State of Illinois
Illinois Department on Aging

STATE PLAN ON AGING

FY 2022–FY 2024

ACKNOWLEDGEMENTS

The Department on Aging would like to thank the people and organizations who provided feedback and input during the development of the State Plan on Aging. The Department is also grateful for staff members who helped contribute content and provided editorial support. Finally, the Department is grateful to Health & Medicine Policy Research Group for its expertise and support to ensure the voices of older adults across Illinois were represented.

TABLE OF CONTENTS

Acknowledgements 1
Message from the Governor 2
Message from the Director 3
Verification of Intent 4
Executive Summary 5

Purpose and Development of State Plan 8
Impact of COVID-19 9
Context and Emerging Trends 10
Goals, Strategies, Objectives, and Outcomes 23
Quality Management and Implementation 60

Appendices
- Appendix A: State Plan Assurances and Required Activities 61
- Appendix B: Information Requirements 73
- Appendix C: Interstate Funding Formula (included as separate attachment)
- Appendix D: Public Stakeholder Process and Feedback 82
    1. Public Hearings
    2. Summary of Comments and Responses (included as separate attachment)
- Appendix E: Demographic Data 84
- Appendix F: Area Agencies on Aging 92

OFFICE OF THE GOVERNOR
207 STATE HOUSE
SPRINGFIELD, ILLINOIS 62706

JB PRITZKER
GOVERNOR

July 14, 2021

Dear Fellow Illinoisans,

Taking care of Illinois' most vulnerable seniors is at the core of our state's values and the top of our priorities. Illinois, as a requirement of the federal Older Americans Act and the Administration for Community Living, submits a State Plan on Aging every three years. Developed and administered by the Illinois Department on Aging, this plan details goals, strategies, and objectives designed to meet the changing needs of older adults and their caregivers. Bound by the Department on Aging's mission—promoting respect for yesterday, support for today, and a plan for tomorrow—the plan will promote quality, culturally appropriate services for a rapidly diversifying community of older adults.

The COVID-19 pandemic has tragically and inordinately affected Illinois' older adults, highlighting the changing nature of need in our senior communities. Through extensive stakeholder input and partnerships with a wide network of organizations, the State Plan on Aging incorporates innovative approaches to address these issues. Over the next three years, this plan seeks to meet today's unprecedented challenges and to target older Illinoisans with the greatest financial and social need, particularly focusing on older adults' ability to safely live in their homes.

Illinois' older are treasured and integral residents of our state. This plan is designed to meet their needs, providing the highest quality services possible through the hard work of the Department on Aging and its many partners and stakeholders.

Sincerely,

ural Resources Way, Suite 100, Springfield, Illinois 62702-1271
Phone: 800-252-8966 • 888-206-1327 (TTY) • Fax: 217-785-4477

A Message from Director Paula Basta

The Illinois Department on Aging is committed to serving and advocating on behalf of older Illinoisans and their caregivers. It has been an honor to work with our staff, partners and stakeholders inside and out of our Aging Network on the development of the three-year Illinois State Plan on Aging, which will be executed through Federal Fiscal Year 2024. This plan reflects IDoA's mission of providing programs that promote partnerships and encourage independence, dignity and quality of life to the aging population.

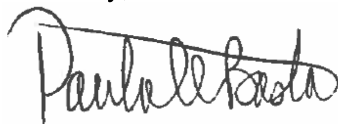
Older Illinoisans have shaped our state's rich history, and it's our obligation to ensure that they have the services and supports they depend on to live healthy lives. Recognized by the federal government as the designated State Unit on Aging, the Department on Aging is bound by the federal Older Americans Act to focus programs and develop targeted outreach to support older Illinoisans with the greatest economic and social need.

The fact is our population is living longer and fuller lives. Since 2000, Illinois' older population (60 years of age and older) has grown from 1.9 million to 2.8 million. It now represents 22% of the population in Illinois. By 2030, it is estimated that the 60 years of age and older population will increase to 3.6 million and will represent 25% of Illinois' population. This continued growth reflects an increase in needs for services, as well as refining our services so that older adults impacted by factors such as physical and mental disabilities, language barriers, cultural, social or geographical isolation, including isolation caused by racial or ethnic status, are able to continue living in their own homes with assistance through a person-centered plan of care.

In March of 2020, the country was inundated with cases of the Coronavirus (COVID-19), which resulted in a worldwide pandemic. We learned that the greatest risk for severe illness from COVID-19 is among our older adults; particularly if they are 85 years of age or older, as well as those that have underlying medical conditions. During this unprecedented time, the Aging Network continued to be strong and resilient; forging new partnerships and innovative solutions to coordinate better at the local level, ensuring that our older adults continued to receive the services they depend on.

This State Plan establishes department priorities which exceed and surpass our obligations, as well as making investments for the future after years of financial turbulence. I thank all of you who took the time to review the plan, provide input and pledge your support to help us meet our goals, while also being a part of a systems change. We look forward to continued collaboration with other agencies and our network partners as we together accomplish ***respecting yesterday, supporting today,*** **and** ***planning for tomorrow***.

Sincerely,



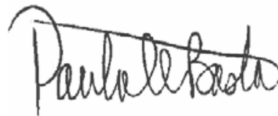
Paula Basta, M.Div.
Director, Illinois Department on Aging

VERIFICATION OF INTENT

The State Plan on Aging is hereby submitted for the State of Illinois for the period of October 1, 2021, through September 30, 2024. It includes all assurances and plans to be conducted by the Illinois Department on Aging under provisions of the Older Americans Act, as amended, during the period identified. The Illinois Department on Aging has been given the authority to develop and administer the State Plan on Aging in accordance with all requirements of the Act and is primarily responsible for the coordination of all State activities related to the purposes of the Act.

This State Plan is hereby approved by the Governor and constitutes authorization to proceed with activities under the Plan upon approval by the Assistant Secretary for Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements.



12/3/2020
____
Date

____
Paula A. Basta, Director, Department on Aging

12/23/20
____
Date

____
JB Pritzker, Governor

EXECUTIVE SUMMARY

The U.S. Census Bureau has indicated the year 2030 is a turning point for the population of the United States; it marks the year that all baby boomers will be older than 65 and when immigration is likely to be the primary driver of population growth in the country.[1] The State of Illinois is experiencing this change in demographics similar to other states across the nation. In 2018, there were an estimated 2.8 million adults aged 60+ in Illinois, representing 22% of the population.[2] Growth among older adults in Illinois is expected to continue, with those age 60+ increasing to 25% by 2030. This growth does not come without more sobering statistics. In 2018, 9.9% of individuals aged 60+ had incomes below 100% of the federal poverty level, and 39.4% of older adults 60+ lived alone.[3] Despite these challenges, the Aging network continues to provide crucial services so older adults can remain in their homes and communities. In FY 2019, 71,000 individuals received Community Care Program services. With this data in mind, it is crucial for Illinois to take an innovative and forward-thinking approach to developing our State Plan on Aging for FY 2022- FY 2024, to ensure older Illinoisans and their caregivers are provided the necessary services that allow for independence and the ability to maintain their quality of life.

In addition to the changes in the demographics of Illinois' aging population coupled with the projected growth in the population of older adults, we anticipate the needs of these individuals and their caregivers will evolve. We have learned from the experiences of the COVID-19 pandemic that the challenges older adults face today may not be the same in the future. Our older adults are an increasingly diverse population, (LGBT, racial and ethnic minorities and persons with disabilities), with complex co-occurring physical and mental health conditions, substance use disorders, and earlier onset of dementia.

Moving forward, the improved integration of healthcare and social services is paramount. The Aging network has been responding to the social determinants of health (SDOH) throughout its history, for example, promoting food security and access to home delivered meals; however, the Illinois Department on Aging has traditionally viewed its community service model as a "social" model. Over the past several years, the national trend has been moving towards improved integration of healthcare and social services. Here in Illinois, the Aging network plays a critical role in assisting older adults with navigating the managed care landscape and, in addition to quality healthcare that the SDOH play a pivotal role in supporting older adults' ability to remain independent and living in their own homes.

COVID-19 has also brought to the forefront the negative impact of social isolation and loneliness older adult's experience. They are missing the camaraderie and interaction that they previously experienced at adult day services and senior centers. The pandemic has made it even more difficult for family members to provide support; older children live far away and individuals who live in multi-generational households are worried about the risk of contracting the virus. This has further highlighted the need for innovative approaches, including expanded

[1] "Demographic Turning Points for the United States: Population Projections for 2020 to 2026."
[2] U.S. Census table S0101.
[3] U.S. Census table S0101.

access to technology for staying connected but also to ensure access to essential healthcare. Recent analysis of fee-for-service Medicare data during the early period of the COVID-19 shutdown indicated 40% of primary care visits were completed via telehealth. This is an increase from 0.1% of primary care visits via telehealth prior to the public health emergency.[4] However, technology, like a tablet or iPad is not enough; we have learned from grant programs and the Area Agencies on Aging initiatives that education and proper technical support is vital for full utilization of a device.

Over the last several years, the Department has been moving in the direction of utilizing data to drive policy and programmatic decisions. The implementation of the automated critical event reporting system and the adult protective case management system provide the Department with the ability to analyze trends and better evaluate the effectiveness of services. The implementation of the new Aging Cares Community Care Program (CCP) case management system will provide additional data points related to the CCP population. We expect growth in the number of older adults who may be eligible for CCP in future years, and when SDOH (i.e. access to transportation, healthy and nutritious food) are taken into consideration it is critical for the Aging network to prepare to meet older adults' current needs and address those we anticipate in the future.

How we address the changing needs while still ensuring that older adults are able to "age in place" as much as possible presents a challenge for the Aging network. In order to prepare for the changing landscape, we worked to develop goals, strategies, and objectives in the State Plan "to answer the needs and experiences of older adults and the families who stand by them now and into the foreseeable future".[5]

The FY 2022 - FY2024 State Plan aligns with the broader Department strategic priorities that were established in 2019. The priorities created the foundation for development of the goals for the Plan and align with the four focus areas as outlined in the Administration for Community Living (ACL) State Unit on Aging Directors Letter #02-2019. The strategic priorities include:

1) Support older adults' ability to remain independent and in their own homes through the provision of quality home and community-based services with a strong focus on healthy aging and prevention.

2) Respond and follow up on reports of abuse, neglect, and exploitation of older adults and persons with disabilities through the Adult Protective Services and Long-Term Care Ombudsman Program.

3) Ensure adequate capacity for services and supports in the Aging network for the projected growth in the Aging population. Stabilize the Aging workforce and partner with experts in the field to expand training opportunities.

4) Maximize federal, state, local and private resources to sustain and expand services and

---

[4] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.
[5] Aging Today, September-October 2019; California's Master Plan for Aging: putting the Golden State's aging population front and center; Bruce Chernof, Shelley Lyford and Christopher Langston.

supports to older adults. Ensure Aging provider network is an integral component of options covered by Managed Care.

5) Promote responsive management through the enhanced use of data to drive programmatic decisions and enhanced IT systems to improve efficiencies within the delivery of services.

6) Address social determinants of health including but not limited to housing, food, education, employment, healthy behaviors, transportation, and personal safety to improve health and reduce longstanding disparities in health and health care. Continue statewide expansion of Age-Friendly communities.

The FY 2022 - FY 2024 State Plan on Aging focuses on key goals and objectives of the Illinois Department on Aging, and in partnership with the Aging network, will work to implement and monitor to ensure older adults and their caregivers are provided with the highest quality services and resources over the next three years and into the future.

Goal 1: Fulfill mandate as the State Unit on Aging to effectively administer the Older Americans Act, Title III and Title VII core programs in partnership with the Area Agencies on Aging and other partners in the Aging network.

Goal 2: Expand and ensure equitable access to programs that address the social determinants of health with a focus on identifying and understanding the needs of underserved and diverse populations.

Goal 3: Maximize federal, state, local, and private resources to sustain and expand services and supports to older adults.

Goal 4: Ensure that adequate capacity for services and supports is developed in the Aging network to prepare for the projected growth and diversity in the Aging population.

Goal 5: Enable older Illinoisans, their families, and other consumers to choose and easily access options that support older adults' ability to stay in their homes and communities.

Goal 6: Ensure implementation of federally mandated Person-Centered Planning practices Statewide.

Goal 7: Prevent and improve response to abuse, neglect and exploitation while preserving rights of older adults and persons with disabilities in all settings.

Goal 8: Promote responsive management and improve efficiencies within the delivery of services through the use of data and enhanced IT systems.

PURPOSE AND DEVELOPMENT OF THE STATE PLAN ON AGING

The Illinois State Plan on Aging is the planning document that the Illinois Department on Aging (IDoA) produces in collaboration with stakeholders to guide Older Americans Act-related programmatic activities and services for older adults. In order to be eligible to receive funds under the Older Americans Act, Section 307 of the Act requires the State to submit to the Administration for Community Living (ACL), a State Plan on Aging which meets the criteria established by ACL through federal regulations. Each State Unit on Aging has been afforded the opportunity by ACL to develop its own format for the State Plan and determine the effective duration of the Plan. Illinois has opted to create a three-year State Plan for the period of federal fiscal years 2022-2024. The IDoA maintains the authority for the development and implementation of this plan through Title 89, Chapter II, Part 230 of the Illinois Administrative Code.[6]

In developing the State Plan on Aging, State Units on Aging are expected to discuss their leadership role in developing comprehensive service systems for older individuals served through the Aging network. Key questions that were considered in the development of the State Plan included the following:

- What are Illinois' goals, objectives, strategies, and outcomes for home and community-based services?
- What is Illinois' current capacity (e.g., workforce, fiscal outlook, etc.) to meet the current and future demand for home and community-based services?
- What challenges will Illinois face and how are these being addressed through measurable objectives to maximize outcomes and efficiencies to sustain services for a growing population of older adults?
- What are the lessons learned by the Aging network as a result of the COVID-19 pandemic; how will the Aging network need to change and reinvent itself to address the lasting impacts of the pandemic?

In addition to the key questions that were considered in the development of the plan, IDoA conducted an extensive stakeholder engagement process that included virtual public hearings, webinars, and the solicitation of written and electronic comments. A detailed summary of the stakeholder engagement process can be found in Appendix D.

[6] https://www.ilga.gov/commission/jcar/admincode/089/089002300A00300R.html

IMPACT OF COVID-19

The COVID-19 pandemic has made a significant impact on the planning process for the State Plan as well as the landscape of the Aging service delivery system. The Aging network has been overwhelmingly resilient and strongly committed in their efforts to support Illinois' older adults' ability to maintain their health, welfare, and safety during the pandemic. The collaboration at the local level between the AAAs, nutrition providers, senior centers, adult day centers, in-home providers, care coordination units, adult protective service agencies, and legal service providers has been truly inspiring.

COVID-19 dramatically impacted the state of Illinois early on in the pandemic. The Pritzker Administration along with the Illinois Department of Public Health demonstrated strong leadership in the State's response to the pandemic and they continue to guide the human service agencies in our collective response to ensuring the health, welfare, and safety of our most vulnerable citizens.

To date, Illinois has 787,573 COVID-19 positive cases with 13,255 deaths which ranks Illinois the seventh and fourth in the United States for number of cases and deaths, respectively.[7] Illinois also had 50,418 cases in long term care facilities with 6,527 deaths. Illinois, like the rest of the country, has seen a disproportionate number of minority and ethnic populations aged 65 and above impacted by COVID-19.[8] The COVID-19 pandemic has significantly changed the delivery of home and community-based services (HCBS) across the spectrum of human services in Illinois. As with any significant change, there are lessons to be learned as well as potential opportunities to make permanent changes that have resulted in positive outcomes for older adults.

The COVID-19 pandemic required the expeditious transition of IDoA's programs and services to initially a remote service model except for the provision of home delivered meals (HDMs) and in-home services. IDoA has seen a 48% increase in the demand for HDMs with 6.7 million HDMS provided with an average of 43,000 meals per day. Through the federal Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act funding, the AAAs were able to respond to the increased demand for HDMs. Through coordination with Illinois Emergency Management Agency (IEMA), over 600,000 shelf stable meals were also provided to older adults. Additionally, IDoA was able to secure $5 million in its FY 20 budget to respond to the emergency needs of older adults, including access to groceries, transportation, assistive devices, home modifications, and the provision of culturally appropriate meals.

Prior to the COVID-19 pandemic, social isolation had been identified by the AAAs as the statewide initiative for 2019. IDoA budgeted an additional $1 million in FY 19 and FY 20 to provide the AAAs with the tools needed to respond to the needs of older adults who are experiencing social isolation. The COVID-19 pandemic has further escalated social isolation as a result of the social distancing recommendations and fears related to contracting COVID-19. The

---

[7]Number from December 4th, 2020. Accessed from: https://covid.cdc.gov/covid-data-tracker/#cases_deathsinlast7days.

[8] http://www.dph.illinois.gov/covid19/statistics/covid-raceethnicity-metrics.

Aging network has responded with innovative programming to ensure older adults remain connected; senior centers and adult day service agencies have provided remote services, including telephone reassurance, the provision of assistive technology devices, and caregiver supports. Providing access to technology, including access to broadband/internet will continue to be critical moving forward. Another critical component is how we balance telehealth service provisions with the need to also make those human connections that are crucial.

IDoA also quickly recognized the necessity to build and expand relationships with traditional and non-traditional partners, including sister state agencies and local partnerships. Access to personal protective equipment (PPE) through IDoA's collaboration with the IEMA, collaboration with the Illinois Department of Public Health specific to COVID-19 guidance and future vaccine distribution, and forging new relationships with Illinois universities and hospitals to provide experts to train the Aging network on best practices around COVID-19 are examples of relationships that have proven to be invaluable during the pandemic. IDoA will continue to expand its more "traditional" partnerships to be more inclusive and strategize on how to meet the evolving needs of Illinois' older adult population.

CONTEXT AND EMERGING TRENDS

The number of people ages 65 and older in the United States has increased steadily during the past century, and growth has accelerated since 2011, when baby boomers first started to turn 65. Between 2020 and 2060, the number of older adults is projected to increase by 69% from 56.0 million to 94.7 million. Although much smaller in total size, the number of people ages 85 and older is projected to nearly triple from 6.7 million in 2020 to 19.0 million by 2060.[9] Specific to the older population here in Illinois, 15.9% of older adults aged 65 and above makes up Illinois' total population ranking Illinois 39th amongst the 50 states.[10] The older population is becoming more racially and ethnically diverse. Between 2018 and 2060 the share of the older population that is non-Hispanic white is projected to drop from 77% to 55%. [11] With the aging demographic boom, access to quality and innovative home and community-based services as well as healthcare will be critical over the next 20 years. Appendix E provides a representation of demographic data that was examined in preparation of the Plan.

In addition to the projected growth in the aging population, the characteristics of older adults should be considered, and services need to be comprehensive to address complex social and health needs. The IDoA has long supported person-centered practices and has advocated for a holistic approach to service delivery rather than a segregated approach or one that views older adults based on their weaknesses, condition, or diagnosis. It is from this viewpoint, that we review the emerging trends identified here in order to strengthen our person-centered approaches to community-based services as well as ensure that we are planning for a system that has the capacity to address the changing needs of older adults.

---

[9] U.S. Census Bureau, Population Projections.

[10] Population Reference Bureau, Population Bulletin, Elderly Americans, 2018. https://www.prb.org/aging-unitedstates-fact-sheet/

[11] U.S. Census Bureau, Population Projections.

1) Alzheimer's Disease and Related Disorders

The demand for aging services will also be driven by a steep rise in the number of Americans living with dementia, including Alzheimer's disease. As the size of the U.S. population age 65 and older continues to increase, the number of Americans with Alzheimer's or other cognitive issues will grow. The baby boom generation has already begun to reach age 65 and beyond, the age range of greatest risk for Alzheimer's and related disorders. The oldest members of the baby boom generation turn age 74 in 2020, which could more than double by 2050 to 13.8 million, from 5.8 million today.[12]

In Illinois, there are an estimated 230,000 people with Alzheimer's living in Illinois in 2020. In 2025 the projected number is 260,000, a 13% increase.[13] Demographically, African-Americans are nearly twice as likely to contract Alzheimer's or other dementias as non-Hispanic whites.[14] Variations in medical conditions, health-related behaviors and socioeconomic risk factors across racial groups likely account for most of the differences in risk of Alzheimer's and other dementias. There does not appear to be a genetic link, but socioeconomic factors such as poverty, poor education, greater exposure to discrimination and adversity leading to health conditions that contribute to dementia appear to play a significant role. Hispanic populations are diverse and need to be considered individually.[15]

The Illinois Department on Aging (IDoA) has been the recipient of three federal discretionary grants awarded by the Administration on Community Living, These grants enabled IDoA to fund services through the Area Agencies on Aging and other community partners and stakeholders, with the agreement that once the grant periods ended, the services would be sustained by each individual partner. The programs include: Music and Memory, Opening Minds through Art (OMA), Stepping Up (mental and physical exercise), Timeslips, the Dementia Friendly America Initiative (DFA), Supportive Gap Filling Services, Tales and Travels, and Care Navigation. Because of the success of these programs, the Illinois General Assembly awarded IDoA $1 million in both FY 2020 and 2021 to sustain the Supportive Gap Filling Program and the evidence-based caregiver education programs Savvy Caregiver and Stress-Busting for Caregivers.

As mentioned later in this section, Illinois is also experiencing challenges when it comes to the direct care and health care workforce trained and available to provide services to older adults; this concern is also true for those caring for older Illinoisans' with Alzheimer's and other dementia-related diseases. In 2019, there were approximately 587,000 caregivers for people with

---

[12] 2020 Alzheimer's Disease Facts and Figures. Alzheimer's Association Report. Alzheimer's & Dementia: The Journal of the Alzheimer's Association. Accessed: https://alz-journals.onlinelibrary.wiley.com/doi/epdf/10.1002/alz.12068.

[13] 2020 Alzheimer's Disease Facts and Figures. Alzheimer's Association Report. Alzheimer's & Dementia: The Journal of the Alzheimer's Association. Accessed: https://alz-journals.onlinelibrary.wiley.com/doi/epdf/10.1002/alz.12068.

[14] Potter GG, Plassman BL, Burke JR, Kabeto MU, Langa KM, Llewellyn DJ, et al. Cognitive performance and informant reports in the diagnosis of cognitive impairment and dementia in African Americans and whites. *Alzheimer's Dement* 2009;5(6):445-53.

[15] Lines LM, Sherif NA, Wiener JM. Racial and ethnic disparities among individuals with Alzheimer's disease in the United States: A literature review. *Research Triangle Park*, NC: RTI Press; 2014.

dementia in Illinois, which provided 668 million hours in unpaid care.[16] This unpaid care, often provided by family members, was valued at $8.76 billion.

