporting Activities
<p>Outcome: <i>Reduce future LTC need</i> Older adults will be empowered to manage their own health risks and, as a result, will age successfully, requiring fewer acute health and long-term care services.</p> <p>Rationale: According to Transform 2010, the numbers of persons with multiple chronic illnesses and disabilities will be on the rise as the population ages. Close to 80 % of persons over age 65 have one or more chronic conditions and 65% have multiple chronic conditions. While many chronic conditions cannot be cured or eliminated, the risk factors associated with them can be reduced or ameliorated. Falls also pose significant health concerns for older adults, 30% of whom fall each year. Older adults' risk for falls can be reduced through evidence-based interventions that also address chronic conditions. The Area Agencies on Aging and their local partners can provide the statewide infrastructure to deliver evidence-based interventions for older adults that will reduce health and long-term care costs.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> 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. 2. New/expanded implementation of at least one evidence-based disease management intervention (focusing on chronic disease self-management, or depression). <u>Measure:</u> Number of new/expanded evidence-based intervention(s) and estimates of persons served in quarterly reports 	<ol style="list-style-type: none"> 1. Provide technical assistance with development and/or expansion of 4 evidence-based healthy eating interventions; target northwest area of SW PSA. <i>Document number of new and/or expanded evidence-based interventions developed and number of persons served by intervention(s).</i> 2. Provide technical assistance to Blue Earth/Nicollet County “Feed Our Communities” committee with addressing nutritional deficiencies of older adults. <i>Document assistance provided and outcome of committee activities.</i> 3. Disseminate information 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. <i>Document dissemination activities and initiatives explored/developed.</i> 4. Provide technical assistance with development and/or expansion of 9 evidence-based Matter of Balance programs. <i>Document number of individuals trained as Matter of Balance coaches; number of evidence-based Matter of Balance programs expanded and/or developed; and number of Matter of Balance class participants.</i> 5. Strategize with Discharge Planner Networks, public health, county human services, etc. to determine how to better target at-risk older adults and family caregivers and how to raise awareness about availability of evidence-based programs. <i>Document strategies identified to better target at-risk older adults and family</i>

		<p><i>caregivers and strategies identified to raise awareness about availability of evidence-based programs.</i></p> <ol style="list-style-type: none">6. Monitor and provide assistance, as needed, to on-going EnhanceFitness classes in Blue Earth and Nicollet Counties. <i>Document assistance provided and number of class participants.</i>7. Partner with Age Well Network; continue efforts to pilot evidence-based “Cognitive Fitness for a Lifetime of Memory Health” in SW PSA; provide technical assistance with planning efforts involved with Minnesota Senior Games to be held in Mankato in 2011 and 2012. <i>Document assistance provided and status of efforts.</i>8. Provide technical assistance in development of 6 evidence-based chronic disease self-management interventions. <i>Document assistance provided; number of interventions developed; and number of persons served.</i>
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PD&C: Targeted LTC Supports	Strategies and Measure(s)	Supporting Activities
<p>Outcome: High risk persons are supported with effective interventions. Older adults and family caregivers who are at high risk are able to sustain their community living by accessing services that meet their identified need and are of value to them. As a result they are able to better manage risk factors and delay or avoid spend-down to MA.</p> <p>Rationale: Minnesota’s new criteria for determining eligibility for the Elderly Waiver and Alternative Care programs will identify older persons who are in need of support to remain independent, but who do not meet the stricter criteria for these programs. In order to support these and other identified high-risk persons, it will be necessary to ensure that critical services are available in their communities, and that protocols and referral patterns are in place to help them access these services.</p> <p>In addition, at-risk older adults and family caregivers who are identified through other community partners require assistance to manage their risks, to make informed decisions about available options, and to better conserve and extend their own resources, including family/informal caregivers and their own financial resources. Minnesota’s Area Agencies on Aging and their local partners can connect directly with older adults who are at-risk for nursing home placement and/or Medicaid spend-down and their family caregivers. They will play an important role in providing a set of essential services to help them maintain their community living.</p>	<p>AAA can document the following:</p> <ol style="list-style-type: none"> Using DHS-provided template, inventory service capacity (and gaps) of essential community services in the PSA. <ul style="list-style-type: none"> Personal emergency device or system Caregiver support (including evidence-based caregiver support programs) Homemaker Chore Home Delivered Meals <p><u>Measure:</u> By June 30, 2010 AAA has completed a DHS-supplied inventory of essential community service capacity in their PSA and has identified service weaknesses/gaps.