While there is no cure for Alzheimer's, Illinois is rich in resources. The National Institute on Aging funds 31 Alzheimer's Disease Research Centers around the country, two of which are in Chicago: the Mesulam Center for Cognitive Neurology and Alzheimer's disease at Northwestern Medicine; and Rush University Alzheimer's Disease Center. Researchers at these Centers work to translate research advances into improved diagnosis and care for people with Alzheimer's disease, as well as working to find a treatment or way to prevent Alzheimer's and other types of dementia. An outgrowth is the collaboration between these two institutions to create a statewide initiative, the Illinois Cognitive Resource Center to create Dementia Friendly communities state-wide.[17]

2) Behavioral health

A 2012 study from the Institute on Medicine found that approximately one in five older adults in the U.S. experience a mental illness, substance use disorder, or both. That ratio, should it still exist in 2030, equates to approximately 15 million people nationwide. According to SAMSHA, there is a growing number of older adults who have mental health, substance use disorders, or both mental health and substance use disorders. A SAMHSA survey noted that 5.7 million adults aged 65 and older who reported binge drinking in the past month and 1.5 million who used an illicit drug in the past month. There were over 7,000 opioid-overdose related deaths of older adults in 2016 reported by the CDC.[18]

The CDC estimates that 20% of people age 55 years or older experience one or more type of mental health problem, with the most common conditions being anxiety, severe cognitive impairment, and mood disorders, such as depression or bipolar disorder. Suicide is often linked to mental health issues and older men have the highest suicide rate of any age group. The CDC notes, "men aged 85 years or older have a suicide rate of 45.23 per 100,000, compared to an overall rate of 11.01 per 100,000 for all ages."[19] Even though rates of depression in Illinois are higher than the national average (14.5%), the state of IL spends 40% less than the national average per capita on community mental health. Additionally, Illinois lacks sufficient mental health providers to address treatment demands. There are 18 mental health providers for every 10,000 residents in Illinois, lower than the national average, with the state ranking at 29th on this measure.[20] This is compounded by ageist attitudes toward older adults resulting in providers not identifying treatable mental illnesses in older adults, and older adults adopting a sense of helplessness and hopelessness in response to their context and circumstances.

[16] 2020 Alzheimer's Disease Facts and Figures. Alzheimer's Association Report. Alzheimer's & Dementia: The Journal of the Alzheimer's Association. Accessed: https://alz-journals.onlinelibrary.wiley.com/doi/epdf/10.1002/alz.12068.
[17] https://ilbrainhealth.org/get-involved/dementia-friends-illinois/.
[18] https://blog.samhsa.gov/2019/05/20/bringing-awareness-to-the-mental-health-of-older-adults.
[19] https://www.cdc.gov/aging/pdf/mental_health.pdf.
[20] https://healthpolicy.usc.edu/wp-content/uploads/2017/02/2017_IL20Mental20Health20Chartbook.pdf, pp 27.

The COVID-19 pandemic and the associated economic downturn have harmed the mental health of adults across age groups. A Kaiser Family Foundation poll noted that in July 2020, among adults aged 65 and older, almost half (46%) said that "worry and stress related to coronavirus" has negatively affected their mental health; this is significantly elevated over the 31% figure recorded in May.[21] It is clear that the Aging network needs to further explore what role it has to help educated and connect older adults to services to address their increasing behavior health needs.

3) Social isolation and loneliness

Addressing the impact of social isolation and loneliness have long been a concern within the Aging network. The COVID-19 pandemic has only further escalated the impact of social isolation on older adults. COVID-19 has also resulted in residents of long-term care facilities experiencing isolation due to restrictive policies that focus on prevention of the transmission of COVID-19. Prior to the pandemic, the Area Agencies on Aging designated addressing social isolation as their Statewide Initiative in FY 20, and they continue to focus on this important issue in FY 21. An additional $1M was provided by the legislature and the Administration in FY 20 and 21 to support the AAAs efforts on outreach and provide services to older adults who are socially isolated. In order to combat older adults experiencing social isolation and loneliness, AAAs and other providers have increased their service offerings. Services provided by the AAAs include friendly visiting, including remote phone calls, virtual gatherings, promotion of resources to address social engagement on AAA websites, and the use of libraries to host events for older adults to connect.

Isolation and loneliness are two separate issues. Some people are fine being alone, while others are lonely despite the appearance of having a healthy family/friend support system. The physical and emotional impact of loneliness was well known prior to the pandemic. Research has demonstrated that loneliness has a negative impact on the course of cancer patients' illness.[22]Researchers estimate that loneliness can be as dangerous to health as smoking 15 cigarettes a day.[23]

Loneliness and social isolation in older adults are serious public health risks affecting a significant number of people in the United States and putting them at risk for dementia and other significant medical conditions. A new report from the National Academies of Sciences, Engineering, and Medicine (NASEM) points out that more than one-third of adults aged 45 and older feel lonely, and nearly one-fourth of adults aged 65 and older are considered to be socially isolated. The report notes that older adults are at increased risk compared to the rest of the population for loneliness and social isolation because they are more likely to face factors such as living alone, the loss of family or friends, chronic illness, and hearing loss.[24]

---

[21] https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic.

[22] https://ascopubs.org/doi/abs/10.1200/JCO.2017.35.15_suppl.10070.

[23] https://www.hrsa.gov/enews/past-issues/2019/january-17/loneliness-epidemic.

[24] National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older*

Although it's hard to measure social isolation and loneliness precisely, there is strong evidence that many adults aged 50 and older are socially isolated or lonely in ways that put their health at risk. Experiences of social isolation, loneliness, and poor social relationships had several negative health associations, including:

- Increased risk of premature death from all causes. This risk may rival those of smoking, obesity, and physical inactivity.
- An approximately 50% percent increased risk of dementia.
- A 29% increased risk of heart disease and a 32% increased risk of stroke.
- Increased rates of depression, anxiety, and suicide.
- Among heart failure patients, loneliness was associated "with a nearly 4 times increased risk of death, 68% increased risk of hospitalization, and 57% increased risk of emergency department visits."[25]

It is important that the Aging network take lessons learned from current programs and deploy the more widely in a preventative manner; addressing social isolation and loneliness before it occurs.

4) Disability support

According to the CDC, in a study of six physical and cognitive disability categories (hearing, vision, cognition, mobility, self-care, or Independent Living) two out of every five older adults in the U.S. were found to have one or more disabilities. This is higher than the one out of every four among all US adults.[26] This shows that disabilities become more common as people age. As older adults make up a larger group of Illinois' population and disabilities are more common among people in this group, we expect that the needs for services and supports to assist such groups will grow considerably in the decades to come.

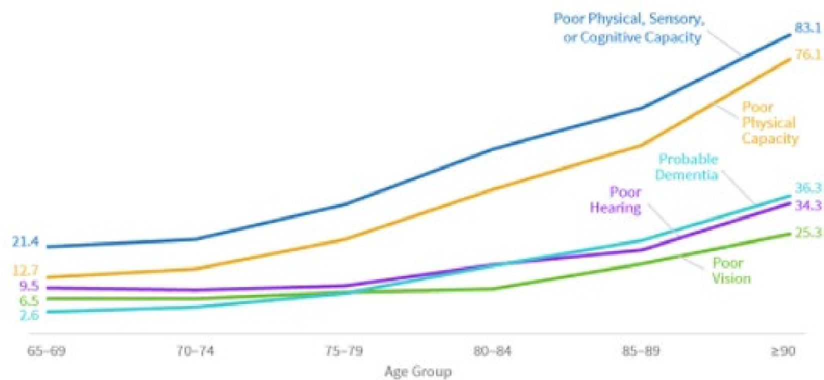
The likelihood of disability increases with age. Illinois' population of 85+ is expected to increase considerably and while just over 20 percent of adults ages 65 to 69 have either poor capacity (physical limitations, poor vision, poor hearing, or probable dementia), more than 80% have poor capacity by age 90, according to the National Health and Aging Trends Study.[27]

Adults: Opportunities for the Health Care System. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663.

[25] National Academies of Sciences, Engineering, and Medicine. 2020. *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25663.

[26] https://www.cdc.gov/ncbddd/disabilityandhealth/features/kf-adult-prevalence-disabilities.html.

[27] https://www.prb.org/eight-demographic-trends-transforming-americas-older-population.



According to data from the 2014 Illinois Behavioral Risk Factor and Surveillance System, about 35% of Illinoisans aged 65 and older have a disability, significantly higher than younger people.[28] Depending upon whether someone has a physical or cognitive disability and other factors, such as severity and type of disability, the health and social services needed are typically much higher for people with disabilities. Health problems and the need for accessible services can increase significantly when people are also dealing with poverty alongside disability, which is also higher among people with disabilities.[29] Given the growth of the overall number of older adults, it is expected that the number of older adults with disabilities will also increase. Ensuring accessible and equitable services and resources for people with disabilities, and countering ableism alongside ageism and other inequities, are all essential to an age-friendly state.

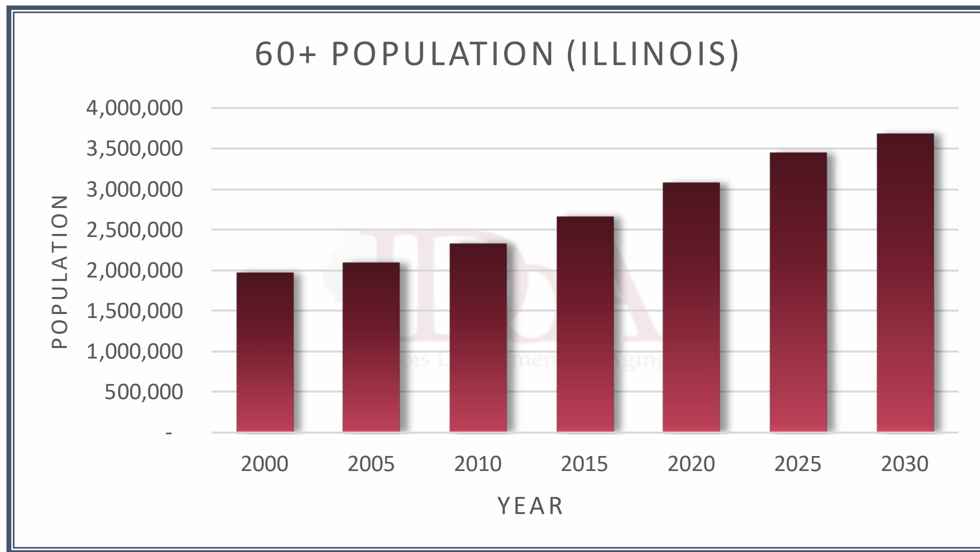
5) Focusing on Equity and Inclusion for Illinois' Diverse Population of Older Adults

With a population of nearly 12.7 million people, Illinois is the fifth most populous state in the U.S. - people live across varied communities in Illinois' cities, suburbs, exurbs, rural towns, and the countryside. Segregation and inequity by race and class remain major challenges to advancing an equitable, inclusive, and age-friendly state.

Illinoisans come from all walks of life and demographic backgrounds. As the state's population of older adults grows, the group will become increasingly diverse as well. Currently, with about 3 million older adults in Illinois, the number is expected to grow to nearly 3.7 million

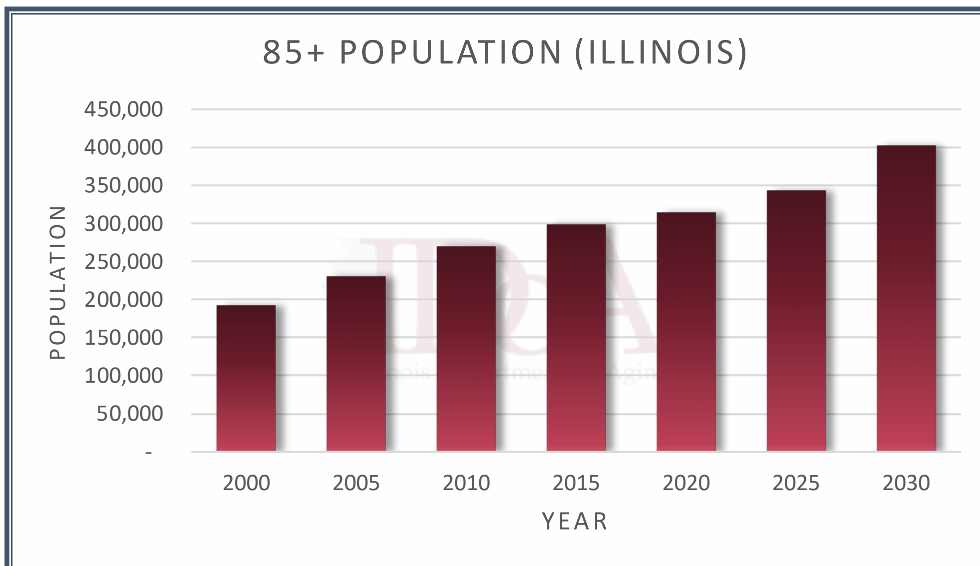
[28] http://dph.illinois.gov/sites/default/files/publications/publicationsohpm2014-data-report.pdf.
[29] https://www.cdc.gov/ncbddd/disabilityandhealth/features/kf-adult-prevalence-disabilities.html.

in 2030.



Source: U.S. Census Bureau and Illinois Department of Commerce & Economic Opportunity (2012)

Additionally, the number of people who are 85+ years of age is expected to increase significantly in the coming decades, growing from 314,000 in 2020 to 402,000 by 2030.



Source: U.S. Census Bureau and Illinois Department of Commerce & Economic Opportunity (2012).

With a wide diversity of demographic backgrounds, older adults have varied life experiences, cultures, languages, and challenges. More importantly from an age-friendly and health equity perspective, people are impacted differently by structural inequities, policies, systems, and values that distribute access and quality of social determinants of health that people need to live a

fulfilling and healthy life.

Illinois is a racially diverse state, with people of color making up both a growing portion of the overall population—and of people who are 65 or older. At the same time, the portion of Illinois' population identified as White, non-Hispanic older adults is expected to be reduced from roughly 80.5% of the state's population in 2010 to 76.6 in 2019.[30, 31] This trend is expected to continue with people of color making up roughly 39.7% of the overall state population, with 61.3% White, non-Hispanic, 14.2% Black, 17.1% Hispanic or Latino, 5.5% Asian, and 0.2% American Indian or Alaska Native. As this comparatively more diverse population ages, older adults will become a more racially diverse group than it is today. This matters to this plan because structural racism and White supremacy are long-term factors that cut across systems, policies, and history to unfairly harm the health and wellbeing of people of color while advantaging White people. A growing number of older adults in Illinois will have lived and aged in this context which shapes their health and life circumstances. More broadly, achieving an age-friendly state and advancing health equity both require dismantling and redressing racism. Equitable provision of services to older adults of all backgrounds is one important part from the perspective of IDoA and this plan.

The number of lesbian, gay, bisexual, and transgender older adults is also set to grow in the coming decade. SAGE (Advocacy and Services for LGBT Elders) estimates that nationwide, the number of LGBT adults who are 50 years or older will grow from roughly 3 million in 2018 to 7 million in 2030 (Illinois-specific data are currently unavailable; the state's population is likely to generally follow the national trend).[32] The article notes that LGBT older adults are more likely than heterosexual and cis-gender people to be single and live alone, childless, faced discrimination and prejudice; and face poverty, homelessness, and mental and physical health problems. Countering heterosexism, genderism, and transphobia are essential to an age-friendly state.

Illinois has long been a destination for immigrants to the United States, especially the Chicago region. In addition to a large and growing population of older adult immigrants, according to a recent report published by Rush University, the population of older adult immigrants who are undocumented is set to grow substantially. From 2020 to 2030, there is expected to be a 1,283% increase as the number goes from 3,986 to 55,154.[33] According to the National Equity Atlas, the overall percentage of Illinoisans who are immigrants has increased

[30]https://data.census.gov/cedsci/table?q=United%20States%20Populations%20and%20People&g=0400000US17&tid=ACSST5Y2010.S0103&hidePreview=false.
[31]https://data.census.gov/cedsci/table?q=United%20States%20Populations%20and%20People&g=0400000US17&tid=ACSST5Y2019.S0103&hidePreview=false.
[32] https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-the-facts-on-lgbt-aging.pdf.
[33] https://healthequitychicago.org/wp-content/uploads/2020/12/FINAL_A-Collaborative-Report-on-the-Aging-Undocumented-Population-of-Illinois-1.pdf.

from 8% in 1990 to 14% in 2017.[34] Immigrants face a variety of specific health and social issues that will challenge their ability to age with adequate supports. Xenophobia, anti-immigrant bias, White Nationalism, the threat and use of police violence, incarceration, and deportation are systems of oppression that immigrants face and needs to be counteracted to support an age-friendly Illinois. Undocumented older adult immigrants face specific challenges of not qualifying for many public safety net programs, such as Medicare and Social Security. Fortunately, Illinois is in the process of implementing a Medicaid look-alike program for older adult undocumented immigrants, but more supports will be needed to support older adult immigrants of all statuses.

Understanding how people from varying backgrounds relate to or experience root causes of health inequities is essential to advancing healthy aging such that systems, policies, and practices can be developed to counter systemic oppression. Health inequities are the systematic differences in health status and outcomes measured across different population groups that are unfair, unjust, and remediable. Long-standing patterns of health inequities are known to exist across demographic groups such as race, class, and other socially constructed categories. Health inequities are causally linked to structural inequities, policies, systems, and values that differently distribute access to and quality of social determinants of health that people need to live a full and healthy life. The root causes of structural inequities are systems of oppression such as racism, anti-Blackness, White supremacy, socioeconomic class inequity, gender inequity, sexism, heterosexism, transphobia, xenophobia, anti-immigrant bias, White Nationalism, ableism, ageism, Islamophobia, anti-Semitism, and other identity-based discrimination, hatred, and deprivation. In short, ageism overlaps with other systems of inequity that harm health and deny people of their inherent dignity. An intersectional lens that considers and seeks to counteract and redress the overlapping and compounding systems of oppression is necessary for advancing an age-friendly state.

While each of these systems of oppression are important, the crucial point here is that these inequities are harmful to individual and community health. Systems of oppression cause health inequities. The reality is that these systems distribute privilege, oppression and age people differently based on differing levels of opportunity, advantage, and disadvantage that shows up in the differing quality and access to important social determinants of health, including education, jobs, housing, transportation, and healthcare. Life expectancy varies across different demographic groups, with groups disadvantaged by health inequities less likely to reach and enjoy older adult life. Systems of oppression and inequity result in longstanding trends of inequity in money, power, and resources that require sustained action to overcome in service of older adults and their families and advancing an equitable, age-friendly Illinois.

6) Workforce

Given the growth of the older adult population, the preparation and recruitment of an

[34] https://nationalequityatlas.org/indicators/Nativity-and-ancestry#/?geo=02000000000017000.

appropriately trained workforce is essential. It is fully expected that there will be an increased demand for in-home workers due to growth in the aging population and a need for enhanced supports for caregivers so they can provide good care for older adults. A 2008 Institute of Medicine report titled "Retooling for an Aging America: Building the Health Care Workforce" noted three overarching priorities: 1) enhancing geriatric competence of the entire health workforce; 2) increasing recruitment and retention of geriatric specialists and caregivers; 3) improving the models of care for older adults to: a) achieve comprehensiveness to cover needs; b) provide services efficiently; and c) encourage older adults to be partners in their care. More than a decade later, these remain important yet challenging priorities.[35]

Recruiting and maintaining the home care and health workforce is and has historically been a serious problem, approaching crisis proportions with the growth of the older adult population. The Geriatrics Workforce Enhancement Program (GWEP) is the only federal program that focuses on developing a health care workforce that maximizes patient and family engagement while improving health outcomes for older adults. Three of these Federal GWEPs have been funded in Illinois at University of Illinois, University of Chicago and Rush University Medical Center. In 2018, the Older Adults Services Committee (OASAC) established a Workforce Stabilization Workgroup to address what provider agencies characterized as a crisis in the availability of home care workers and care coordinators. A 2018 survey of CCP home care providers reported a 35% annual turnover rate and need to hire an average of 12,000 replacement workers and 2,000 new workers to meet growing needs. The care coordination units reported almost 50% of care coordinators were employed less than a year, and once trained, more than 90% transitioned to roles with managed care organizations or hospitals.

IDOA, working with OASAC, is pursuing strategies to develop workforce pipelines to build a more robust home care and health care workforce that is trained and sensitive to the needs of older adults. Efforts include partnerships with the Illinois State Board of Education to introduce geriatric education into high schools, partnerships with colleges and universities that have affiliation with the American Gerontological Society's Academy for Geriatrics in Higher Education (AGHE) and the Illinois Worknet Center.

7) Technology

As mentioned earlier in the Plan, COVID-19 has only amplified the demand and need for technology among older adults. Technology will continue to evolve and the ways we deliver services needs to evolve as well. We've learned that technology is not just for communication, but also assistive technology helps with activities of daily living (ADLs) and to keep older adults healthy and in their homes. In order to address these needs, the Department and our partners will need to think about how to provide older adults and their caregivers with technology solutions that are easy to use, cost-effective and evidenced-based. For example, Illinois Care Connections, a $1.7 million grant from the federal CARES Act, provides tablets, iPads, and Wi-Fi connectivity to older adults and persons with disabilities who experience social isolation or loneliness as a result of COVID-19. During the implementation of the program, over 20% of the participants referred for a device were also in need of Wi-Fi connectivity. The Department recognizes this

[35] Accessed via: https://www.ncbi.nlm.nih.gov/books/NBK215403/#ddd00206.

demonstrated need for basic broadband access across the state and will continue to bring this to the attention to the Illinois Broadband Development Council and Governor's Rural Affairs Council.

As mentioned earlier in this section, older adults have become more socially isolated from their family, friends and in some instances, afraid to do things they normally would have such as maintaining preventive care and other medical appointments. In some instances, telehealth has provided a secure and safe alternative for older adults who need medical care. Prior to the declaration of the federal public health emergency in March, "approximately 13,000 fee-for-service Medicare beneficiaries received telemedicine in a week, and in the last week of April, nearly 1.7 million beneficiaries received telehealth services."[36] In Illinois, the Southern Illinois University College of Medicine cited that from January 31 to May 31, 2020, telehealth visits increased from 171 per month to 12,163 per month.[37]

During the public health emergency, CMS has allowed for flexibility on the geographic and provider restrictions around Medicare telehealth services, and there is a push among states and providers to continue these flexibilities, not only in the Medicare program but also for parity in payment for telehealth by both Medicaid and private insurance companies. On March 19, 2020, Governor Pritzker signed Executive Order #2020-09, which provided that health insurers regulated by the Department of Insurance will cover the costs of all telehealth services at the same rate as in-person visits and eliminated other regulatory restrictions on the provision of telehealth.[38] The Department, as a member of the Governor's Rural Affairs Council, supports this executive action and advocates for future policy initiatives to permanently extend.

Putting technology into the hands of older adults is just the first step; they also need support and education on how to operate and utilize the devices. Technology starts-ups, application developers and companies marketing solutions for older adult learning and connectivity are abundant, but the early feedback from the Illinois Care Connections program that older adults need primary education on setting up their devices and learning the basics to start. Organizations such as the Illinois Assistive Technology Program and private companies provide step-by-step user guides for devices like iPads and tablets. It will be important to provide this education and support in an accessible manner and in multiple modalities to avoid abandonment of the technology.

8) Integration of medical and social needs and coordination with Managed Care Organizations

Historically, the Aging Network has focused on the social needs and the delivery of home and community-based services that are required under the Medicaid Section 1915c Section home and community-based services waiver and by the Older Americans Act. These services and supports are vital to ensuring older adults can maintain independence and that caregivers feel supported. Aging Network providers are a trusted resource and often touch older adults and their caregivers more frequently than medical providers. It's more cost-effective for community-based

[36] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.
[37] Minutes. 10 October, 2020. Governor's Rural Affairs Council. https://www2.illinois.gov/sites/ltg/issueslist/R3/Documents/GRAC%20Minutes%20-%209.10.20.pdf.
[38] https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-09.aspx

organizations and healthcare providers to integrate the medical and social needs of older adults.

The Administration for Community Living (ACL) recently introduced a state roadmap for the development of a nationwide infrastructure of community-based organization (CBO) networks and integration into the healthcare environment. This is based on the premise that "healthcare transformation provides state aging and disability agencies with a critical, strategic, opportunity to facilitate efforts to integrate the medical and social service systems."[39] The Aging network can play an integral role in working with healthcare partners to explore co-locating with healthcare providers. Further, the Department is working with its sister agencies to understand how Aging Network providers can work collaboratively with managed care organizations (MCOs). Around 53% of CCP clients are also on Medicaid, and we are eager to explore opportunities to align and expand long-term services and supports and waiver services as we review our Medicaid Section 1915c home and community-based services waiver for renewal in 2021. In addition, HFS plans to expand the Medicare-Medicaid Alignment Initiative (MMAI) in July 2021. This will provide older adults with an opportunity to receive their Medicare and Medicaid benefits, including long-term care services and supports, in an integrated, person-centered model.

The integration of the social and health care services must also address the social determinants of health. Aging network providers already render services that allow older adults to stay healthy and remain in their communities including transportation, home delivered meals and assistance with applying for other benefit programs. Addressing these needs help keep people healthy, but beyond providing funding, the real innovations are yet to come. For example, Illinois recently passed a law to allow SNAP recipients to utilize online ordering at several grocery stores. Other states such as California are piloting a restaurant meals program that allows SNAP recipients to buy prepared foods from supermarkets and grocery stores. These flexibilities provide more access, especially for those who might not have a place to prepare meals.

9) Caregivers

Given a rapidly aging population, many issues arise for the broader society and economy including younger adults, many of whom will remain in or will enter the workforce –are increasingly taking on roles previously filled by older adults who exit the workforce. These issues include rising healthcare costs, a reduced proportion of the population that is working-age, increased dependency ratio, and broad changes to the economy. The economy is likely to shift to providing care, services, and housing focused on the needs and desires of the growing population of older adults.

While the normal trend of people tending to retire as they reach older adulthood is expected to continue, there is also a countervailing trend of older adults remaining in the workforce for longer periods of time, whether by choice or necessity. There are also unemployed and discouraged older workers who would like to work but may face challenges to employment

[39]Virtual Presentation: "Administration for Community Living: STRATEGIC FRAMEWORK FOR ACTION: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities: June 2020. Accessed from: https://acl.gov/sites/default/files/programs/2020-06/ACL_Strategic_Framework_for_Action_v1_%20June%202020_final_508_v2.pdf?eType=EmailBlastContent&eId=66bddcd6-ac95-4911-8728-e7d90f90e5c2.

related to training or ageist discrimination.

Many young and middle-aged adults will experience increased pressures being a part of a "sandwich generation;" people who are simultaneously caring for children and older adults in their families. While this is not a new phenomenon, the scale and number of people expected to be impacted will grow massively with the aging of the baby boomer cohort. Coupled with the many challenges, trends, and inequities listed herein, the massive shift of the boomer cohort to older adults (followed by Generation X starting in 2025) is expected to increase stress and could negatively impact health and well-being of older adults. This is especially true if the challenges that arise from these trends and stressors are not planned for and appropriately responded to; simultaneously, this will also challenge the sandwich generation caregivers' ability to care for themselves, their children, and to prioritize fulfilling their own health, finances, and social needs.

A rapidly aging population means there are fewer working-age people in the economy. This can lead to a supply shortage of qualified workers, making it more difficult for businesses to fill in-demand roles. An economy that cannot fill in-demand occupations faces adverse consequences including declining productivity, higher labor costs, delayed business expansion and reduced international competitiveness.

Caregiving is typically delivered one-on-one, and so it is often considered at the individual level. While that is important for tailoring services to the needs and desires of individuals, caregiving must be also considered at the collective level. Nearly everyone is likely to be involved in caregiving, receiving care, or both at varying points in their lives. The expected growing needs to care for an increasing population of older adults requires creative ways of planning and responding that consider this broader context and emerging trends.

GOALS, OBJECTIVES, STRATEGIES, AND OUTCOMES

Pursuant to the State Unit on Aging Director's letter (#02-2019, 10/23/19) from the Administration for Community Living (ACL), the Illinois Department on Aging developed visionary goals that describe the strategic direction being taken to best serve and advocate for older Illinoisans and their caregivers. The lens through with this document is prepared with intention to advance health equity, ensure equitable distribution to address the social determinants of health, and a focus on helping support people's unmet social needs. These goals (and the objectives, strategies and outcomes that support them) provide the framework for the State Plan on Aging for FY 2022-FY 2024.

As required by ACL, the goals, objectives and strategies are included in each of ACL's four focus areas, plus a fifth focus area of interest to the Illinois Department on Aging (IDoA).

Focus Areas:

1. Older Americans Act (OAA) Core Programs (and incorporating a focus on the socials determinants of health (SDOH)—see goals, objectives, strategies and outcomes under goals 1, 2 and 5

2. Administration for Community Living (ACL) Discretionary Grants—see goals, objectives, strategies and outcomes under goals 1, 3 and 4

3. Participant-Directed/Person-Centered Planning Practices—see goals, objectives, strategies and outcomes under goal 6

4. Elder Justice-see goals, objectives, strategies and outcomes under goal 7

5. Data and Information Technology: IDoA also recognizes the importance of a robust and efficient data collection system in order to provide the Aging network and service participants with quality programs and outcome data to support those programs, and has included this as an additional focus area— see goals, objectives, strategies and outcomes under goal 8

Goals:

Goal 1: Fulfill mandate as the State Unit on Aging to effectively administer the Older Americans Act, Title III and Title VII core programs in partnership with the Area Agencies on Aging and other partners in the Aging network.

Goal 2: Expand and ensure equitable access to programs that address the social determinants of health with a focus on identifying and understanding the needs of underserved and diverse populations.

Goal 3: Maximize federal, state, local, and private resources to sustain and expand services and supports to older adults.

Goal 4: Ensure that adequate capacity for services and supports is developed in the Aging network to prepare for the projected growth and diversity in the aging population.

Goal 5: Enable older Illinoisans, their families, and other consumers to choose and easily access options that support older adults' ability to stay in their homes and communities.

Goal 6: Ensure implementation of federally mandated Person-Centered Planning practices Statewide.

Goal 7: Prevent and improve response to abuse, neglect and exploitation while preserving rights of older adults and persons with disabilities in all settings.

Goal 8: Promote responsive management and improve efficiencies within the delivery of services through the use of data and enhanced IT systems.

Principles:

The Illinois State Plan on Aging seeks to advance and be guided by the following principles:

Legal, social, and economic justice, principles laid out as priorities in the preamble of the Illinois Constitution.

Health equity, which can be understood both as an outcome in which populations are free of health inequities; and as a process of assurance of the conditions for optimal health of all people that requires at least three things: 1) Valuing all individuals and populations equally; 2) Recognizing and rectifying historical injustices; and 3) Providing resources according to need. Health inequities will be eliminated when this process is achieved.[40]

Human rights, including taking positive action in support of Illinoisans' enjoyment of basic human rights.

Pro-equity engagement, learning, and action that purposely engages with and centers individuals and communities who have experienced discrimination, oppression, and injustice for guidance on how to redress both historical and contemporary systems of oppression, including, but not limited to: racism, anti-Blackness, socioeconomic class inequity, gender inequity, sexism, heterosexism, transphobia, xenophobia, anti-immigrant bias, White Nationalism, ableism, ageism, Islamophobia, anti-Semitism, and other identity-based discrimination, hatred, and deprivation.

An age-friendly Illinois that actively supports older adults, people who care for them, their families, and healthy and equitable aging for all people across the entire life course.

[40] Jones, Camara. Systems of Power, Axes of Inequity: Parallels, Intersections, Braiding the Strands. Medical Care. Volume 52, Number 10, Supplement 3. 2014.

Goal 1: Fulfill mandate as the State Unit on Aging to effectively administer the Older Americans Act, Title III, and Title VII core programs in partnership with the Area Agencies on Aging and other partners in the Aging network.

Objective 1.1: Remove barriers and expand access to health promotion and disease prevention services.

Strategy 1.1a: Expand evidence-based outreach opportunities and methods.

Strategy 1.1b: Educate and encourage older adults to participate in preventive service options and continue to counsel older adults on the availability of preventive services, including the use of evidence-based programs.

Strategy 1.1c: Conduct an evaluation of Title III-D and Title III-B services with the Area Agencies on Aging to ensure evidence-based health promotion programs are being offered in the 13 planning and service areas.

Strategy 1.1d: Identify underserved population of older adults who don't receive health promotion and disease prevention services and utilize targeted outreach to increase their participation.

Outcomes for Objective 1.1:

- Increased rate of queries (from baseline) for information and referral systems regarding evidence-based disease prevention and health promotion for clients and their caregivers.
- Increased rate of participation (from baseline) in information and referral systems regarding evidence-based disease prevention and health promotion for clients and their caregivers.
- Increased rate (from baseline) of utilization of Medicare preventive services by fee- for-service Medicare beneficiaries.
- Increased participation rate (from baseline) in health promotion and disease prevention programs among underserved populations, such as people returning to communities from carceral settings or others previously institutionalized.

Objective 1.2 Integrate core programs with ACL's Discretionary Grants.

Strategy 1.2a: Work with Falls Prevention grantees to bring to scale and sustain evidence-based falls prevention programs that have been proven to reduce falls, fear of falling, and fall related injuries in older adults.

Strategy 1.2b: Work with chronic disease self-management education program grantees to develop capacity in areas with no or limited evidence-based program infrastructure. Take action to introduce, deliver, and expand the reach (program participants and

completers) of evidence-based chronic disease self-management education (CDSME) and self-management support programs within underserved geographic areas and/or populations to improve their confidence in managing their chronic condition(s).

Strategy 1.2c: Support AAA Nutrition Innovations (under Title III-C1) grantee with achieving the following: 1) targeting an unmet need through an alternative delivery mechanism using unique partnerships, 2) providing a new lower cost decreased overhead option of 21 meals per week 3) providing opportunities for socialization, 4) decreasing food waste; increasing consumption, and 5) targeting an ethnically, racially diverse and limited English-speaking older adults and those with chronic conditions.

Strategy 1.2d: Support Alzheimer's Disease Program Initiative (ADPI) AAA grantees with educational and collaborative initiatives to assist isolated older adults with or at risk for Alzheimer's disease and related disorders that live in high-rise buildings, to be able to remain in their communities.

Strategy 1.2e: Support AAA initiatives aimed at empowering Medicare beneficiaries (ex. Senior Medicare Patrol program) in Illinois through education, outreach, and collaboration with local, state, and national organizations.

Outcomes for Objective 1.2

- Implementation of methods and lessons learned from chronic disease self-management and falls prevention grantees.
- Nutrition Innovations grantee will achieve stated outcomes.
- Trainings about ADPI conducted at supportive living facilities, senior housing, with management companies, with family and service provider and with high rise building property managers and staff.
- Increase referrals to ADPI for older adults living in senior buildings.
- Expansion of evidence-based programs to a minimum of two planning and service areas.
- Expansion of education and resources about Medicare fraud available to older adults and their families.

Objective 1.3: Evaluate current legal services offerings in order to maximize services for those with the greatest economic and social needs.

Strategy 1.3a: Utilize the findings from the recently completed survey of Older Americans Act Title III Legal Services providers to identify priority areas for the legal services working group.

Strategy 1.3b: Convene working group of AAA representatives to identify gaps and barriers that older adults are experiencing when accessing legal services.

Strategy 1.3c: Continue to work with Area Agencies on Aging and legal services providers

to prepare for Federal Fiscal Year 2022 reporting changes and recognize legal concerns about chilling effects in capturing additional sensitive personal information unless related to underlying request for assistance.

Strategy 1.3d: Continue use of brief surveys on specific topics to increase understanding of needs and issues affecting legal service providers in order to advocate for system improvements.

Outcomes for Objective 1.3

- Workgroup convened.
- Surveys are conducted annually.
- Prioritization of recommendations from legal services survey.

Goal 2: Expand and ensure equitable access to programs that address the social determinants of health with a focus on identifying and understanding the needs of underserved and diverse populations.

Objective 2.1: Take action on structural inequities that result in a maldistribution of the social determinants of health by ensuring ongoing and active application of health equity, social justice, anti-oppression, and trauma-informed lenses. Use these while engaging with, centering the voices of, and re-focusing resources to better reach underserved communities and individuals and people who face one or more forms of oppression and discrimination.

Strategy 2.1a: Work with equity-oriented partners to identify the needs of diverse populations of older adults and develop appropriate health equity, social justice, and broader equity training with key concepts essential to Strategy 2.1b and make training mandatory for IDoA staff and vendors.

Strategy 2.1b: Ensure ongoing, active engagement by Aging network of individuals and communities who are underserved and under-represented in Aging services in order to identify specific needs, respond to inequities and gaps in services and programs, and understand how they can be made to be more equitable and accessible to better meet the needs of people who are underserved by:

- Learning and using an intersectional lens that seeks to understand and tailor services to redress the various overlapping, interlocking, and compounding systems of oppression that individuals experience including, but not limited to: racism, anti-Blackness, socioeconomic class inequity, gender inequity, sexism, heterosexism, transphobia, xenophobia, anti-immigrant bias, White Nationalism, ableism, ageism, Islamophobia, anti-Semitism, and other identity-based discrimination, hatred, and deprivation.
- Focusing specifically on anti-racism by engaging individuals and organizations serving Black, Indigenous, and people of color who have faced historical and contemporary forms of racism, White nationalism, slavery, and genocide that negatively impact potential for trust and need for services.

- Integrating insights and lessons from these active, ongoing engagements across IDoA and Aging network partner programming.

Strategy 2.1c: Engage in ongoing discussions through the Aging network and ensuring openings on IDoA advisory councils committees—using lessons from ongoing active engagement described in the Strategy 2.1b—and modify in response programming, funding, resources, and partnerships to better reach and meet their needs of such groups as:

- older adults who are disproportionately underserved by or under-represented in aging network services, especially groups and individuals facing one or more systems of oppression or discrimination
- older adults living with HIV, with a focus on reaching those who have also faced injustice and discrimination and may not trust public systems
- older adult immigrants, especially undocumented immigrants
- older adults who have experienced trauma and mental illness, including historical trauma
- older adults experiencing or who have experienced homelessness
- older adults who have one or more disabilities

Strategy 2.1d: Seek sustained funding to develop a new Director of Health Equity and Community Partnerships at IDoA to lead integration of this objective across IDoA and the Aging network, and to develop a program to identify the needs of diverse older adult populations (including minority populations).

Outcomes for Objective 2.1

- Equity-oriented trainings provided to IDoA, AAA, APS and CCU staff.
- Increased number of discussions focused on understanding and developing ideas for redressing oppression and injustice hosted between IDoA, AAA, APS and CCU staff and centering the voices of individuals and organizations serving communities experiencing one or more system of oppression.
- Number of equity-focused changes to programming, funding, resources, communications, and partnerships to respond to engaged discussions focused on advancing equity and redressing injustice.

Objective 2.2: Address nutritional deficits and food insecurity, a significant social determinant of health, in older adults.

Strategy 2.2a: Partner with Healthcare and Family Services (HFS) to ensure all Managed Care Organizations (MCOs) are actively referring individuals to home delivered meal providers with plans and benchmarks to reduce inequities in usage among underserved populations.

Strategy 2.2b: In collaboration with HFS, MCOs, AAAs, CCUs and nutrition providers develop a tracking mechanism or feedback loop to report the number of home delivered

meal (HDM) referrals for each MCO by planning and service area.

Strategy 2.2c: Increase the number of trainings available to MCOs and Care Coordination Units (CCUs) on the HDM program, other AAA evidence-based nutrition programs, and apply a health equity approach to nutrition programming.

Strategy 2.2d: Expand AAAs' assessments of unmet nutritional needs and of under-represented populations, inform nutrition program offering expansion, and increase nutrition program use and to ensure healthy, nutritionally adequate, and culturally responsive meals are provided to the most vulnerable and marginalized older adults, especially in underserved communities, inclusive of older adults leaving carceral settings.

Strategy 2.2e: IDoA will provide training to AAA staff by registered, licensed dietitians concerning the adult meal pattern requirements of the Older Americans Act Senior Nutrition Program to assure delivery of nutritious home-delivered meals.

Strategy 2.2f: Advocate for increased federal and state CACFP administrative expense funds to support nutrition education training expenses of staff to promote increased fruits & vegetables (contingent upon expected meal pattern changes) and healthier choices for snacks.

Strategy 2.2g: Work with the Department of Human Services (DHS), AAAs, Aging network service providers, and local public health departments to expand the Senior Farmers' Market Nutrition Program (SFMNP) in additional counties throughout the state.

Strategy 2.2h: Conduct cost, consumer preference, and needs studies, to address deficiencies of home delivered meals (HDM) and congregate meal sites to expand diet options, meal choices/options, and emergency shelf-stable meals for HDM participants statewide.

Strategy 2.2i: All planning and service areas (PSAs) will have written emergency/disaster plans that include a minimum of three days of emergency meals (e.g. three congregate or three HDM, shelf stable meals) for participants in the congregate and home delivered meal program.

Strategy 2.2j: Provide trainings on DETERMINE nutrition screening and additional nutrition/malnutrition screening tools and resources to partner organizations to increase number of participants being screened/rescreened for nutritional risk in both the congregate and HDM programs. Focus on sub-populations who are under-represented among participants.

Strategy 2.2k: Strengthen the Department's policies and monitoring of nutrition screening/assessment for the Senior Nutrition Program and provide training(s) to the Aging network on updates to the Department's policies.

Strategy 2.2l: Create a workgroup consisting of the IDoA, AAAs, nutrition providers,

and older adults (including people who are underrepresented in nutrition programs) to assess: 1) feasibility of providing meal choices; 2) feasibility of providing more than one dietary option; 3) strategies for implementation; and 4) outcomes of providing choice (e.g. increased participation/meal counts, increased satisfaction with food, increased voluntary contribution, reduced inequities in participation, etc.).

Strategy 2.2m: Develop a tool for all PSAs to determine which additional dietary options are needed by area or county with a focus on improving nutrition and reducing inequities in program participation among underserved populations.

Strategy 2.2n: Work with DHS and the Illinois Coalition to End Hunger to evaluate how many older adults qualify for SNAP and other food and nutrition programs but are not enrolled.

Outcomes for Objective 2.2

- MCOs will increase referrals for HDM by 25% over baseline.
- Quarterly reports on HDM referrals for MCO and non-MCO recipients.
- Reduction (from baseline) in the number of individuals on HDM waiting lists.
- Increased number of meals distributed to those in minority and underserved populations.
- At least two trainings provided by a registered, licensed dietitian to AAA staff.
- A minimum of three (preferably five) emergency (shelf stable) meals will be available for HDM participants in the event of an emergency (e.g. pandemic, major disaster).
- Increased number of participants from underserved populations being screened/rescreened for nutritional risk in both congregate and home delivered meal programs.
- Seventy-five percent or greater of participants will have reduced or stable nutritional risk.
- Nutrition program providers will provide at least two diet options (e.g. low sodium diet, diabetic diet, kosher diet, etc.) for participants in the congregate and HDM programs as feasible, meeting nutrition requirements and when feasible, meet cultural, ethnic, or religious requirements.
- Increased number counties will have SFMNP.
- Increase number of eligible but not enrolled older adults in SNAP.

Objective 2.3: Expand and improve transportation options for older adults to maintain quality of life and independence.

Strategy 2.3a: Evaluate current transportation options statewide by utilizing PSA plan, state advisory council reports and other sources to understand where there are gaps in access to safe, accessible transportation.

Strategy 2.3b: Coordinate with the Illinois Department of Human Services on the Social Services Block Grant (Donated Funds Initiative (DFI)) to ensure an increased portion is directed toward older adults

Strategy 2.3c: Convene a transportation coordination commission to find solutions that eliminate barriers to adequate transportation services across state and local government boundaries with the Rural Transit Assistance Center (RTAC), Human Services Transportation Plan (HSTP) Coordinators, Illinois Department of Transportation (IDoT), the AAAs, and others.

Strategy 2.3d: Publicize and assist AAAs, their service providers, and other community organizations that provide transportation services to access available training and funding opportunities.

Strategy 2.3e: Provide tools and technical assistance on older adult transportation issues to local advocates.

Outcomes for Objective 2.3

- Increased percentage of the Donated Funds Initiative is dedicated to senior transportation.
- Transportation coordination commission is established.
- Transportation and coordination commission develops a plan to coordinate transportation across boundaries.

Objective 2.4: Ensure that older adults can secure accessible, safe, healthy, affordable, and inclusive housing that allows for aging in place and community integration.

Strategy 2.4a: IDoA and other Aging network representatives will participate in the statewide working groups for progress development on the Illinois Housing Blueprint goals.

Strategy 2.4b: Inform policymakers about the gaps and recommendations for reducing gaps in housing with supportive services for older adults, particularly marginalized older adults returning to their communities from carceral settings.

Strategy 2.4c: Collaborate with IHDA, DHS, and HFS to provide support for the ongoing maintenance of the housing locator system at www.ILHousing Search.org and statewide housing coordinators.

Strategy 2.4d: Collaborate with IHDA, DHS, and HFS to more seamlessly ensure that older adults and people with disabilities have accessible, affordable housing in their communities, including ensuring provision of wraparound services.

Strategy 2.4e: Advocate for and secure adequate funding to maintain affordable assisted living and other affordable and accessible community-based housing options.

Strategy 2.4f: Collaborate with local municipalities, AAAs, housing developers and housing providers on identifying housing subsidies and vouchers to increase accessible, safe, healthy, affordable, and inclusive housing.

Strategy 2.4g: Promote Senior Real Estate Specialist certification as part of advocating for age-friendly housing options.

Outcomes for Objective 2.4

- Implementation of action items related Illinois Housing Blueprint goals that improve housing options for older adults.
- Increased funding is secured for assisted living and other affordable housing options with in-home services.
- Establish internal workgroup to identify partners listed above for collaboration.
- Meet with statewide housing coordinators to understand how to increase collaboration with Department and Aging Network.