</p> Develop local essential services capacity (includes basic business planning and access to funding sources other than Title III , e.g., private pay, third party payers, CS/SD, etc.). <u>Measure:</u> Documentation that Title III and other providers are prepared and in place to meet estimated need by Jan. 1, 2011. AAAs are prepared to implement the Return to Community and Essential Community Services following the guidance developed by Expert Panel Stakeholder Group regarding roles and referral protocols between the AAA and the lead agencies in their PSA. <u>Measure:</u> By December 30, 2010, AAA has an Implementation plan for their PSA. Use of DHS-supplied data on county-level Case Mix, MDS and RUGS data, NAPIS and other data sources to guide targeting and service development activities. <u>Measure:</u> Status of data analysis and system development progress included in quarterly reports. 	<ol style="list-style-type: none"> Inventory service capacity, including gaps, of essential community services in SW PSA; utilize DHS-provided template, Resource House, Discharge Planner Networks, etc. <i>Document completion of inventory and identification of service capacity and weaknesses/gaps by June 30, 2010.</i> Develop capacity of local essential community services by providing technical assistance to communities and organizations applying for CS/SD and other grant funding; assist with basic business planning and development of services for private-pay market; encourage organizations to participate in on-line sustainability training; etc. <i>Document names of communities/organizations provided with grant-writing technical assistance; names of communities/organizations assisted with basic business planning; types of services developed for private-pay market; and number and types of essential community services developed.</i> Maintain partnership with West Central Integration Collaborative in order to identify methods to improve targeting of services to high-risk Hispanic older adults. <i>Document methods identified and implemented.</i> Ensure Title III nutrition providers gather

		<p>complete and accurate information for NAPIS reporting. <i>Document NAPIS data is reviewed for accuracy.</i></p> <ol style="list-style-type: none"> 5. Allocate Title III-C and Title III-E funding for consumer directed/consumer choice services. <i>Document assistance provided and number of persons served.</i> 6. Develop implementation plan for Return to Community and Essential Community Services initiatives, provide input to DHS in regard to development of roles and referral protocols between AAAs and lead agencies. <i>Document development of implementation plan by December 30, 2010.</i> 7. Provide technical assistance to Project ROSE partners and other providers with implementation of Live Well at Home Rapid Screen tool. <i>Document name of providers who implement Rapid Screen tool.</i> 8. Provide technical assistance to 8 providers with implementation of Powerful Tools for Caregivers. <i>Document assistance provided and names of providers who implement Tool.</i> 9. Continue provision of technical assistance to Caregiver Coaches, including working with counties to contract for service provision. <i>Document assistance provided and names of counties who enter into contracts for caregiver coach service.</i> 10. Continue provision of technical assistance to Alzheimer's Disease Early Stage Memory Loss projects. <i>Document assistance provided.</i>
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<u>PD&C: Transform 2010 - Preparing for an Aging Population</u>	Strategies and Measure(s)	Supporting Activities
<p>Outcome: <i>Communities for a Lifetime</i> 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>Rationale: Most boomers and current older people want to remain in their own homes and communities as long as possible and to 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"> 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. 2. Provision of information on Communities for a Lifetime promising practices to community groups and organizations. <u>Measure:</u> Number of groups/organizations that received information included in quarterly reports. 	<ol style="list-style-type: none"> 1. Provide education about aging of the population by providing presentations in 12 communities to 12 organizations/ community groups. Presentations will focus on information from Transform 2010 and results from Communities for a Lifetime (CFL) survey. <i>Document number of presentations conducted; names of communities where presentations held; and names of organizations/community groups that hosted presentations.</i> 2. Provide information on CFL promising practices to 7 organizations/community groups. <i>Document number and name of organizations/communities that received CFL promising practices' information.</i> 3. Convene broad range of partners to address needs related to aging of the population, such as transportation, housing, physical and social infrastructures, etc., in 4 communities. <i>Document number of communities where partners convened; types of assistance provided; and results of assistance provided.</i> 4. Assist interested communities to provide CarFit or Older Driver Programs. <i>Document assistance provided; number of programs held; and number of program participants.</i> 5. Provide MBA-developed Working Caregiver resources to 6 businesses; when requested, provide technical assistance to businesses in development of working caregiver supports. <i>Document number and name of businesses that received resources and types of assistance provided.</i>