Objective 2.5: Promote healthy aging and social integration.

Strategy 2.5a: Reframe the public perception of aging by cultivating more visible, informed conversations about older adults and aging, advancing a set of core ideas to create the shifts in public understanding and narratives essential to building a more age- integrated and age-friendly society.

Strategy 2.5b: Regularly engage with both state and federal legislators to highlight current services provided to seniors and their caregivers in addition to advocating for additional resources and partners to ensure seniors remain independent and successfully age in place in Illinois.

Strategy 2.5c: Promote evidenced-based health, prevention, and wellness programs for older adults and persons with disabilities through Area Agencies on Aging, senior centers, hospitals, health clubs, park districts, religious institutions, and community centers, to increase physical activity and improve nutrition including the use of Older American Act Title III-D.

Strategy 2.5d: Increase number of people accessing meal options by expanding the nature and type of dining opportunities available (i.e. congregate lunch setting and dine-out options), integrating social and cultural opportunities.

Strategy 2.5e: Promote use of senior centers as community supports for older adults and caregivers and help them expand preventive programming especially regarding physical fitness, social integration, and volunteerism.

Strategy 2.5f: Promote volunteerism among older adults and their families and friends.

Strategy 2.5g: Collaborate with AAAs and other partners to develop intergenerational program initiatives to create a community support system to use

the time and talent of youth and older adults to maximize community strengths and connections.

Strategy 2.5h: Senior center and adult day services sites will plan for and deliver remote and/or virtual activities and services, particularly marginalized older adults returning to their communities from carceral settings.

Strategy 2.5i: Explore opportunities for funding to increase the use and integration of information technology for older adults to remain connected with family and friends.

Outcomes for Objective 2.5

- Outreach efforts from senior centers will grow by 2% in FY 22 and FY 23.
- The number of evidenced based programs implemented at community centers including senior centers will increase by 3% including virtual programs and activities, in addition to in-person activities once senior centers are fully reopened.
- Dependent on Medicaid waiver authority and the continued public health emergency, 25% percent of senior centers and adult day services will have plans for remote or virtual activities.
- Creation of inventory and IDoA website page dedicated to resources for technology and connectivity.

Objective 2.6: Work toward becoming a dementia-friendly state by increasing capacity of existing Alzheimer's and dementia initiatives statewide in collaboration with AAAs, Aging Network, and other organizations specializing in Alzheimer's disease and dementia care.

Strategy 2.6a: Collaborate with technology incubators and academic institutions to gain new federal grant funding to develop technology and robotics to support individuals and families impacted by Alzheimer's disease.

Strategy 2.6b: Provide training and supports to caregivers to decrease caregiver burden and caregiver stress, such as Savvy Caregiver Program, Stress Buster Program with AAAs.

Strategy 2.6c: Collaborate with advocacy organization including the Alzheimer's Association and the Illinois Cognitive Resource Network to increase public awareness, education, and sensitivity.

Strategy 2.6d. Collaborate with the Area Agencies on Aging to develop training webinars and tools to educate local governmental officials, community organizations, and other partners on their role in building dementia and age friendly communities.

Strategy 2.6e: Identify service and support gaps and explore opportunities to increase caregiver support through respite and dementia gap filling services.

Strategy 2.6f: Fund and support the Alzheimer's disease and related dementias (ADRD)

programs available in all PSAs.

Strategy 2.6g: Work with Aging Network partners to build a dementia-capable workforce.

Strategy 2.6h: Plan and collaborate with the Illinois Department of Public Health and the Illinois Guardianship and Advocacy Commission on the State Plan on Alzheimer's Disease, pursuant to 410 ILCS 405; IDoA representative on the Alzheimer's Disease Advisory Committee will advocate for older adults and Aging network providers.

Strategy 2.6i: Analyze data from FY20 ADRD program and make necessary changes to improve services and adopt best practices across all PSAs.

Strategy 2.6j: Coordinate services and transitions between waiver programs with the Division of Rehabilitation Service for adults under the age of 60 with early onset Alzheimer's disease.

Strategy 2.6k: Collaborate with partners and organizations with the capacity to develop an Illinois-based education and technical assistance center for communities interested in becoming designated as a dementia friendly community.

Strategy 2.6l: In partnership with the Area Agencies on Aging, evaluate existing dementia friendly communities in Illinois to understand and disseminate best practices and lessons learned.

Outcomes for Objective 2.6

- Two full dementia trainings will be offered for professionals and paraprofessionals in FY 22. Three full dementia trainings will be offered for professionals and paraprofessionals in FY23 and FY24. Include collaboration with IDOC to conduct dementia pieces of training for its staff.
- Participation in Alzheimer's and Dementia initiatives/programs will experience 3% increased participation among individuals and caregivers each year.
- Services and/or funding available through ADRD programs will increase annually over baseline.
- Establish one dementia friendly community in each PSA by 2023 that currently does not have a community with this designation.
- Increase the number of dementia friendly cities by one in each PSA with an existing dementia friendly community.

Objective 2.7: Expand employment, volunteer, and training opportunities for older adults in the private and public sectors.

Strategy 2.7a: Evaluate whether regional Senior Citizen Supported Employment Program (SCSEP) grantees are meeting placement goals on a quarterly basis.

Strategy 2.7b: Coordinate with the SCSEP national contractors to achieve optimal equitable distribution of authorized SCSEP slots allocated annually by the U.S. Department of Labor.

Strategy 2.7c: Collaborate with Local Workforce Investment Area Boards, Illinois Department of Employment Security (IDES) One-Stop Centers, and Veteran service offices to promote employment opportunities for older adults.

Strategy 2.7d: IDoA will have representation on the Workforce Innovation and Opportunity Act (WIOA) State Interagency Workgroup.

Strategy 2.7e: Coordinate activities with the Illinois JobLink system, a web-based job search and training resource developed and managed IDES. Additionally, utilize the Illinois WorkNet system for job or training opportunities for older workers.

Strategy 2.7f: Collaborate with the federal Corporation for National and Community Service (CNCS) to provide Senior Companion volunteer opportunities for low-income older adults, Retired Senior Volunteer Program (RSVP) and Foster Grandparent Programs.

Strategy 2.7g: Collaborate with SCSEP contractors to ensure an increase in establishing participant goals and helping them meet the goals as outlined in participant Individualized Employment Programs (IEP).

Outcomes for Objective 2.7

- Increase (from baseline) the number of host agencies available to older adults under Title V and require national contractors operating in the state.
- Maintain or increase the number of people who participate in the Senior Companion, RSVP, and Foster Grandparent Programs.
- 100% of regional SCSEP programs will meet their goals.
- 100% of SCSEP program participants will have established goals.
- 100% of SCSEP program participants will have moved toward meeting their goals.
- One monthly training of SCSEP grantees on infectious disease transmission risk reduction.

Objective 2.8: Explore the expansion of new Age-Friendly Communities throughout the State.

Strategy 2.8a: Educate AAA's about Age-Friendly Communities and the role they can play in their area.

Strategy 2.8b: Collaborate with AARP and others to develop an Illinois-based education and technical assistance center for communities interested in becoming a designated Age Friendly community.

Strategy 2.8c: Evaluate existing age-friendly communities in Illinois to understand

and disseminate best practices and lessons learned.

Outcomes for Objective 2.8

- Collaboration established with AARP and others.
- Education materials prepared and shared with AAAs and communities.
- Governor takes executive action via declaration or executive order to designate "Age- Friendly Illinois."
- Governor takes executive action via declaration or executive order to designate "Age-Friendly State Agencies" with required aligned actions by those agencies (e.g., Illinois Department of Corrections).

Objective 2.9: Expand programming to reduce social isolation and loneliness.

Strategy 2.9a: Provide training and education opportunities to AAAs, CCUs and other Aging Network partners to become educated for signs of social isolation and loneliness.

Strategy 2.9b: Evaluate the AAAs implementation of the UCLA loneliness scale.

Strategy 2.9c: Work with academic partner to evaluate social isolation and loneliness data collected from evidenced-based programs.

Strategy 2.9d: Investigate availability of funding from Illinois Broadband Council for internet, WiFi and other connectivity devices.

Strategy 2.9e: Work with AAAs to maintain and expand programs to reduce social isolation and loneliness, such as volunteers and senior calling programs.

Outcomes for Objective 2.9

- Number of training opportunities for AAAs and partners on social isolation and loneliness.
- Percentage of AAAs using UCLA loneliness scale.
- Increased funding for broadband internet WiFi and other connectivity for older adults.
- Number of new programs initiated to reduce social isolation and loneliness.

Objective 2.10: Ensure integration of healthcare and social models with an increased focus on health promotion and prevention.

Strategy 2.10a: Evaluate capacity of AAAs (via training and program development) to conduct health promotion and prevention screenings.

Strategy 2.10b: Work with AAAs to ensure seamless referrals to both healthcare services and social programs to meet needs identified through screenings (e.g., suicide prevention, traumatic brain injury). Develop data tracking system to track and analyze

referrals made by the AAAs information and referral programs.

Strategy 2.10c: Conduct follow-up calls and other outreach to individuals with screenings indicating unmet needs and for those who have received referrals to ensure connections to programs focused on social determinants (e.g., food, transportation, housing, anti- poverty programs).

Strategy 2.10d: Grow capacity of the Aging network (via training, program development, and seeking grants) to provide disease prevention and health promotion education and to include organizations working with older adults returning to their communities from carceral settings.

Outcomes for Objective 2.10

- Percent increase (from baseline) in preventive health screenings.
- Percent increase (from baseline) in referrals to health and social programs.
- Establish content and schedule of trainings for AAA staff focused on disease prevention and health promotion.
- Establish content and schedule of training for Aging network staff working with older adults returning from carceral settings, focused on disease prevention and health promotion.

Objective 2.11: Provide education about serving older adults who are formerly incarcerated and those returning to their communities from carceral settings.

Strategy 2.11a: Research agencies that work with people returning from carceral settings and their referral protocols and services offered.

Strategy 2.11b: Provide information to agencies working with people returning from carceral settings, to ensure knowledge of services offered by IDoA

Strategy 2.11c: Require one training a year and ongoing training as needed for all entities by criminal justice experts, to better understand the needs of people who are formerly incarcerated, with a focus on the transition back to communities from carceral settings.

Strategy 2.11d: Revise documents used by all entities to reflect data gathering information on people returning to communities from carceral settings.

Strategy 2.11e: Revise materials used by all entities to be inclusive of people returning from carceral settings.

Strategy 2.11f: Welcome stakeholders to take part in representing people returning from carceral settings in meetings and advisory councils.

Strategy 2.11g: Use data to note gaps in service and act in bridging those gaps for people returning from carceral settings.

Outcomes for Objective 2.11

- Annual trainings for all entities.
- Presentations of IDoA services to agencies working with people returning from carceral settings.
- Collect data on people returning from carceral settings to determine a baseline.
- Share data with all invested entities to determine the next best steps and practices.

Goal 3: Maximize federal, state, local and private resources to sustain and expand services and supports to older adults.

Objective: 3.1: Ensure that older adults who are eligible are enrolled in Medicaid.

Strategy 3.1a: Build upon work of the IDoA Older Adult Services Advisory Committee (OASAC) Community Care Program (CCP) Medicaid Enrollment Sub-Committee to maximize Medicaid enrollment and federal claiming under the HCBS Persons who are Elderly waiver.

Strategy 3.1b: Identify barriers to completing and submitting Medicaid applications and retaining Medicaid eligibility through collaboration with HFS and DHS to overcome these barriers.

Strategy 3.1c: Identify barriers to completing and submitting Medicaid applications for older adults returning from carceral settings, and identify sub-populations who are underrepresented in enrollment, and work with the Illinois Department of Corrections (IDOC), HFS, and to overcome these barriers.

Strategy 3.1d: Monitor the effectiveness of enrollment and retention through electronic reporting and data collection on IDoA Medicaid application report uploader.

Strategy 3.1e: Work with Department of Healthcare and Family Services to identify older adult sub-populations who are under-represented among enrollees in Medicaid or Medicaid look-alike programming and use outreach specific to reaching those individuals (e.g., people returning to communities from carceral settings).

Strategy 3.1f: Provide education and outreach to Aging network and older adults about the Illinois Health Benefits for Immigrants 65 Years and Older.

Strategy 3.1g: Collaborate with IHDA, DHS, and HFS to more seamlessly ensure that seniors and people with disabilities are enrolled in Medicaid and are receiving appropriate HCBS.

Outcomes for Objective 3.1

- Increase (from baseline) the number of Medicaid applications which CCUs assist with completion.
- Report quarterly to OASAC on the results of the CCP Medicaid Enrollment subcommittee.
- Evaluate IDoA Medicaid application report uploader data to establish

baseline number of Medicaid applications which CCUs assist individuals with completion.
- Maintain baseline number, or increase where feasible, percentage of CCP program clients enrolled in Medicaid.

Objective 3.2: Improve public benefit outreach to older adults and persons with disabilities through the Aging network.

Strategy 3.2a: Expand MMAI activity through the Title XVIII Social Security Senior Health Insurance Program (SHIP) network by securing a new grant.

Strategy 3.2b: Build on expansion of Senior Health Insurance Program and Senior Health Assistance Program outreach activities and enrollment events in collaboration with the Area Agencies on Aging to assist older adults gain access to public benefits.

Strategy 3.2c: Collaborate with "Make Medicare Work" Coalition, Latino Outreach Network, Centers for Independent Living, faith-based organizations, Coalition of Limited English-Speaking Elderly, Family Caregiver Resource Centers, Jane Addams Center for Social Policy & Research, federally qualified health centers, and other organizations on scheduling enrollment events to provide one-on-one counseling.

Strategy 3.2d: Continue to expand outreach for additional help for Medicare Part D and the Medicare Savings Programs outreach with the Area Agencies on Aging, ADRCs and SHIP sites through Medicare Improvements for Patients and Providers Act (MIPPA) funding.

Strategy 3.2e: Implement federally mandated performance reporting system to capture client demographics, types of service and outcomes received through Senior Health Insurance Program and Senior Health Assistance Program counseling efforts.

Strategy 3.2f: AAAs will continue active management and ongoing funding of the federal Veteran-Directed Home and Community Based Services Program, and advocate to expand the initiative to include additional planning and service areas and funding all VA medical centers in the state.

Strategy 3.2g: Partner with the Illinois Department of Veterans Affairs and AAAs to develop strategies to increase the Aging network's awareness of Veterans' benefits and the utilization of benefits among the state's older adult Veteran population.

Strategy 3.2h: Analyze ways to continue to simplify online enrollment in the two-year rolling Benefit Access Program application and improve electronic receipt of application data.

Strategy 3.2i: Collaborate with the AAAs to maintain work performance targets by planning and service area for participating Senior Health Insurance Program and Senior Health Assistance Program sites.

Strategy 3.2j: Explore opportunities to educate non-traditional partners, for

example, EMS and fire, about Aging programs and services.

Outcomes for Objective 3.2

- Increase the number of Low-Income Subsidy applications, Medicare Savings Program, and Benefit Access Applications completed by the Aging network providers by 2% each year.
- Senior Health Insurance Program grant goals are met.
- Creation of strategies to educate Veterans about accessing benefits.
- Establish baseline for the number of non-traditional partner organization/agencies.
- Increased number of unique visits to IDoA website from baseline.

Objective 3.3: Ensure that access to quality coverage extends to participants in the State's Managed Long Term Supports and Services (Managed Care) programs for older adults.

Strategy 3.3a: Collaborate with the Department of Healthcare and Family Services (HFS) and Department of Human Services (DHS) with the ongoing implementation of PA 96- 1501 (long-term care rebalancing) to move eligible recipients with comprehensive medical benefits across LTC programs to risk-based integrated care (managed care) options.

Strategy 3.3b: Provide regular trainings to Managed Care Organization (MCO) management and case management staff on Community Care Program services and supports, OAA services, and other issues.

Strategy 3.3c: Regional LTC Ombudsman Programs will provide community education sessions to inform the public as well as stakeholders about the role of the managed care and the Ombudsman programs.

Strategy 3.3d: Advocate for MCOs to support and fund services provided by the Aging network that integrate healthcare and social or non-medical needs that allow older adults to live in the least restrictive setting as possible.

Strategy 3.3e: Investigate opportunities to fund person-centered activities through MCOs at senior centers.

Outcomes for Objective 3.3

- LTC Ombudsman will track issues and resolutions that are reported to federal and state agencies and MCOs and report regularly to the Long-Term Care Council.
- Regional LTC Ombudsman Program will conduct regular community education sessions annually.
- Development of at least one pilot project between a senior center and MCO to provide and demonstrate the integration of health and social services.

- IDoA will present to MCO/HFS workgroup regularly.

Objective 3.4: Maintain current statewide contingency plans and training events to respond to disaster declarations and public health emergencies, including COVID-19 related issues, to ensure access to services with limited interruptions for older adults.

Strategy 3.4a Convene a COVID workgroup including AAAs, CCP providers, and stakeholders to discuss the "lessons learned" from COVID to ensure the Aging network is prepared for a future public health emergency.

Strategy 3.4b: Partner with the Illinois Emergency Management Agency (IEMA), the Illinois Department of Public Health, other state departments and the American Red Cross to access available, ongoing disaster or emergency training for the AAAs.

Strategy 3.4c: Coordinate with the Illinois Emergency Management Agency and the American Red Cross to develop a "Mutual Aid" agreement with the Illinois Association of Area Agencies on Aging so they can assist other AAAs in Illinois that need assistance with disaster or emergency situations.

Strategy 3.4d: Coordinate with IEMA and the American Red Cross to train AAAs and their service providers about Functional Needs Support Services (FNSS) and how to effectively incorporate these services in their disaster and emergency plans.

Strategy 3.4e: Evaluate the AAAs current disaster and emergency plans to assure that coordinate with and assist the American Red Cross in assessing the functional needs of older adults.

Strategy 3.5f: Provider organizations and vendors (including but not limited to: AAAs, CCUs, in-home, AMD, EHRS, adult day services, senior centers) will incorporate planning and protocols for suspension of services or normal business operations into their emergency or disaster plans. Disaster and emergency plans will include processes and protocols consistent with CDC and IDPH guidance, emergency meal distribution, procedures for workforce shortages, and other precautions that are necessary in order ensure continuity of services.

<u>Outcomes for Objective 3.4</u>

- Convening of a COVID cross program workgroup to evaluate the "lesson learned" from the public health emergency.
- Disaster plans coordinated across relevant public and private agencies exist in all planning and service areas.
- Annual training sessions on disaster preparedness.
- Number of evaluations of disaster and emergency plan completed after event.
- IDoA will ensure that the Aging network has readily accessible personal protective equipment (PPE) in preparation for public health emergencies.

Objective 3.5: Expand caregiver and agency support programs that reduce stress and burnout and promote trauma-informed care.

Strategy 3.5a: Expand availability of and increase participation in the Savvy Caregiver program for family caregivers of individuals with Alzheimer's who continue to live at home. Consider offering program virtually, based on guidance from "Savvy Caregiver Tips and Guidelines for Online Group Delivery."

Strategy 3.5b. Establish a workgroup consisting of stakeholders and experts throughout the Aging network for the purpose of identifying needs, supports, and new initiatives aimed at supporting caregivers.

Strategy 3.5c: Make available and promote trauma-informed care and burnout prevention webinars and other trainings for staff working at AAAs, Aging network providers, care coordination units (CCUs), and state agencies working with significant sub-populations of older adults, such as IDOC working with incarcerated older adults.

Strategy 3.5d: Partner with AAAs to explore feasibility of their agencies and their partner organizations to become trauma-informed organizations and to take initial steps where feasible.

Outcomes for Objective 3.5

- Maintain number of participants in Savvy Caregiver program and convert to online participation.
- Number of trauma-informed webinars and other trainings made available.
- Implementation of at least one other evidenced-based program that allows for virtual/remote education/interaction.

Objective 3.6: Link older adults to services that address experiences of behavioral health disorders, including mental health and substance abuse disorders.

Strategy 3.6a: Increase knowledge base about and reduce stigma associated with mental health and substance use in the aging network through training and education programs.

Strategy 3.6b: Advocate for community mental health and substance use disorder treatment funding for people with anxiety, depression, and for non-serious-mental illness related challenges.

Strategy 3.6c: Seek new funding and work with the Department of Human Services, Division of Mental Health to develop programming to increase referrals to appropriate evidence-based mental health screenings and mental health and substance use disorder healthcare services, such as medication-assisted treatment (MAT) and naloxone distribution, through AAAs, CCUs, and other providers.

Strategy 3.6d: Develop new workforce training to increase rates of screening, triage, and referrals to appropriate mental health and substance use disorder services through

AAAs, CCUs, and other providers.

Strategy 3.6e: Develop and distribute trauma-informed and culturally responsive communications materials (e.g., brochures, posters) for aging network partners to use to de-stigmatize mental illness and substance use disorders and encourage older adults to seek appropriate assessment, and when needed, referral and healthcare.

Outcomes for Objective 3.6

- Establishment of screenings for mental health and substance use disorders.
- Established method to make referrals to behavioral health services and ability to track this data.
- Communication materials developed and distributed across Aging network.
- Training module or webinar opportunity for Aging network developed.
- Strengthen collaboration between IDoA and the DHS, Division of Mental Health, to enhance referrals between Aging network and community behavioral health agencies.

Goal 4: Ensure that adequate capacity for services and supports is developed in the Aging network to prepare for the projected growth and diversity in the aging population.

Objective 4.1: Grow the direct care workforce by expanding resources, providing additional training opportunities, and developing new workforce career tracks.

Strategy 4.1a: Create a common, statewide CCP curriculum that will raise awareness of ageism through implicit bias, approach person-entered care planning through the lenses of equity, adaptability, and resilience; and understand how adverse childhood experiences (ACEs) and other traumatic experiences impact older adults.

Strategy 4.1b: Expand efforts statewide to include the cultural humility, structural competency, and equity trainings encompassing the diverse aging population throughout Illinois.

Strategy 4.1c: Utilize the Older Adults Services Advisory Council (OASAC) Workforce Stabilization work group to identify opportunities for workforce development of people who provide care to older adults in collaboration with DCEO, workforce development programs, and the Workforce Innovation and Opportunity Act.

Strategy 4.1d: Develop a geriatric specialist career track for high school graduates and GED students for a viable career in direct homecare for older adults through collaboration with academic institutions offering courses, degrees, and certificates in gerontology, the Illinois State Board of Education, the Illinois Board of Higher Education, the Illinois Commerce Commission, the Department of Community and Economic Opportunity, and the Illinois Department of Public Health.

Strategy 4.1e: Stabilize the workforce of older adult service providers, and partner with experts in the field to expand education and training opportunities.

Outcomes for Objective 4.1

- Identify the OASAC recommendations that IDoA can implement and provide technical assistance through its advisory committees.
- Establish at least one pilot program focused on geriatric specialists in high schools.
- Increased collaborations between CCU's and universities to provide meaningful field placement experiences.
- Workforce development sessions/presentations are included in IDoA annual conferences.

Objective 4.2: Expand awareness and enhance understanding of serving older adults who are Lesbian, Gay, Bi-Sexual, or Transgender (LGBT).

Strategy 4.2a: Conduct LGBT trainings provided by SAGE within the next year to both IDoA staff and all our provider agencies, AAAs and other Aging network providers.

Strategy 4.2b: Provide ongoing training to Senior HelpLine staff about culturally appropriate practices and revise the intake process to collect LGBT demographics.

Strategy 4.2c: Provide targeted outreach and communication materials that are LGBT affirming across IDoA, with specific focus on reducing social isolation and reaching people with dementia.

Strategy 4.2d: Identify diverse stakeholders who identify as part of and/or represent the interests of older adults who are LGBT to serve on IDoA advisory councils.

Strategy 4.2e: Work with SAGE to develop a needs assessment to identify needs and a capacity survey to inform planning for and address the specific gaps in service delivery to older adults who are LGBT.

Strategy 4.2f: Encourage individuals who identify with the lesbian, gay, bisexual, and transgender (LGBT) community to plan for long-term care and end of life options through education and counseling about options for older adults.

Strategy 4.2g: Utilize lessons and insights from the pro-equity engagements outlined in Objective 2.1 to guide outreach and communications to build trust and communicate the presence of welcoming and affirming services for LGBT older adults, recognizing that experiences and fears of stigma and discrimination will need to be overcome.

Outcomes for Objective 4.2

- Annual trainings will be conducted and administered across IDoA divisions,

and to the Aging network, including CCP providers.

- 20% increase of people who identify as LGBT being engaged in or receiving services in Aging network.
- Demographic information collected by Senior HelpLine staff will be shared with CCUs and other Aging network providers, as appropriate, to be incorporated into person-centered care planning.

Objective 4.3: Provide culturally appropriate information aligned with national Culturally and Linguistically Appropriate (CLAS) Standards in a variety of formats to older adults, their families, and caregivers, considering linguistic and cultural differences.

Strategy 4.3a: Provide information and referral assistance in culturally and linguistically appropriate manner regardless of ethnicity, race, language, gender, religion, sexual orientation, gender identity, or socioeconomic status.

Strategy 4.3b: Educate Area Agencies on Aging (AAA), care coordination units (CCUs), and Aging network providers about the unique needs of diverse older adults; especially those with greatest economic need, with physical or mental health issues, limited English proficiency, facing cultural or social isolation including LGBT individuals, and older adults in rural communities.

Strategy 4.3c: AAAs, CCUs, and Aging network providers will notify IDoA in a timely manner about updates to the IDoA website provider profile.

<u>Outcomes for Objective 4.3</u>

- Print, digital and electronic informational materials will be adapted to accommodate linguistic and cultural differences and translated into the top five most common language spoken in the state and among Community Care Program participants.
- Information and Assistance Centers will receive bi-annual trainings and materials to assure that older adults and caregivers receive information in a culturally and linguistically sensitive manner.
- On-going education and training conducted for Aging network on diversity of older adults and their needs.

Objective 4.4: Expand awareness and enhance understanding of serving older adults who were formerly incarcerated and are returning to their communities from carceral settings.

Strategy 4.4a: Conduct trainings about older adults returning from carceral settings provided by Jane Addams Center for Social Policy and Research for both IDoA staff and Aging network providers.

Strategy 4.4b: Provide targeted outreach and communication materials across IDoA that are affirming for older adults returning from carceral settings, with specific focus on reducing social isolation and reaching people with dementia.

Strategy 4.4c: Identify diverse stakeholders who identify as part of and/or represent the interests of older adults who are formerly incarcerated to serve on IDoA advisory councils.

Strategy 4.4d: Work with Center to develop a needs assessment to identify needs and a capacity survey to inform planning for and address the specific gaps in service delivery to older adults who are returning to communities from carceral settings.

Strategy 4.4e: Educate Area Agencies on Aging (AAA), care coordination units, and Aging network providers about the unique needs of older adults; returning from carceral settings especially those with greatest economic needs, with physical or mental health issues, limited English proficiency, and those facing discrimination or social isolation.

Outcomes for Objective 4.4

- On-going education and training conducted for Aging network on returning older adults and their needs.
- Distribution of communication materials to education Aging network about the unique needs of returning older adults.
- Partnership established with Jane Addams Center for Social Policy and Research at UIC.

Objective 4.5: Guide development of outreach, communication, and inclusion in oversight systems by expanding awareness and enhancing understanding of people facing one or more system of oppression and centering voices of people who face one or more systemic injustice.

Strategy 4.5a: To better meet the needs of older adults from all backgrounds, review outreach and communications materials during (and use lessons from past) pro-equity and anti-oppression engagements outlined in Objective 2.1 to guide modifications to existing and new communications and outreach of IDoA, AAAs, and CCUs. Use this review to modify items to reach disengaged individuals from backgrounds who are underrepresented in and underserved by aging services, build trust, and involve them in relevant services.

Strategy4.5b: Identify individuals and organizations to newly involve in program input, oversight, and governance to advance equity, diversity, inclusion, and trust.

Outcomes for Objective 4.5

- Modifications to communications based on feedback or insights gained from pro-equity engagements.
- Decreased inequities in service utilization rates across different demographic population groups.

Goal 5: Enable older Illinoisans, their families, and other consumers to choose and easily access options that support older adults' ability to stay in their homes and communities.

Objective 5.1: Provide quality home and community-based services (HCBS) designed to enable older adults to remain safely at home.

Strategy 5.1a: Research other state's HCBS waivers for best practices and identify services to be added to Illinois' HCBS Persons Who are Elderly Waiver.

Strategy 5.2b: Research and consider adding new services and flexibilities that were instrumental to the success of the Money Follows the Person demonstration and those included in Appendix K (during the COVID-19 public health emergency) to the HCBS Persons Who are Elderly Waiver (e.g., one-time services, environmental modifications, assistive technology devices).

Strategy 5.1c: Notify HFS and the Centers for Medicare and Medicaid Services (CMS) of the intent to add new services to the HCBS Persons Who are Elderly Waiver in 2021.

Strategy 5.1d: Complete and submit the required reporting, revisions, and updates to the HCBS Persons Who are Elderly Waiver.

Strategy 5.1e: Ensure individuals are aware of community-based service options prior to admission to an institutional setting via the Choices for Care screening program and streamline the process for establishing services post-hospitalization or rehabilitation placement.

Strategy 5.1f: Provide education and training programs for the Aging Senior HelpLine, the Aging network, and other partners serving No-Wrong-Door populations to ensure consistent information delivery on waiver and other programs serving older adults and people with disabilities.

Strategy 5.1g: Continue to support the State's effort to comply with the Colbert and Williams consent decrees rebalancing efforts and implementation as led by the Illinois Department of Human Services.

Strategy 5.1h: Collaborate with IHDA, DHS, and HFS to more seamlessly ensure that seniors and people with disabilities are able to access appropriate HCBS.

Strategy 5.1i: Work with HFS to find and reduce gaps in managed care related to HCBS by modifying MCO contract language as needed to better meet needs of older adults who depend upon such services.

<u>Outcomes for Objective 5.1</u>

- Research on other State's Waiver programs will be conducted to determine effective services that can be added to Illinois' waiver.
- Application will be made to HFS and CMS to renew waiver

Objective 5.2: Continue to communicate and raise awareness across the state, the Aging network, and with stakeholders about options and services that are available to older adults

and caregivers in Illinois so they can make informed choices about remaining in their homes or communities.

Strategy 5.2a: Develop and implement a comprehensive statewide promotion and outreach plan that includes translating and distributing brochures, key forms, fact sheets, and webpages in the top five languages spoken in the state of Illinois. Ensure all online and print materials are accessible for people with disabilities, including people who are deaf, hard of hearing, blind, low vision, or have some combination of these conditions, using written format, ASL, audio formats, and plan language for outreach and all forms.

Strategy 5.2b: Provide clear and comprehensive information to older Illinoisans and their caregivers to help inform their options for services and supports via an interactive and easy-to-access Provider Profile. Re-design the Department's website inclusive of services and supports through sister agencies and regional entities.

Strategy 5.2c: Strengthen and standardize partnership agreements and mutual referral protocols between Area Agencies on Aging, care coordination units, organizations working with individuals with disabilities, individuals with mental health and behavioral health, housing, transportation, and other services at the community level.

Strategy 5.2d: Stimulate communication and collaboration among aging and disability partners and providers through cross-training, information, and facilitation to ensure appropriate translation services are available for older adults who need it.

Strategy 5.2e: Strengthen and expand collaboration and communication with Aging network stakeholders through the advisory groups to inform of change and new policies and rules. Utilize advisory groups more effectively to communicate policy and rules changes and to obtain feedback on impact and improvements.

Strategy 5.2f: Evaluate the outcomes of the TCARE, caregiver assessment tool, and determine the broader application of the assessment in all planning and service areas.

Strategy 5.2g: Provide updates for older adults regarding policy and programmatic responses to emergencies (i.e. natural disasters, public health emergencies) that support people’s access to services and resources (e.g., unemployment assistance, eviction protections, moratoria against utility shut-offs, meals and food or other assistance, and public health and safety).

Outcomes for Objective 5.2

- Plan will be developed, translated, and disseminated throughout the state on a regular and on-going basis.
- Revision of provider profile completed.
- IDoA website will be redesigned and include Aging and AAA provider information and link to MCO information provided by HFS.
- Increase percentage of referrals (from baseline) between AAAs, CCUs and other organizations.

- Quarterly calls with Aging network provider groups.
- Advisory groups will advise on and share information with their constituencies.
- TCARE evaluation for potential scaling to all planning and service areas.

Objective 5.3: Employ data and evidence-based programs to mitigate risk of unnecessary institutionalization.

Strategy 5.3a: Utilize critical event reporting systems to identify and address individual risk.

Strategy 5.3b: Analyze critical event data to expand programs responsive to identified risks.

Strategy 5.3c: Work with Area Agencies on Aging, care coordination units, stakeholders, and academic institutions to develop and expand the use of effective, evidence-based programs such as Matter of Balance and Pro-Home.

Strategy 5.3d: Evaluate existing demonstration projects to determine their effectiveness. Make data-driven decisions regarding the development of new projects and the termination or expansion of existing projects.

Outcomes for Objective 5.3

- Implementation of risk mitigation strategies based on critical event data.
- Standards will be developed to measure effectiveness of program in meeting goals.
- Demonstration programs will be evaluated on a bi-annual basis for effectiveness.

Objective 5.4: Expand the availability, integration, and access to assistive technology for older adults.

Strategy 5.4a: Evaluate ability to add assistive technology to HCBS waiver.

Strategy 5.4b: Support AAAs working with Illinois Assistive Technology Program to evaluate sustainable funding sources for assistive technology, including from ACL, Medicare, MCOs, or other sources.

Strategy 5.4c: Evaluate and seek sustainable funding by working with relevant MCOs and Medicare Advantage Plans to integrate reimbursements for assistive technology for older adults.

Strategy 5.4d: Seek grant funding to support use of assistive technology (e.g., grants from ACL, CMS, etc.).

Strategy 5.5e: Work with AAAs, CCUs, and Aging network providers to implement assessment and referrals for linking people to appropriate assistive technology.

Strategy 5.5f: Conduct racial equity impact analysis that is attentive to the racial wealth gap, inequities in income and wealth, and overlap of racism with classism, genderism,

ableism, ageism, and other inequities to guide potential changes to spending and outreach for such items as home modifications and assistive technology.

Outcomes for Objective 5.4

- Increased % of older adults utilizing assistive technology.
- Increased funding available for assistive technology.
- Information and referral resources established about assistive technology.

Objective 5.5: Work with legal services providers, legal advocacy organizations and others to advocate for funding and resources to provide legal assistance to older adults so they can access social services that allow them to live independently.

Strategy 5.5a: Establish subcommittee of the Older Adult Services Advisory Committee to identify gaps and barriers that older adults are experiencing when accessing legal services.

Strategy 5.5b: Revise the listings under the provider profile to include legal service providers. Ensure this information is also shared with staff on the Senior HelpLine.

Strategy 5.5c: Explore options for education and training on legal issues spotting for Aging network.

Outcomes for Objective 5.5

- Subcommittee established.
- IDoA website is updated with listings of legal service providers.
- At least one legal services training module is developed.

Goal 6: Implement federally mandated person-centered planning requirements statewide.

Objective 6.1: Utilize effective pre-screening and assessment tools to identify people who can return to the community from hospitals, nursing homes, and other institutions.

Strategy 6.1a: Continue to partner with care coordination units, the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services, the Illinois Department of Corrections, and other agencies to make improvements to the pre-screening and de-institutionalization processes to prevent or minimize unnecessary institutionalization and to ensure that persons admitted to nursing facilities for short-term stays can return to the community if they choose.

Strategy 6.1b: Coordinate with Illinois Department of Healthcare and Family Services and Department of Human Services as they re-design the existing model to ensure compliance with the federal Pre-Admission Screening & Resident Review (PASRR) requirements.

Strategy 6.1c: Train Choices for Care pre-screeners on assessment strategies and new PASRR requirements.

Strategy 6.1d: Continue to work with Area Agencies on Aging to incorporate the principles of person-centered planning in all Older Americans Act services as mandated by Administration for Community Living.

Strategy 6.1f: Develop and maintain standardized toolkit of resources, processes, formal guidance, and performance expectations to ensure person-centered counseling appropriately identifies available resources and services for participants and caregivers.

Outcomes for Objective 6.1

- All AAAs will report on their plan and implementation strategies to meet the person-centered planning mandate in each of their OAA services.
- Toolkit developed, disseminated to participants and caregivers, and for effectiveness.
- Quarterly training for Choices for Care screeners in collaboration with HFS and DHS.

Objective 6.2: Explore options for education and training of Aging network (in particular for caregivers and participants) about end of life care planning.

Strategy 6.2a: Develop a workgroup including representatives of providers, Area Agencies on Aging, stakeholders, and experts to improve planning and decision-making for older adults and their families surrounding palliative care and end of life decisions.

Strategy 6.2b: Develop training and educational materials to integrate hospice and palliative care referrals into existing community-based long-term care supports and services.

Strategy6.2c: Partner with adult education and enrichment/lifelong learning programs at community colleges, trade associations and/or advocacy organizations.

Outcomes for Objective 6.2

- Establishment of at least one partnership with adult education and enrichment/lifelong learning program at a community college, trade association, or advocacy organization on end of life care planning.
- Establishment of workgroup.
- Development of at least one training module for care coordination units about hospice and palliative care

Goal 7: Prevent and improve response to abuse, neglect and exploitation while preserving rights of older adults and persons with disabilities in all settings.

Objective 7.1: Protect older adults and persons with disabilities by strengthening interagency collaboration to prevent abuse, neglect and exploitation, and increase public awareness.

Strategy 7.1a: Engage the Elder Abuse Task Force to raise awareness and educate stakeholders about adult and elder abuse, neglect, and exploitation.

Strategy 7.1b: Investigate best practices to combat and prevent incidences.

Strategy 7.1c: Support and work toward standardizing the regional abuse Fatality Review Teams (FRTs) in each planning and service area, which include representatives from the coroners' or medical examiners' offices, State's Attorneys' Offices, law enforcement, health care, and social service. Work to standardize Fatality Review Teams across all planning and service areas.

Strategy 7.1d: Establish standards to ensure that Fatality Review Teams provide a more consistent and robust review of cases and improve communication among these individuals outside of the Fatality Review Team meetings.

Strategy 7.1e: Use the information gleaned from the Fatality Review Teams to improve program delivery and training.

Strategy 7.1f: Ensure representation of people who have disabilities on each of the Fatality Review Teams.

Strategy 7.1g: Provide training to law enforcement by participating in the Office of Attorney General's 40-hour Elderly Service Officers' training curriculum.

Strategy 7.1h: Participate in the Illinois State Triad, a collaborative effort among law enforcement, community advocates, and social services, to prevent crime on behalf of older adults. Division of Adult Protective Services staff will participate and present at the State Triad as requested.

Strategy 7.1i: Work with the Fatality Review Team Advisory Committee and the Adult Protective Services Advisory Committee to drive process improvement based on their respective annual report deliverables generated from case reviews and to provide coordination and oversight for regional fatality review teams and activities in the state.

Strategy 7.1j: Distribute mandated minimum training standards to financial institutions for their current and new employees with direct customer contact through B*SAFE on- site training and training of trainers.

Strategy 7.1k: Coordinate with utility and electric companies, the Illinois Attorney General's office, County State's Attorneys' offices and others to alert older adults regarding consumer fraud and telemarketing schemes.

Strategy 7.1l: Participate in iFAST, the state's model financial abuse specialist team, which is a team of professionals that focuses its effort on providing expert advice to adult protective services provider agencies on how best to address complex financial

exploitation cases.

Strategy 7.1m: Designate domestic violence as a cause and result of adult and elder abuse. Identify overlap and education gaps in organizations working with victims of domestic violence to prevent and appropriately intervene in domestic violence situations involving older adults and persons with disabilities.

Strategy 7.1n: Present monthly quality webinars that are targeted to stakeholders in Adult Protective Services ranging from APS case workers, homemakers, banking industry, to law enforcement. Utilize the data gathered from the APS CMS system to drive webinar topics as well as feedback from APS stakeholders. Identify specific risks and needs of older adults who are LGBTQ and persons with disabilities.

Strategy 7.1o: Collaborate on training with the Illinois Family Violence Coordinating Councils' Statewide initiative to encourage adoption of model protocols for various professionals when responding to victims of abuse, neglect, and exploitation.

Strategy 7.1p: Participate in "Envision Illinois," a collaborative partnership addressing domestic violence in the lives of people with disabilities and people who are deaf or hard of hearing throughout the State.

Strategy 7.1q: Participate in "Illinois Imagines," a statewide project to improve services to women with disabilities who have been victims of sexual violence.

Strategy 7.1r: Increase awareness of abuse, neglect, and exploitation with a public awareness campaign through the ACL OAA Elder Abuse Prevention Interventions Program grant. The themes will be coordinated with sister agencies to ensure the messaging targets as many individuals as possible. Campaign materials will also be in multiple languages to expand the reach of the message.

Outcomes for Objective 7.1

- Implementation of the recommendations from the Elder Abuse Task Force.
- Adult Protective Services reports/intakes will increase by 10%.
- The Fatality Review Team Advisory Committee and the Adult Protective Services Advisory Committee will demonstrate process improvements based on annual deliverables that were generated from case reviews.
- Increased number of trainings offered for Adult Protective Services case workers, homemakers, financial employees, and law enforcement
- Use APS quality review scores to ascertain the effectiveness of the trainings and if there was an increase in the number of reports from a specific entity (i.e. financial institutions being trained on financial exploitation (FE) result in increased reports of FE.
- Increase (from baseline) in self-reports by older adults and adults with disabilities of abuse, neglect, and exploitation.

Objective 7.2: Strengthen the capacity of Adult Protective Service provider agencies to respond to reports of abuse, neglect and exploitation, and to promote the prevention of abuse

in older adults and adults with disabilities.

Strategy 7.2a: Utilize Adult Protective Services information technology system for data-based evaluation of program effectiveness and performance measurement.

Strategy 7.2c: Utilize findings from quality reviews in the creation of quality webinar trainings to provide feedback on quality improvement and track trainings to ensure compliance.

Strategy 7.2d: Evaluate effectiveness of current training modules and explore additional web-based training to enhance current training modules.

Strategy 7.2e: Incorporate the Administration for Community Living (ACL) Older Americans Act Elder Abuse Prevention Interventions Program grant simulation training and vicarious trauma and trauma-informed care training.

Strategy 7.2f: Create training modules from Fatality Review Team suggestions to be made available via the IDoA website to foster consistency across the state and compliance with the established practices for the prevention of premature deaths and the review thereof.

Strategy 7.2g: Improve the components of the statewide assessment instrument to increase the depth of the program's investigation and improve factors considered in care plan development.

Strategy 7.2h: In collaboration with sister agencies and IDoA work groups study, recommend, review and modify, and implement best practices to ensure health, safety, and welfare issues are addressed along with continuous process evaluation.

Strategy 7.2i: Standardize written procedures for all Adult Protective Services provider agencies related to the local multidisciplinary team (M-Team). Procedures should include:

- recruiting members
- preparing and conducting meetings to ensure adequate documentation of suggestions and resultant outcomes
- financial management of M-Team funds
- written agreement outlining members' roles and responsibilities.

Strategy 7.2j: Evaluate and analyze the Adult Protective Services intake process to ensure consistency in the application of requirements/standards. The evaluation should include the:

- after-hours call center
- process of re-routing calls from local Adult Protective Services agencies to IDoA's HelpLine
- routing calls from the HelpLine to local Adult Protective Services agencies.

Strategy 7.2k: Coordinate the provision of legal assistance services with Adult

Protective Services and establish priorities for legal assistance services with cases in collaboration with sister agencies and IDoA work groups.

Strategy 7.2l: Develop and conduct trainings for legal professionals focused on responding to elder abuse, neglect, and exploitation and retain directory of trained legal professionals who wish to provide support to affected individuals and families.

Outcomes for Objective 7.2

- Increased effectiveness of the quality webinars by comparing the quality review scores pre- and post-training.
- Increased effectiveness of the APS classroom training and the APS simulation training to ascertain if there is increased comfort and knowledge of APS policies, procedures, and expectations and ways in which APS practices change as a result of training.
- Increased caseworker retention from enhanced training and support and implementation of trauma-informed practices.
- Better trained legal professionals for responding to elder abuse, neglect, and exploitation.
- Increased reporting by key mandated reporters of elder abuse, neglect, and exploitation.
- Increased prosecution of abuse, neglect, and exploitation cases.

Objective 7.3: Evaluate and implement best practices related to the implementation of services targeted to address self-neglect.

Strategy 7.3a: Review self-neglect data from the Adult Protective Services information technology system to ascertain trends and/or gaps in services to more readily predict and respond to future self-neglect reports.

Strategy 7.3b: Organize at minimum annual meetings with sister agencies and care coordination entities to ensure current care coordination practices are meeting the needs of participants, with a focus on engaging people in seeking their own services and care.

Strategy 7.3c: Develop education and outreach materials to help people identify and respond to self-neglect. Ensure these materials are trauma-informed and incorporate best practices from other states.

Outcomes for Objective 7.3

- Measure the number of Adult Protective Services self-neglect cases that were coordinated with other care coordination entities.
- Number of multiple reports of self-neglect cases decrease.
- Measure the number of care plans from external care coordination entities that were shared with Adult Protective Services Provider Agencies.

Objective 7.4: Strengthen authority and capacity of the State Long-Term Care (LTC)

Ombudsman Program and maximize program services to meet the needs of older adults residing in LTC facilities including (board and care facilities) and in the community.

Strategy 7.4a: Strengthen the LTC Ombudsman Program/Home Care Ombudsman Program by collaborating with other agency stakeholders i.e.; IDPH, HFS, DHS, Illinois Guardianship and Advocacy Commission.

Strategy 7.4b: Build on progress by Adult Protective Services programming pertaining to financial exploitation in assisted living facilities.

Strategy 7.4c: Revise the current Illinois Long-Term Care policies and procedures manual to comply with federal rules. Establish policies and procedures specifically for the Home Care Ombudsman Program.

Strategy 7.4d: Develop best practices for Regional Ombudsman Programs to develop and implement M-Teams. Seek funding for this purpose.

Strategy 7.4e: Strengthen communication between the State Office and the Regional Ombudsmen programs by developing a website with a portal for Ombudsman to access current forms, rules, policies and procedures, and training opportunities.

Strategy 7.4f: Continue to provide Ombudsman services to individuals in the community who are receiving services under a managed care organization and who are eligible for the Medicaid and Medicare Alignment Initiative (MMAI).

Strategy 7.4g: Continue to provide Ombudsman services to and collect data on individuals in the community who are receiving services under the following Waivers: Persons who are Elderly, Persons with Disabilities, Brain Injury, Persons with HIV or AIDS.

Outcomes for Objective 7.4

- Completion of best practices report.
- Completion of updates to policies and procedures.
- Development of website for ombudsman to access current rules, etc.
- Access data from Peer Place system.

Objective 7.5: Improve the credibility and value of services provided by the LTC Ombudsman Program.

Strategy 7.5a: Enhance the Consumer Choice website to include filters for specific searches, such as searching by county, city, zip code, and services offered by the facility.

Strategy 7.5b: Revise/modify monitoring and assessment tool to quickly identify programs that do not meet IDoA standards.

Strategy 7.5c: Create a corrective action plan for under-performing programs.

Strategy 7.5d: Continue to provide up-to-date training and workshop sessions that

are revised to comply with newly released federal training standards for all Ombudsmen. These trainings will include: 1) mental health and trauma-informed service provision, 2) identifying and countering risk factors for LGBTQ seniors and persons with disabilities, 3) anti-racism training, and 4) implicit bias training toward older adults returning from carceral settings.

Strategy 7.5e: Maintain the Long-Term Care Advisory Group.

Strategy 7.5f: Develop plans to assure that residents and their families and friends retain access to Ombudsman staff, services, and resources during emergencies, such as COVID- 19 and potential future pandemics.

Strategy7.5g: Strengthen communication and relationships between the Department of Healthcare and Family Client enrollment broker and the contracted Medicare Medicaid Alignment Initiative (MMAI) plans to ensure MMAI beneficiaries are actively referred to the Illinois Home Care Ombudsman Program, when appropriate, for assistance with complaint resolution, appeals, and grievances.

Outcome for Objective 7.5

- Completion of program website improvements.
- Revision of monitoring and assessment tool.
- Development of corrective action plan completed.
- 100% of Ombudsmen will have completed training as outlined in program policies and procedures.
- Hold at least four Long-Term Care Advisory Group meetings.
- Increase in number of MMAI participants served by Home Care Ombudsman Program.

Objective 7.6: Create LTC Ombudsman Program legislative and outreach plan to advance residents' rights.

Strategy 7.6a: Develop issue paper outlining the benefits of amending the Illinois Nursing Home Care Act to close a loophole regarding involuntary transfers and discharges.

Strategy 7.6b: Work with regional Long-term Care Ombudsmen Programs to identify legislators to sponsor and support legislation.

Strategy 7.6c: Work together with nursing home associations to ensure that resident rights are being addressed.

Strategy 7.6d: Develop, pilot test, refine, and begin using posters and brochures regarding the Ombudsman expansion to include individuals' rights regarding home and community-based waiver services provided by managed care organizations

Outcome for Objective 7.6

- Issue paper on benefits developed.

- Posters and brochures developed.
- Introduction of legislation.
- Ongoing outreach to House Human Service Committee members by State Long-Term Care Ombudsman and Deputy Ombudsman.

Goal 8: Promote responsive management and improve efficiencies within the delivery of services using data and enhanced IT systems.

Objective 8.1: Improve information technology infrastructure and data collection and reporting capabilities.

Strategy 8.1a: Collaborate with the Aging network of Area Agencies on Aging (AAAs) and care coordination units (CCUs) to ensure changes meet their needs. Update the IDoA Dashboard to provide a quick reference to active work by interfacing with all active, existing applications, providing a single place for the network to access applications and information and improve communication.

Strategy 8.1b: Replace the current PC-based Case Management Information System (CMIS) with a web-based application to track all assessments and case authorizations to ensure consistency in case management and provide improved statistics for quality monitoring and management.

Strategy 8.1c: Improve regular data analysis and feedback to the CCUs on compliance measures using interactive dashboards in the new systems.

Strategy 8.1d: Replace the Benefit Access Application (BAA) with a new improved application using the latest technologies (in a language that can be supported by the Illinois Department of Innovation and Technology) to make it easier for older adults to apply for benefits.

Strategy 8.1e: Replace the twenty-year old electronic Community Care Program Information System (eCCPIS) in order to increase security and the efficiency in the billing process and improve data availability for monitoring and quality management. Directly interface the new system with the new ERP accounting system.

Strategy 8.1f: Create an online provider application process for greater ease of "all willing and qualified" applications as well as more efficient warehousing of all pertinent records.

Strategy 8.1g: Continue to use the Senior Health Insurance Program (SHIP) Tracking and Reporting System (STARS) as the consolidated reporting platform for SHIP, the Senior Health Assistance Program, and Medicare Improvements for Patients and Providers Act activities.

Strategy 8.1h: Continued enhancement of the critical event reporting system to provide a user-friendly system that allows for accurate and comprehensive data.

Strategy 8.1i: Collaboration with sister agencies to enhance current network Electronic Visit Verification (EVV) reporting capabilities and statewide data collection and analysis to bring the State into compliance with the federal mandate included in the 21st Century Cures Act.

Outcome for Objective 8.1

- IDoA dashboard updated.
- New case management information system.
- New Benefit Access Application developed.
- New Community Care Program information system deployed.
- Enhanced Electronic Visit Verification capabilities implemented.

Objective 8.2: Utilize technology to enhance access to and compliance with training.

Strategy 8.2a: Expand the use of the training tracking system by adding every case worker and provider to the system, and ensure they are properly trained and authorized to perform services in the state.

Strategy 8.2b: Provide on-line training, webinars, and other technology-based training options for the Aging network and IDoA staff for certification, re-certifications, and ongoing education.

Strategy 8.2c: Conduct periodic surveys of providers or develop other mechanisms to ascertain the extent to which providers are engaged in service delivery without having received the necessary pre-service and in-service training.

Strategy 8.2d: Maintain ongoing collaborations with internal and external stakeholders, sister agencies for innovation training and education options for staff and the Aging network.

Outcome for Objective 8.2

- 100% of workers engaged in contracted services will have completed required pre- service and in-service training.
- 100% compliance by CCUs with training tracking application.

QUALITY MANAGEMENT AND IMPLEMENTATION

The Department works with the Governor's Office of Management and Budget, the Department of Healthcare and Family Services (the state Medicaid agency), and other state agencies to maintain quality performance measures for long-term care and other community-based services. IDoA is also responsible for regularly reporting standards of quality for Community Care Program (CCP) services consistent with federal Centers for Medicare & Medicaid Services (CMS) guidelines and ensure related quality assurance monitoring activities are completed.

Other initiatives that address how we plan to collect data to assess ongoing program implementation, remediation of problem areas, and continuous improvement:

- Improving and expanding IT data collection infrastructure and reporting capabilities
- Reviewing and making necessary changes to policies and procedures as necessary
- Ensure timely determinations of provider reviews and participant appeals, and management of participant services to ensure effective operations and quality services and supports
- Continuous internal audit review of all program areas
- Presentation of plan to sister agencies to obtain support for goals
- Continued engagement with members of the public about goals
- Align with other statewide plans where applicable

The IDoA acknowledges the robust and ambitious goals laid out in the Plan. Our intent is that the State Plan is a living document that we will review regularly and work with our partners in the Aging network to make incremental progress during the three-year cycle of the Plan. In order to monitor and ensure transparency of the progress on the outcomes, we plan to monitor progress by the following:

- Present plan and collaborate with sister state agencies to help meet goals and objectives
- Provide regular updates as IDoA advisory councils and committees including: Older Adults Services Advisory Committee, Illinois Council on Aging, Community Care Program Advisory Council, Long-Term Care Council
- Monthly meetings with the Area Agencies on Aging
- Tracking of progress via implementation plan document
- Annual "check-ins" and interim progress reports

We look forward to continued dialog with the Aging network about how to achieve the goals outlined in the State Plan.

APPENDIX A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2020

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

Sec. 305, ORGANIZATION

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

(2) The State agency shall—

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

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

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

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

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

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

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

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

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

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

have the capacity to carry out the area plan.

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

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

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

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

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

Note: STATES MUST ENSURE THAT THE FOLLOWING ASSURANCES (SECTION 306) WILL BE MET BY ITS DESIGNATED AREA AGENCIES ON AGENCIES, OR BY THE STATE IN THE CASE OF SINGLE PLANNING AND SERVICE AREA STATES.

Sec. 306, AREA PLANS

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

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

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

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

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

(C) legal assistance;

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

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) older individuals residing in rural areas;

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

(III) older individuals with greatest social need (with particular attention to low-income

minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

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

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

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

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

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

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

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

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

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

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

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

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials,

providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the identity of each nongovernmental entity with which such agency has a contract or

commercial relationship relating to providing any service to older individuals; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Such assessment may include—

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

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

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

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

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and

service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;
(B) land use;
(C) housing;
(D) transportation;
(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness;
(K) protection from elder abuse, neglect, and exploitation;
(L) assistive technology devices and services; and
(M) any other service as determined by such agency.

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

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

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

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

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

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

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

(i) providing notice of an action to withhold funds;
(ii) providing documentation of the need for such action; and
(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

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

(B) If the State agency determines that the area agency on aging has not taken corrective action,

or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—
(1) contracts with health care payers;
(2) consumer private pay programs; or
(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:
(1) The plan shall—
(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) be based on such area plans.
(2) The plan shall provide that the State agency will—
(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;
(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and
(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).
(3) The plan shall—
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and
(B) with respect to services for older individuals residing in rural areas—
(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

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

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

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

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

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

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

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

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

(B) The plan shall provide assurances that—

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

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

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

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

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

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

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

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide

information and assistance services and outreach.

(9) The plan shall provide assurances that—

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

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

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

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

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

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

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

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

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

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

(A) the plan contains assurances that any area agency on aging carrying out such services will

conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

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

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

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) older individuals residing in rural areas;

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

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

(iv) older individuals with severe disabilities;

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

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

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

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

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall—

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

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

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

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

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

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

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

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

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

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

(B) Such assessment may include—

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

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

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

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

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

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

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

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

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

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

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

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

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

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

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of

older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

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

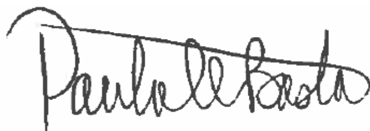
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

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

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

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

(iii) upon court order…



12/3/2020

Signature of Authorized Official *Date*

Paula A. Basta, Director, Illinois Department on Aging

Printed Name and Title of Authorized Official

APPENDIX B

INFORMATION REQUIREMENTS

Section 305(a)(2)(E)
Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

State's Response:

One of the underlying principles the Plan is guided by is pro-equity engagement, learning, and action. The intent is that the plan is inclusive of all individuals and communities. The objectives and strategies outlined in Goal 4, are specific to understanding the needs of underserved and diverse populations, including older individuals who are low-income, low-income minority, limited English proficiency and/or residing in rural areas. Furthermore, this will be achieved as part of the assurances in each Area Agency on Aging (AAAs) area plan to assess the needs of the above-mentioned populations in order to structure their program offerings to ensure preference is given. This is also required by the Illinois Administrative Code: Title 89, Chapter II, Part 230, Section 230.130(b)(1).

Section 306(a)(6)(I)
Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

The Department has administered an assistive technology program since August 2020, and it will continue in state FY22. Program eligibilty requires participants to be enrolled in a Title III, Title VII, or in the Community Care Program (coordination for home and community based services). AAAs make referrals to the program. Over the three years of this plan, the Community Care Program will add assistive technology/assistive devices as a home and community based services program offering (and a Medicaid HCBS waiver service). Information and assistance programs and care coordinators will make referrals for older adults to the program, information about the program will be available on the Department's website, and educational materials will be made available to all Aging network providers.

Section 306(a)(17)
Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

State's Response:

The Department requires AAAs to have a disaster and emergency plan as part of the requirements for

their area plans. The Department also provides additional details regarding long-range emergency preparedness and plans to strengthen local and state partnerships in Objective 3.4.

Section 307(a)(2)

The plan shall provide that the State agency will —…

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). (Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)

State's Response:

The Department will maintain the minimum percentages for the three-year plan period. The following minimum percentages will apply during FY 2022-2024.

Access	33.1%
In-Home	0.04%
Legal	3.02%

A special note of caution is needed when reviewing the percentage of Title III-B funds established for in-home services in Illinois. On face value, this percentage would appear to be remarkably low compared to the increasing need for such services by older persons at risk of inappropriate institutionalization. However, in addition to administering federal programs under the Older Americans Act, the Illinois Department on Aging also administers an in-home services program called the Community Care Program that is state- and federally-funded. Current services available through the Community Care Program include case management services, homemaker, adult day services, emergency home response services, and automated medication dispenser program. The estimated total expenditure for those services in FY 21 is approximately $983 million dollars.

Section 307(a)(3)

The plan shall--

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

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

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

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

State's Response:

The Illinois Department on Aging allocates Title III and State General Revenue funds appropriated for distribution to the thirteen (13) AAAs based on a formula (the Intrastate Funding Formula or IFF) in accordance with the Older Americans Act and its regulations. Section 1321.37(a) of the Older Americans Act regulations further requires the Department to "review and update its formula as often as a new State Plan is submitted for approval." In anticipation of developing the 2022-2024 State Plan the

Department solicited feedback and recommendations from the 13 Area Agencies on Aging on the IFF. The Department received written comments from 7 of the 13 AAAs together with recommendations and proposed changes to the IFF.

The Department subsequently analyzed the impact of the AAAs recommendations across all planning and service areas to ensure preference was given to providing services to older individuals with the greatest economic and social need including but not limited to older individuals residing in rural areas of Illinois. The analysis confirmed the existing IFF and respective weights remains a stable and equitable method of allocating funds to the 13 AAAs and ensures the amounts expended in the three years encompassed under the State Plan will not be less than the amount expended in 2000 for those older individuals residing in rural areas.

Service	Projected FY 2021 Cost*
Assisted Transportation	$ 169,767
Caregiver	$ 3,506,450
Caregiver Counseling, Support Groups, & Training	$ 1,444,057
Caregiver Respite	$ 1,053,128
Caregiver Supplemental Services	$ 500,107
Chore	$ 72,450
Congregate Meals	$ 171,588
Counseling	$ 485,640
Education	$ 255,856
Friendly Visiting	$ 115,000
Grandparents Raising Grandchildren	$ 291,107
Health Promotion	$ 515,775
Health Screening	$ 109,991
Home Delivered Meals	$ 12,982,189
Home Health	$ 13,261
Housing Assistance	$ 15,500
Information and Assistance	$ 5,119,161
Legal Assistance	$ 1,135,139
Medication Management	$ 12,820
Mental Health Screening	$ 7,404
Multi-purpose Senior Center	$ 515,775
Other	$ 50,880
Outreach	$ 848,696
Physical Fitness, Group Exercise, Music, Art, Dance	$ 194,337
Recreation	$ 239,557
Residential Repair/Renovation	$ 268,600
Respite	$ 2,710
Telephone Reassurance	$ 171,588
Transportation	$ 985,080
Total	**$ 31,253,613**

* For FY22 through FY24 the Department anticipates the projected costs of services to increase by a minimum of 6% each year based on funding under the recently reauthorized Older Americans Act.

The AAAs develop initial budgets each year based on awards received from the Administration for Community Living and requisite allocations distributed by the Department. Periodically, the budgets are amended to reflect additional awards and consistently reflect expenditures above those expended in 2000.

Section 307(a)(l0)

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

State's Response:

As part of the preparation for developing a strategic area plan, each AAA conducts public hearings and a needs assessment to determine where gaps exist in the planning and service area. The information and interventions are included in the plans. The Department includes a factor in our funding formula that takes rural population into consideration. In addition, the AAAs maintain established funding formulas that further focus on their respective priority populations, including those in rural areas.

Section 307(a)(l4)

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

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

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

State's Response:

Based on the 2015-2019 American Community Survey (ACS) Special Tabulation (Table S21014B), there was an estimated over 2.6 million persons 60 years of age and older that reside in Illinois. Of that population, the ACS estimates that 254,345 people speak English "well, not well, and not at all." This The number of low income minority older individuals in the state represents 9.73% of the population age 60 and over; 5.98 % of these individuals speak English "not well" and "not at all".

Based on the most recent data available (2013-2017 ACS Special Tabulation; Table S21056), the number of low income minority older individuals in the state is 97,890. The following table reflect the number of low-income minority older individuals with limited English proficiency.

60+ in Illinois	2,541,815	% of 60+ in Illinois
Low Income	231,775	
Speak language other than English	53,440	2.1%
Speak English "very well"	14,400	
Speak English "well"	11,565	
Speak English "not well"	10,465	0.9%
Speak English "not at all"	11,270	

The Plan describes the methods used to service the needs of low-income minority older individuals and low-income minority older individuals, and those with limited English proficiency in the objectives and strategies under Goals 2 and 4. The Department is also in the process of implementing its diversity, equity and inclusion plan, of which one of the objectives is to translate all of the Department's brochures into the top five languages spoken in the state.

Section 307(a)(21)

The plan shall -

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

State's Response:

Based on the 2015-2019 American Community Survey (ACS) Special Tabulation (Table S21006), there was an estimated 18,200 individuals 60 years of age and older that reside in Illinois who identified as American Indian and Alaska Native alone or in combination with other races. This represents .7% of the population of the population 60 and older.

The intent is that the Plan is inclusive of all individuals and communities. The objectives and strategies outlined in Goal 4 are specific to understanding the needs of underserved and diverse populations, including Native Americans. Illinois does not receive a Title VI grant.

Section 307(a)(27)

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

(B) Such assessment may include—

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

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

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

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

State's Response:

In 2000, there were approximately 1.96 million individuals 60 and older adults in Illinois. Today, Illinois has approximately 3 million older adults out of a population of roughly 12.7 million people. Projecting to 2030, this estimate shows that Illinois' aging population could grow another 600,000 people to 3.6

million people. Illinois had fewer than 200,000 people aged 85 or older in 2000. Today, the State has an estimated 314,000 individuals over the age of 85, and this is expected increase to more than 400,000 by 2030 (U.S. Census table S0101). The Department has acknowledged these changing demographics and outlines how to address the anticipated growth of older adults in Goal 4.

Section 307(a)(28)

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

The Illinois Emergency Management Agency (IEMA) is assigned the responsibility for coordination of the overall emergency management program for the state of Illinois.

The Illinois Emergency Operations Plan (IEOP) establishes the structure by which Illinois state government coordinates and manages response and recovery to emergencies and disasters. The IEOP provides policies, procedures and guidelines to ensure safe, efficient and timely actions to assist communities in need and incorporates supportive plans for response, recovery, continuity of operations and continuity of government.

The IEOP is developed in cooperation with the Office of the Governor, executive departments and agencies, the Illinois Terrorism Task Force (ITTF), non-governmental, mutual aid, private sector and volunteer organizations – a whole community approach. The IEOP, in its written form, serves to document the anticipated response and recovery efforts of the state to protect public health and safety, critical infrastructure and the environment.

The IEOP describes the Illinois Disaster Management System (IDMS) utilized by the state, which conforms to the National Incident Management System (NIMS). IDMS is used by all state government agencies when the IEOP is implemented for response or recovery operations in any part of the state affected by an emergency or disaster. The IEOP and IDMS identify and assign specific areas of responsibility for performing functions in response and recovery to an emergency or disaster.

During public health emergencies, such as COVID-19, the Illinois Department of Public Health (IDPH), Office of Preparedness and Response provides emergency response planning, training, exercise, emergency response and evaluation services to all IDPH programs, local public health departments, and the healthcare system.

IDoA works closely with the Illinois Emergency Management Agency (IEMA), IDPH and other participating State Agencies through interagency coordination State Emergency Operations Center (SEOC) under the Illinois Emergency Management Act and the Illinois Emergency Operations Plan (IEOP) in responding to all natural and man-made disasters and public health emergencies. The Department continues to be a signatory of the IEOP, because of the complex needs that exist for frail older adults and the fact that the baby boomers are coming of age. The Department on Aging has a Disaster Coordinator who functions as a liaison and has a seat at the SEOC so the Department can advocate for seniors before, during and immediately after an event.

Section 307(a)(29)

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

State's Response:

IDoA has established connections with IEMA and IDPH. The IDoA Director will collaborate with IEMA to develop and secure the IEOP statewide. IDoA is committed to working with IEMA and IDPH to incorporate appropriate updates to the plan to ensure the needs of older adults are included in any disaster response.

Section 705(a) ELIGIBILITY —

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

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

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

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

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

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

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

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

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

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

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

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

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order.

State's Response:

The IDoA Division of Older Americans Services is responsible of the implementation and monitoring of programs that are funded by the Older Americans Act. The division maintains a staff of regional coordinators that are liaisons to the Area Agencies on Aging. The division works closely with the IDoA fiscal staff to ensure that the funds received for programs under this subtitle are distributed appropriately.

IDoA conducted three virtual public hearings and held a 45-day comment period on the draft Plan in October-November 2020. Comments were accepted verbally during the hearings, via email, mail and online comment form. Over 200 people participated in the virtual public hearings, and nearly 200 individual comments were collected. The Department reviewed the comments and the feedback is incorporated into this Plan. The summary of comments and the Department's responses are included in Appendix D.

The Long-Term Care Ombudsman Program (LTCOP) is mandated by the federal Older Americans Act and supported by a provision in the Illinois Act on the Aging. The Department established and operates the Office of the State Long-Term Care Ombudsman Program (SLTCOP). Regional LTCOP services are delivered through provider agencies by individuals designated by the SLTCO and are operated through a grant or contract with the Department and Area Agencies on Aging. Throughout the state, staff members and volunteers are certified Ombudsmen. Area Agencies on Aging (AAAs) provide administrative and advocacy support to the Regional Long-Term Care Ombudsman Programs in several key program areas. AAAs are involved in the designation of Regional Long-Term Care Ombudsman Programs, provide support and conduct legislative outreach to advance resident rights.

As mandated by the federal Older Americans Act and the Illinois Act on the Aging, the Long- Term Care Ombudsman Program advocates for residents of licensed long-term care facilities. The provision of person-centered resident care and that residents are informed of choice and their rights are top priorities for the LTC Ombudsman Program.

In 2013, the Illinois Act on the Aging was amended to expand Ombudsman services into the community. Ombudsman are now able to advocate on behalf of older persons and persons with

disabilities ages 18-59 residing in their own homes or community-based settings, relating to matters which may adversely affect the health, safety, welfare, or rights of such individuals. Individuals must receive services under a medical assistance waiver administered by the State of Illinois or a managed care organization providing care coordination and other services to seniors and persons with disabilities in order to receive Ombudsman advocacy in the community.

The IDoA also administers the Adult Protectives Services Program that responds to reports of alleged abuse, neglect, and exploitation (ANE) of older adults and adults with disabilities who live in a domestic living situation, works with the individual in resolving the abusive situations. The Adult Protective Services Program is locally coordinated through 40 provider agencies that conduct investigations and work with older adults and persons with disabilities in resolving abusive situations. In state FY 2019, the Adult Protective Services Program expanded its response by accepting reports of alleged self-neglect, which include adults whose health is substantially threatened by an inability to complete essential self-care tasks. Under the Adult Protective Services Act, the Department on Aging has established regional fatality review teams in each of the state's 13 planning and service areas to review suspicious deaths of abuse and neglect victims, and to facilitate communications among coroners, prosecutors, adult protective services and other professionals. Under the Adult Protective Services Act, an Adult Protective Service Registry was also launched, which identifies caregivers against whom a verified finding of abuse, neglect or financial exploitation was made under the Act.

APPENDIX C

Interstate Funding Formula

The Illinois Department on Aging allocates Title III and State General Revenue Funds appropriated for distribution to the thirteen (13) Area Agencies on Aging on a formula basis in accordance with the Older Americans Act and its regulations. Section 1321.37 (a) of the Older Americans Act regulations further requires the Department to "review and update its formula as often as a new State plan is submitted for approval." A new State Plan has been developed for federal FY 2022 through FY 2024. Based upon our review of the formula, the Department has decided not to change the intrastate funding formula.

FORMULA GOALS AND ASSUMPTIONS

The goals to be achieved through the intrastate funding formula are as follows:

- To develop a formula consistent with the purpose and requirements of the OAA and its regulations.
- To provide resources across the state for home and community based services for older persons over the age of 60.
- To target resources to areas of the State with higher concentrations of older persons in greatest economic and social need, with special emphasis on low-income minority older persons.
- To develop a formula that distributes resources solely on the population characteristics of each planning and service area and that will reflect changes in those characteristics among the PSAs as updated data become available.
- To develop a formula that is easily understood.
- In reviewing the intrastate funding formula, certain assumptions were made about the formula, its factors, and the effect of the distribution of funds on the service delivery system across the State. Some of the major assumptions implicit in the review of the formula were:
- The weights assigned to the formula factors should represent the emphasis and priority placed on the specific characteristics of persons over the age of 60.
- Funding formula factors must be derived from data, which is quantifiable by planning and service area, be based on data from the Bureau of the Census, and characterize at least five percent of the State's population 60 years of age and older.
- Older persons are currently receiving services based on existing historical patterns of service delivery. The effect on older persons presently receiving Title III services should be considered when developing and implementing a formula.
- The low revenue generating potential of rural areas and the high proportion of elderly in rural areas, including low-income elderly, necessitates a greater dependence on the Title III service system to meet the service needs of rural elderly. The funding formula should compensate for these factors.

Additional resources to PSAs with greater concentrations of older persons and older persons in greatest economic and social need will provide those Area Agencies with the necessary

resources to implement additional targeting strategies at the regional level. It is the combination of federal, state, regional, and local targeting efforts that will implement this fundamental mandate of the Older Americans Act.

FUNDING FORMULA DEFINITIONS

- **Bureau of the Census** means the Bureau of the Census, U.S. Department of Commerce.
- **Housing unit** means a house, an apartment, a group of rooms, or a single room occupied as a separate living quarters.
- **Living alone** means being the sole resident of a housing unit.
- **Minority group** means those persons who identify themselves as belonging to a particular ethnic/racial grouping as classified by the Bureau of the Census.
- **PSA** means a Planning and Service Area, which is designated by the Illinois Department on Aging and Illinois Act on the Aging.
- **Poverty threshold** means the income cutoff, which determines an individual's poverty status as defined by the Bureau of the Census.
- **Rural area** means a geographic location not within a Metropolitan Statistical Area (MSA) as defined by the Bureau of the Census.

FUNDING FORMULA FACTORS AND WEIGHTS

In order for a particular factor to be included in the intrastate funding formula, it must:
- Be derived from data which is quantifiable by PSA;
- Be based on data which is derivable from the Bureau of the Census; and
- Characterizes at least 5 percent of the state's population 60 years of age and older.

The formula contains the following factors:

- The number of the state's population 60 years of age and older in the PSAs as an indicator of need in general (60+ population).
- The number of the state's population 60 years of age and older at or below the poverty threshold in the PSAs as an indicator of greatest economic need (GEN - 60+ Poverty).
- As indicators of greatest social need, the number of the state's elderly in the PSAs who are:
    - a) 60-years of age and over and a member of a minority group (GSN - 60+ Minority);
    - b) 60-years of age and over and living alone (GSN - 60+ Living Alone); and
    - c) 75-years of age and over (GSN - 75+ Population).
- The number of the state's population 60 years of age and older residing in rural areas of the PSAs as a means of assuring that the state will spend for each year of the State Plan, not less than the amount expended for such services for Fiscal Year 2000.

The funding formula factors are weighted as follows:

60+ Population	41.0%
Greatest Economic Need: (60+ Poverty)	25.0%
Greatest Social Need: (60+ Minority - 10.0%) (60+ Living Alone - 7.5%) (75+ Population - 7.5%)	25.0%
60+ Rural	9.0%

APPLICATION OF THE INTRASTATE FUNDING FORMULA

The intrastate funding formula is:
A= (**.41** POP-60 + **.25** POV-60 + **.10** MIN-60 + **.075** LA-60 + **.075** POP-75 + **.09** RUR-60) X (T)

Where:
A) A = Funding allocation from a specific source of funds to a particular PSA.
B) POP-60 = Percentage of the state's population within the particular PSA age 60 and older.
C) POV-60 = Percentage of the state's population within the particular PSA age 60 and older at or below the poverty threshold.
D) MIN-60 = Percentage of the state's population within the particular PSA age 60 and older and a member of a minority group.
E) LA-60 = Percentage of the state's population within the particular PSA age 60 and older and living alone.
F) POP-75 = Percentage of the state's population within the particular PSA age 75 and older.
G) RUR-60 = Percentage of the state's population within the particular PSA age 60 and older not residing in a MSA.
H) T = The total amount of funds appropriated from a specific source of funds.

The data used in the Intrastate Funding Formula reflects the most current and up-to-date information from the Bureau of the Census, including mid-census estimates when available.

OTHER FUNDING FORMULA PROVISIONS

The only exceptions to the use of the Department’s IFF are for the distribution of the following funds: Title III-B Ombudsman, Title III-D, Title VII Ombudsman, Title VII Elder Abuse, GRF for Community Based Equal Distribution, and GRF for Ombudsman. Title III-B Ombudsman and Title VII Ombudsman funds are distributed on the basis of the number of LTC Licensed Beds in a PSA per an annual report from the Illinois Department of Public Health. For the GRF for Ombudsman funds, 50% of the funds are distributed using the number of LTC Licensed Beds in a PSA and 50% of the funds are distributed using the number of Licensed LTC Facilities in a PSA. The Title III-D funds are distributed via a formula proposed by the 13 Area Agencies on Aging and accepted by the Department. The Title III-D formula is as follows: 60+

Population (20%), 60+ Poverty (30%), Percent 60+ Population by Weight (20%), and Percent 60+ Poverty by Weight (30%). The Title VII-Elder Abuse funds are distributed by a formula that provides $3,000 for every Multi-Disciplinary Team in a PSA and the remaining funds are distributed via the IFF. For any state GRF funds received that have no prescribed formula stated in the appropriation, the Department has the authority to determine the methodology to be used to distribute those funds.

Whenever the Director determines that any amount allotted to an Area Agency on Aging for a fiscal year under this formula will not be used by such Area Agency on Aging for carrying out the purposes for which the allotment was made, the Director may, in accordance with this subsection, make such allotment available for carrying out such purpose to one or more other Area Agencies on Aging to the extent the Director determines that such other Area Agencies on Aging will be able to use such additional amount for carrying out such purpose. Funds will be reallotted to those Area Agencies on Aging, which request and demonstrate the need for additional funds in accordance with procedures developed by the Department. Any reallotment amount made available to an Area Agency on Aging from an appropriation for a fiscal year in accordance with the preceding sentence shall, for the purposes of this title, be regarded as part of such Area Agency's allotment for such year, and shall remain available only until the end of that fiscal year. Funds available for reallotment will be:

- Those in excess of an Area Agency's allowable carryover amount determined by the financial closeout of the Fiscal Year;
- Those carryover funds available to an Area Agency on Aging determined by the financial closeout of the Fiscal Year but not requested by an Area Agency on Aging; and
- Those funds offered to the Department for reallotment by an Area Agency on Aging.

If the Director finds that any Area Agency on Aging has failed to qualify under the Area Plan requirements of the Older Americans Act, or Section 230.140 of the Department's administrative rules, the Director may withhold the allotment of funds to such Area Agency on Aging. The Director shall direct the disbursement of the funds so withheld directly to any qualified public or private nonprofit institution or organization, agency, or political subdivision in order to ensure continuity of services pursuant to Section 230.145 of the Department's administrative rules.

The allotment to an Area Agency on Aging may be reduced by the amount of any disallowance if that Area Agency on Aging has expended funds allocated under this Part:

- For purposes which an audit report determines to be questionable costs which are deemed disallowed by the Department;
- For purposes which an audit report determines to be unallowable; or
- For purposes that are otherwise determined to be unallowable according to cost principles contained in applicable OMB Circulars or the approved grant/contract award.

This reduction will occur in the Fiscal Year following the identification of the disallowance.

If an Area Agency on Aging does not expend the required minimum percentage of their Title III-B allocation on access services, in-home services, and legal services as established by the Department, pursuant to the Older Americans Act in a Fiscal Year as determined by the financial closeout report, and no waiver of the requirement has been granted by the Department

for that Fiscal Year, the Area Agency on Aging must, for the next fiscal year following the submission of their report, expend the minimum percentage in the reported year. If the Area Agency on Aging does not expend the required expenditure amount, it may be withheld from the Area Agency on Aging during the Fiscal Year following the Fiscal Year in which the shortage is determined.

Illinois Department on Aging - FY 2020 Federal Planning Allocations

PSA	Title III-B Ombudsman	Title III-B Comm.-Based	Title III-C1	Title III-C2	Title III-D	Title III-E	Total Title III	Title VII Elder Abuse	Title VII Ombudsman	Total Title VII
01	43,587	772,204	1,065,882	592,048	48,743	409,764	2,932,228	15,948	39,172	55,120
02	155,399	2,430,170	3,354,394	1,863,209	162,115	1,289,553	9,254,840	30,426	139,661	170,087
03	33,870	657,383	907,393	504,014	44,387	348,835	2,495,882	6,361	30,440	36,801
04	31,649	384,840	531,200	295,056	29,137	204,213	1,476,095	4,968	28,444	33,412
05	56,982	861,789	1,189,539	660,733	56,187	457,303	3,282,533	25,406	51,210	76,616
06	10,688	209,454	289,112	160,588	13,797	111,145	794,784	4,071	9,606	13,677
07	33,662	541,300	747,163	415,014	36,399	287,237	2,060,775	14,768	30,253	45,021
08	44,420	633,409	874,302	485,634	48,743	336,114	2,422,622	6,239	39,921	46,160
09	13,396	246,045	339,619	188,643	12,708	130,562	930,973	4,258	12,039	16,297
10	8,953	215,763	297,820	165,425	12,709	114,493	815,163	4,104	8,047	12,151
11	18,531	411,337	567,774	315,372	28,412	218,273	1,559,699	5,103	16,654	21,757
12	96,196	2,846,555	3,929,135	2,182,450	239,269	1,510,504	10,804,109	29,555	86,454	116,009
13	146,724	2,407,458	3,323,045	1,845,796	175,094	1,277,502	9,175,619	36,308	131,862	168,170
TOTAL	**694,057**	**12,617,707**	**17,416,378**	**9,673,982**	**907,700**	**6,695,498**	**48,005,322**	**187,515**	**623,763**	**811,278**

Title III-B Includes:		**Title III-C1 Includes:**		**Title III-C2 Includes:**		**Title III-D Includes:**	
FY 20 Funds	14,225,049	**FY 20 Funds**	18,610,777	**FY 20 Funds**	9,673,982	**FY 20 Funds**	907,700
IDoA Admin.	711,252	**IDoA Admin.**	1,194,399	**IDoA Admin.**	0	**IDoA Admin.**	0
IDoA Ombud.	202,033						
III-B Distrib.	**13,311,764**	**III-C1 Distrib.**	**17,416,378**	**III-C2 Distrib.**	**9,673,982**	**III-D Distrib.**	**907,700**

Title III-E Includes:		**Title VII EA Includes:**		**Title VII Omb Includes:**	
FY 20 Funds	6,695,498	**FY 20 Funds**	197,384	**FY 20 Funds**	656,593
IDoA Admin.	0	**IDoA Admin.**	9,869	**IDoA Admin.**	32,830
		M-Teams			
III-E Distrib.	**6,695,498**	**VII EA Dist.**	**187,515**	**VII Omb Dist.**	**623,763**

Illinois Department on Aging - FY 2020 State Fund Planning Allocations

PSA	PSG Title III Adm. Match*	PSG Title III Serv. Match*	Home Del. Meals	PSG Comm.-Based Services*	Comm.-Based Services	Ombudsman Services	Total State	Total Federal	Total Funds Fed & State
01	98,182	48,510	1,456,560	557,108	134,708	220,508	**2,515,576**	**2,987,348**	**5,502,924**
02	309,813	151,835	4,583,880	1,753,252	134,708	680,931	**7,614,419**	**9,424,927**	**17,039,346**
03	83,559	41,321	1,239,980	474,270	134,708	165,264	**2,139,102**	**2,532,683**	**4,671,785**
04	49,332	23,774	725,900	277,644	134,707	151,649	**1,363,006**	**1,509,507**	**2,872,513**
05	109,913	53,797	1,625,540	621,740	134,708	282,326	**2,828,024**	**3,359,149**	**6,187,173**
06	26,675	13,114	395,080	151,111	134,707	58,688	**779,375**	**808,461**	**1,587,836**
07	68,937	33,891	1,021,020	390,522	134,708	185,765	**1,834,843**	**2,105,796**	**3,940,639**
08	81,149	39,177	1,194,760	456,974	134,708	226,298	**2,133,066**	**2,468,782**	**4,601,848**
09	31,174	15,566	464,100	177,510	134,708	74,182	**897,240**	**947,270**	**1,844,510**
10	27,317	13,670	406,980	155,663	134,707	49,768	**788,105**	**827,314**	**1,615,419**
11	52,225	25,915	775,880	296,760	134,707	98,126	**1,383,613**	**1,581,456**	**2,965,069**
12	361,555	179,191	5,369,280	2,053,654	134,708	366,835	**8,465,223**	**10,920,118**	**19,385,341**
13	307,081	150,252	4,541,040	1,736,867	134,708	569,660	**7,439,608**	**9,343,789**	**16,783,397**
TOTAL	**1,606,912**	**790,013**	**23,800,000**	**9,103,075**	**1,751,200**	**3,130,000**	**40,181,200**	**48,816,600**	**88,997,800**

*** PSG means Planning and Service Grant state funds**

Illinois Department on Aging - FY 2020 NSIP Planning Allocations

PSA	Cong Meals FY 2019	HDM FY 2019	Total Meals FY 2019	Percent of Meals	FY 20 NSIP Allocation
01	132,530	517,120	649,650	6.51	480,775
02	134,774	753,784	888,558	8.91	658,019
03	72,612	275,876	348,488	3.49	257,743
04	41,036	198,086	239,122	2.40	177,244
05	231,019	467,001	698,020	7.00	516,962
06	52,813	141,886	194,699	1.95	144,011
07	104,727	273,484	378,211	3.79	279,898
08	122,542	346,753	469,295	4.70	347,103
09	45,207	115,324	160,531	1.62	119,640
10	82,725	109,197	191,922	1.92	141,795
11	152,808	242,936	395,744	3.97	293,191
12	793,421	3,204,209	3,997,630	40.07	2,959,238
13	292,655	1,070,965	1,363,620	13.67	1,009,553
TOTAL	**2,258,869**	**7,716,621**	**9,975,490**	**100.00**	**7,385,172**

FY 2020 Area Agency Title III Area Plan Administration Calculation

Older Americans Act - Section 304 (d)(1)

		Title III
A.	NGA AMOUNT FROM AoA	50,113,006
B.	IDoA Title III STATE PLAN ADMINISTRATION - OAA Section 308 (b)	1,905,651
C.	SUB-TOTAL	48,207,355
D.	AAA AREA PLAN ADMINISTRATION - OAA Section 304 (d)(1)(A)	4,820,735

PSA	Title III Distrib.	% III Funds	Title III AAA Admin.	Max. Adm. Related D.S.
01	2,932,228	6.11	**294,547**	**702,344**
02	9,254,840	19.28	**929,439**	**2,151,609**
03	2,495,882	5.20	**250,678**	**596,440**
04	1,476,095	3.07	**147,997**	**373,833**
05	3,282,533	6.84	**329,738**	**790,122**
06	794,784	1.66	**80,024**	**209,500**
07	2,060,775	4.29	**206,810**	**507,879**
08	2,422,622	5.05	**243,447**	**591,158**
09	930,973	1.94	**93,522**	**242,576**
10	815,163	1.70	**81,952**	**212,600**
11	1,559,699	3.25	**156,674**	**381,939**
12	10,804,109	22.50	**1,084,665**	**2,419,247**
13	9,175,619	19.11	**921,242**	**2,111,540**
TOTAL	**48,005,322**	**100.00**	**4,820,735**	**11,290,787**

FY 2020 Area Agency Title VII Direct Advocacy Program Activity Calculation

		Title VII
A.	NGA AMOUNT FROM AoA	853,977
B.	IDoA TITLE VII DIRECT ADVOCACY PROGRAM ACTIVITIES	42,699
C.	SUB-TOTAL	811,278
D.	AAA TITLE VII DIRECT ADVOCACY PROGRAM ACTIVITIES	81,127

PSA	Title VII Distrib.	% VII Funds	Title VII AAA Activities
01	55,120	0.10	**5,512**
02	170,087	0.10	**17,008**
03	36,801	0.10	**3,680**
04	33,412	0.10	**3,341**
05	76,616	0.10	**7,662**
06	13,677	0.10	**1,368**
07	45,021	0.10	**4,502**
08	46,160	0.10	**4,616**
09	16,297	0.10	**1,630**
10	12,151	0.10	**1,215**
11	21,757	0.10	**2,176**
12	116,009	0.10	**11,601**
13	168,170	0.10	**16,816**
TOTAL	**811,278**	**0.10**	**81,127**

Illinois Department on Aging

FY 2020 Number of Licensed LTC Facility Beds by PSA

PSA	Licensed Beds	Beds % of State	Minimum Staff *	Number of LTCFs	Facilities % of State
01	9,073	6.28	4.5	128	7.81
02	32,337	22.39	16.2	346	21.12
03	7,026	4.88	3.5	93	5.68
04	6,589	4.56	3.3	84	5.13
05	11,852	8.21	5.9	161	9.83
06	2,226	1.54	1.1	36	2.21
07	7,007	4.85	3.5	115	7.02
08	9,245	6.40	4.6	132	8.06
09	2,789	1.93	1.4	46	2.81
10	1,866	1.29	0.9	31	1.89
11	3,853	2.67	1.9	59	3.60
12	20,010	13.86	10.0	157	9.58
13	30,521	21.14	15.3	250	15.26
TOTAL	144,394	100.00	72.1	1,638	100.00

* Based on current paid staffing levels (1 FTE per 2,000 beds).

Illinois Department on Aging

FY 2020 Title VII Elder Abuse - Work Sheet

PSA	M-Teams Sites	$$$	Other	Total
01	4	12,000	3,948	**15,948**
02	6	18,000	12,426	**30,426**
03	1	3,000	3,361	**6,361**
04	1	3,000	1,968	**4,968**
05	7	21,000	4,406	**25,406**
06	1	3,000	1,071	**4,071**
07	4	12,000	2,768	**14,768**
08	1	3,000	3,239	**6,239**
09	1	3,000	1,258	**4,258**
10	1	3,000	1,103	**4,104**
11	1	3,000	2,103	**5,103**
12	5	15,000	14,555	**29,555**
13	8	24,000	12,309	**36,308**
TOTAL	41	123,000	64,515	**187,515**

Illinois Department on Aging

FY 2020 Title III-D Allocations

PSA	60+ Pop % of State	60+ Pov % of State	% 60+ Pop By Weight	% 60+ Pov By Weight	III-D Weight	III-D Allocation
01	5.85	4.65	7.56	4.31	5.37	48,743
02	24.91	16.47	17.70	14.66	17.86	162,115
03	4.48	3.85	8.83	3.57	4.89	44,387
04	3.62	2.69	4.68	2.50	3.21	29,137
05	6.73	6.08	6.63	5.63	6.19	56,187
06	1.18	1.06	3.32	0.99	1.52	13,797
07	4.12	3.31	6.38	3.07	4.01	36,399
08	5.59	5.17	6.30	4.79	5.37	48,743
09	1.35	1.23	2.08	1.15	1.40	12,708
10	1.15	1.21	2.27	1.17	1.40	12,709
11	2.61	3.06	4.04	2.95	3.13	28,412
12	17.48	32.24	9.57	37.61	26.36	239,269
13	20.93	18.98	20.64	17.60	19.29	175,094
TOTAL	100.00	100.00	100.00	100.00	100.00	907,700

Back-up Work Sheet for Title III-D

Demographic Characteristics and Population/Poverty Percentages by PSA

PSA	Total Population	60+ Population	60+ Poverty	% 60+ Pop By PSA	% 60+ Pov By PSA	60+ Pop/ 60+ Weight	60+ Pov/ 60+ Weight
01	665,777	160,037	10,783	24.04	6.74	26,236	492
02	3,456,507	681,660	38,171	19.72	5.60	61,411	1,674
03	464,214	122,565	8,928	26.40	7.28	30,641	408
04	407,537	99,131	6,233	24.32	6.29	16,251	285
05	827,597	184,046	14,089	22.24	7.66	23,006	643
06	118,659	32,243	2,468	27.17	7.65	11,515	113
07	445,415	112,866	7,683	25.34	6.81	22,131	351
08	663,019	152,941	11,988	23.07	7.84	21,849	547
09	145,266	36,824	2,853	25.35	7.75	7,220	130
10	117,210	31,454	2,804	26.84	8.91	7,864	134
11	279,559	71,430	7,063	25.55	9.89	14,006	336
12	2,716,462	478,259	74,715	17.61	15.62	33,212	4,294
13	2,494,801	572,830	43,998	22.96	7.68	71,604	2,009
TOTAL	**12,802,023**	**2,736,286**	**231,776**	**21.37**	**8.47**	**346,946**	**11,416**

% Share of Demographic Characteristics and Weighted Population/Poverty Amounts

PSA	Total Pop % of State	60+ Pop % of State	60+ Pov % of State	60+ Pop Weight	60+ Pov Weight	% 60+ Pop By Weight	% 60+ Pov By Weight
01	5.20	***5.85***	***4.65***	6.1	21.9	***7.56***	***4.31***
02	27.00	***24.91***	***16.47***	11.1	22.8	***17.70***	***14.66***
03	3.63	***4.48***	***3.85***	4.0	21.9	***8.83***	***3.57***
04	3.18	***3.62***	***2.69***	6.1	21.9	***4.68***	***2.50***
05	6.46	***6.73***	***6.08***	8.0	21.9	***6.63***	***5.63***
06	0.93	***1.18***	***1.06***	2.8	21.9	***3.32***	***0.99***
07	3.48	***4.12***	***3.31***	5.1	21.9	***6.38***	***3.07***
08	5.18	***5.59***	***5.17***	7.0	21.9	***6.30***	***4.79***
09	1.13	***1.35***	***1.23***	5.1	21.9	***2.08***	***1.15***
10	0.92	***1.15***	***1.21***	4.0	21.0	***2.27***	***1.17***
11	2.18	***2.61***	***3.06***	5.1	21.0	***4.04***	***2.95***
12	21.22	***17.48***	***32.24***	14.4	17.4	***9.57***	***37.61***
13	19.49	***20.93***	***18.98***	8.0	21.9	***20.64***	***17.60***
TOTAL	**100.00**	***100.00***	***100.00***	**9.8**	**21.0**	**100.00**	**100.00**

In BOLD ITALICS are the four factors being used for Title III-D.

APPENDIX D

Summary of Public Testimony Submitted on the FY 2022-2024 State Plan on Aging

In accordance with the Older Americans Act and federal guidelines from the Administration for Community Living, the Illinois Department on Aging conducted three public hearings on the draft FY 2022 – 2024 State Plan on Aging. The public hearings were held virtually, with call-in options, due to the COVID-19 pandemic to provide a presentation and to welcome written and verbal testimony from the general public on the draft State Plan. The Department also conducted targeted outreach about the Plan and distributed the draft to: Area Agencies on Aging, Illinois Council on Aging, Community Care Program Advisory Committee, Long-Term Care Council, and Older Adult Advisory Committee.

The hearings had an open invitation and were promoted via IDoA's website, through email listservs, to Aging network partners, and promoted by partner organizations. The hearings were held on October 19, 22, and 29, 2020. There were a total of 224 people who participated in the three hearings. Feedback was also provided via email, letter, or an online comment form on the IDoA website. Public comments were accepted for 45 days.

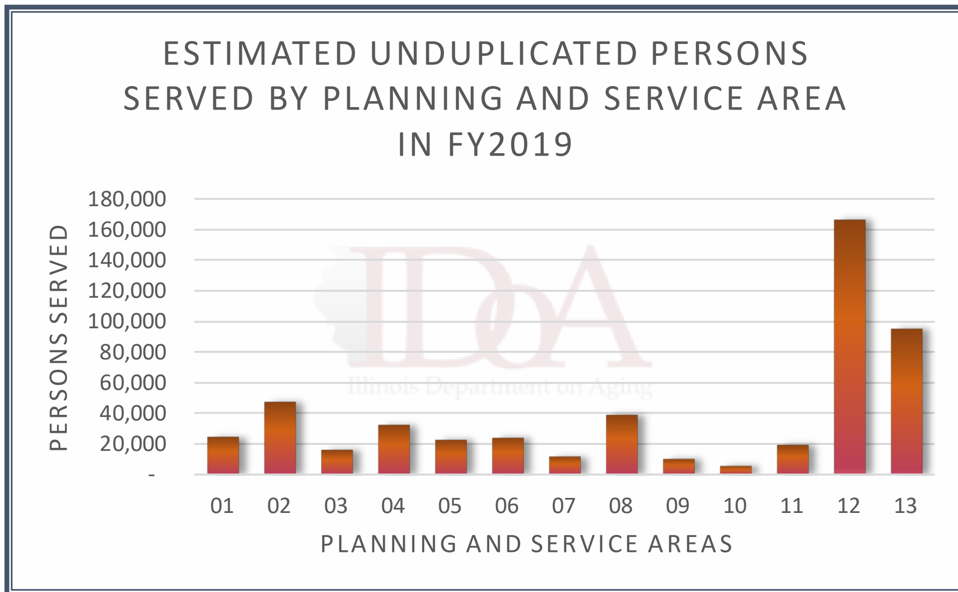
The testimony received has been summarized and organized into to reflect the part of the Plan on which it was focused. Many comments within testimony were divided into individual comments such that they could be considered for the appropriate goals, objectives, strategies, outcomes, or for the Plan. Department responses are included for each issue. For brevity of this summary document, many comments were abbreviated. For the review and consideration of each comment, they were reviewed in-full. There were over 200 comments submitted about the goals, objectives, strategies, and outcomes, via the public hearing, email, letter or online comment form. For purposes of document length, printed copies of the Plan do not include the summary and responses to comments. The comment summary and the Department's responses can be accessed via the electronic version of the document or via the IDoA website: https://www2.illinois.gov/aging/Resources/NewsAndPublications/Publications/Pages/AgingNetworkReports.aspx.

A listing of individuals and organizations who provided comments has been included. The testimony received has been summarized and organized into to reflect the part of the Plan on which it was focused.

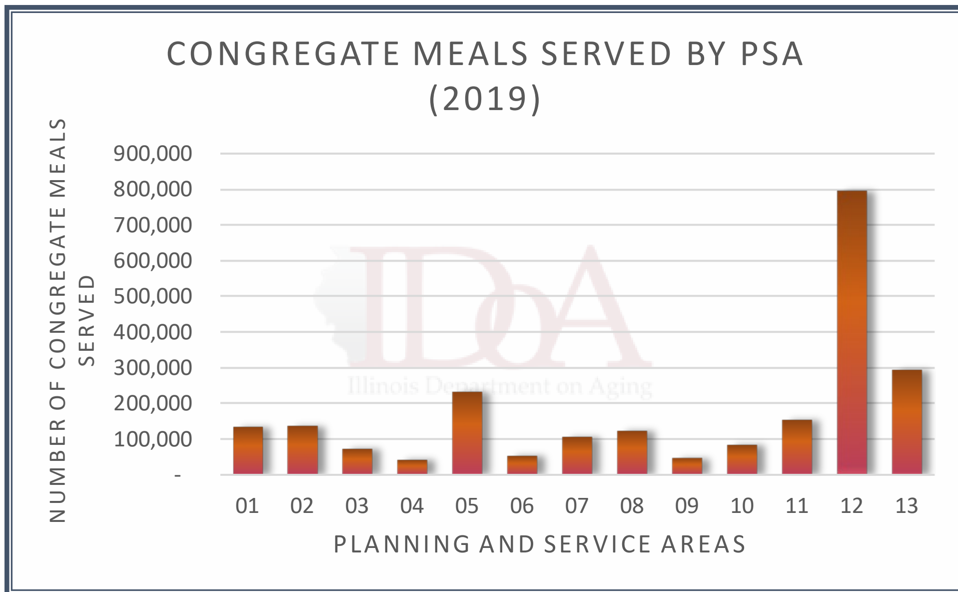
Individuals and organizations who submitted comments:

AARP
Access Living
AgeGuide Northeastern IL AAA
AgeLinc Area Agency on Aging for Lincolnland
AgeOptions, Inc
Alden Foundation
Bonnie Ewald
Center for Life and Learning, Fourth Presbyterian Church
Central Illinois Agency on Aging
Chris Wade
Clara Fitzpatrick
Cynthia Saed
David Linear
David Rubin
Dennis (last name unknown)
Department of Family and Support Services, City of Chicago
East Central Illinois Area Agency on Aging
H.O.M.E. Housing Opportunities & Maintenance for the Elderly
Henry Roach
Howard Brown Health
Illinois Council on Aging (ICoA)
Illinois Hospice & Palliative Care Organization
Jane Addams Center for Social Policy and Research at UIC
Janice Jones
Jewish United Fund of Chicago
John Mattison
Karen Flutie
Kiera Escon
Land of Lincoln Legal Aid
Legal Aid Chicago
Legal Council for Health Justice
Mary Heitschmidt
Mercer County Senior Center, Aledo, Illinois
Michael Passmen
Michele Weinberg
Midland Area Agency on Aging
National Academy of Elder Law Attorneys, IL Chapter
Northwestern Illinois Area Agency on Aging
Patricia Canessa
POLST Illinois Committee of Illinois Hospice and Palliative Care Organization (ILHPCO); Advocate Aurora Health Care
Prairie State Legal Services
Rick (last name unknown)
Rita Escalante
Ron Trout
Rush
Samantha Worley
Sandy Baksys
Sara Data
Sarah Lieber
SEIU Illinois-Indiana
Shandra Summersdale
Shriver Center on Poverty Law
Southeastern Illinois Area Agency on Aging, Inc.
Trish Lumberg
University of Chicago Section of Geriatrics & Palliative Medicine / SHARE Network
Village of Arlington Heights

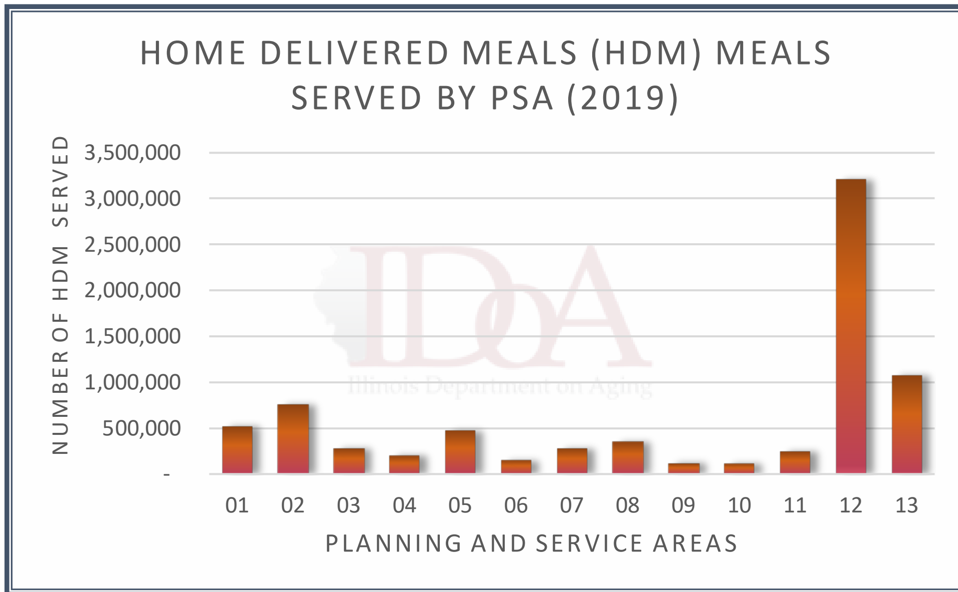
ATTACHMENT E



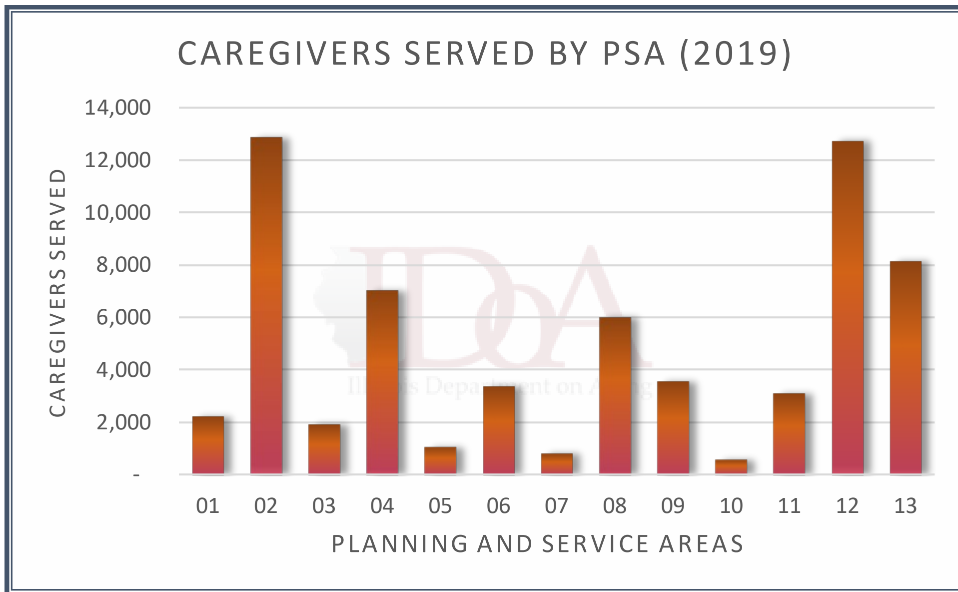
Source: National Aging Program Information System (NAPIS)



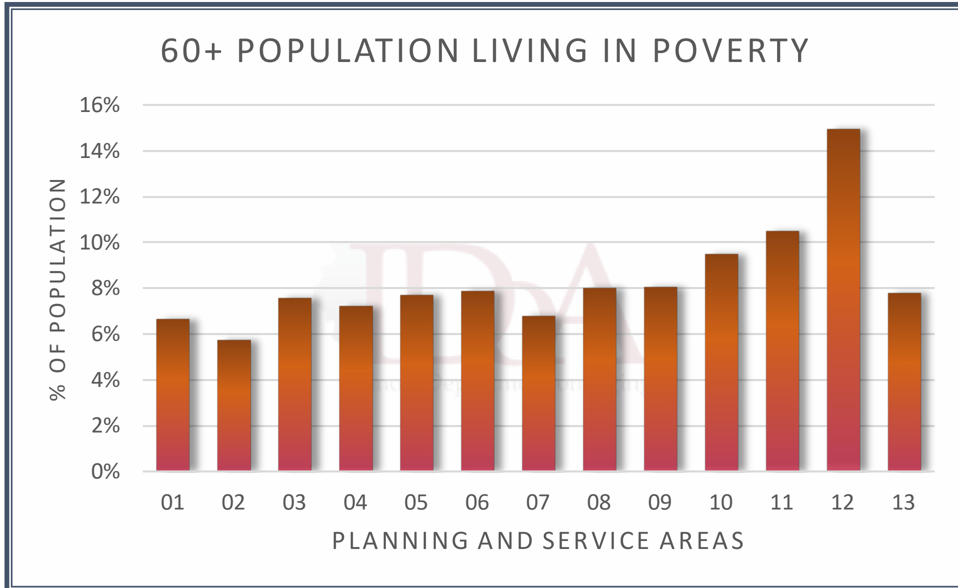
Source: National Aging Program Information System (NAPIS)



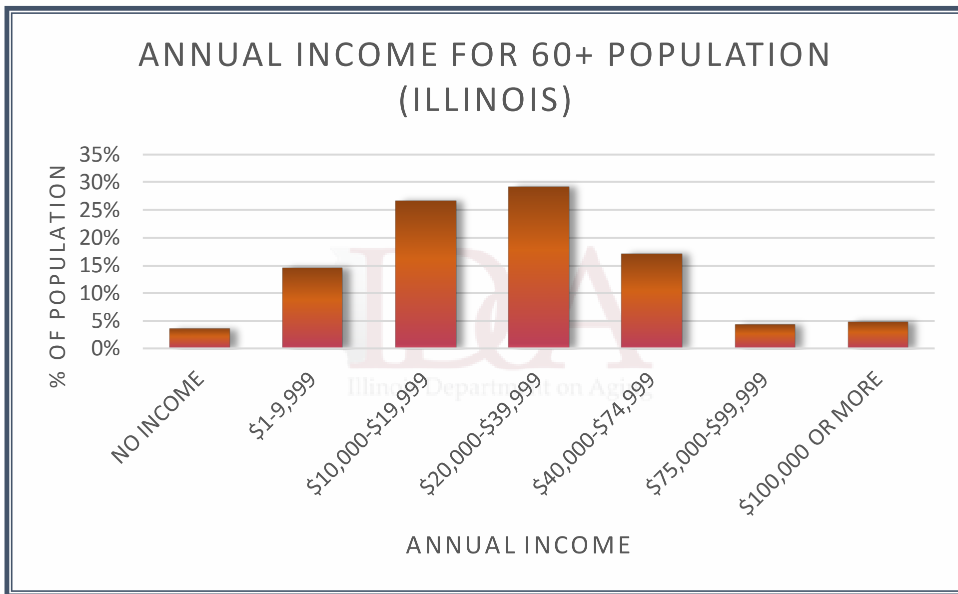
Source: National Aging Program Information System (NAPIS)



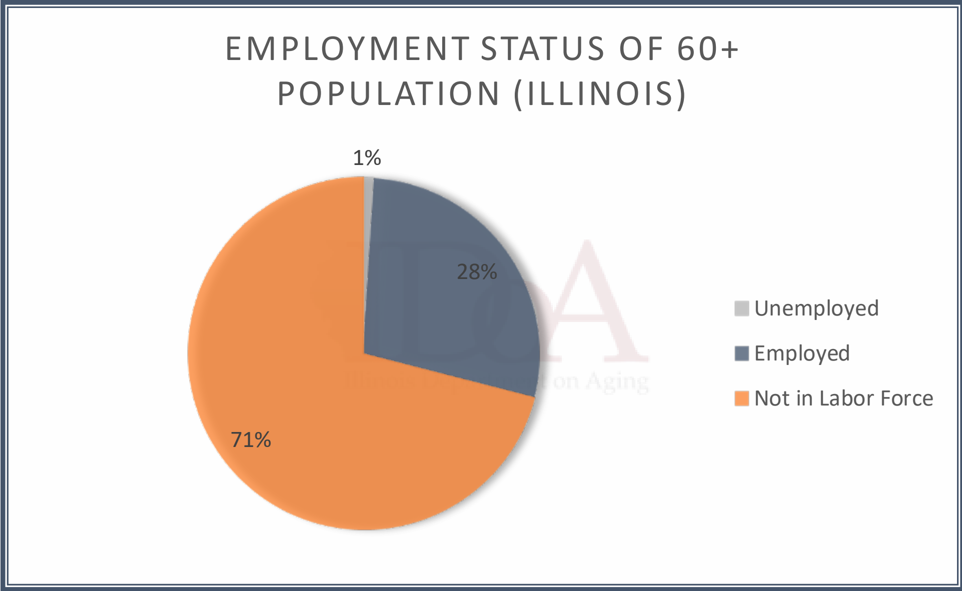
Source: National Aging Program Information System (NAPIS)



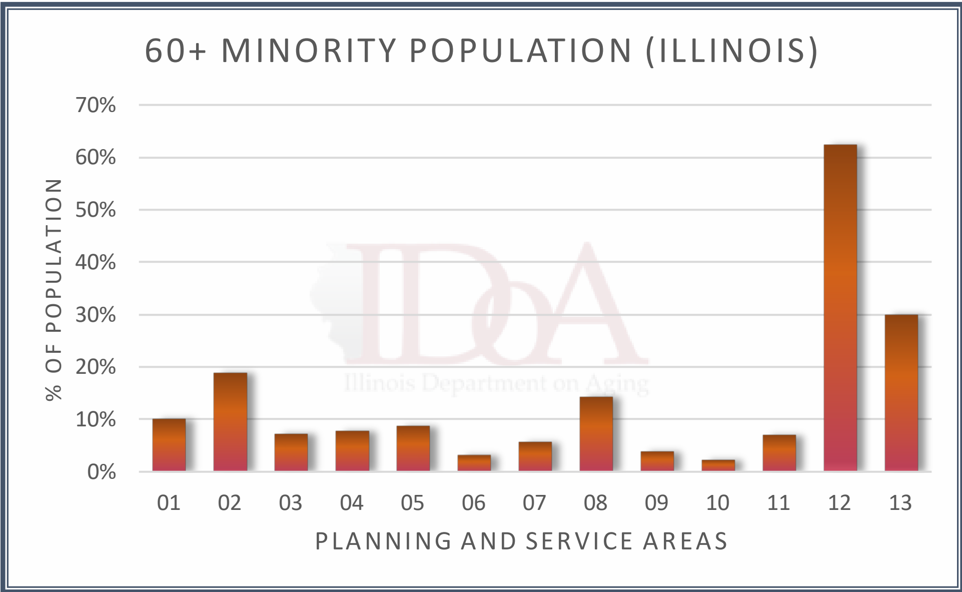
Source: 2018 American Community Survey 5-Year Estimates (Table B17020)



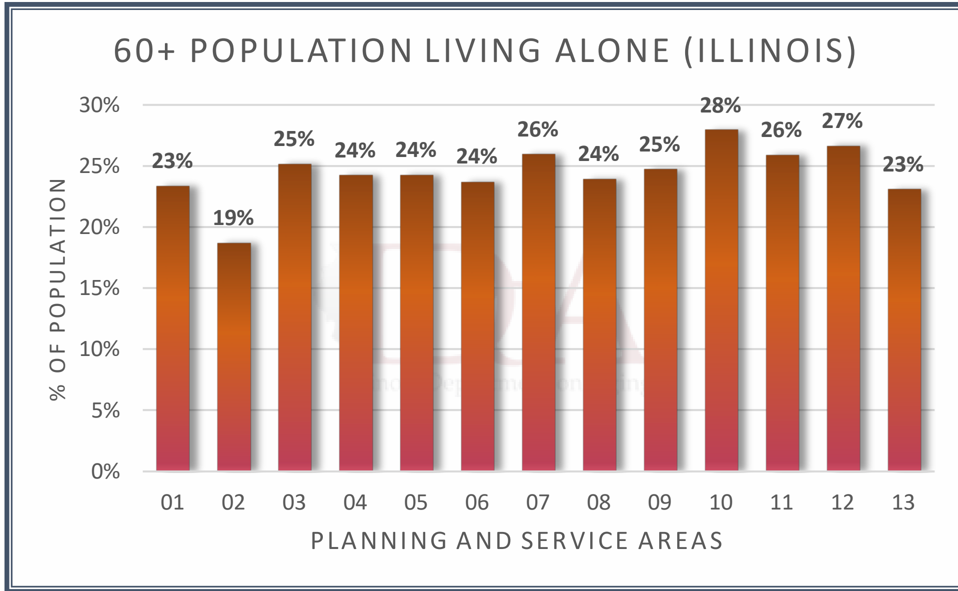
Source: Aging Special Tabulation, 2009-2013 American Community Survey 5-Year Estimates, Table S21023



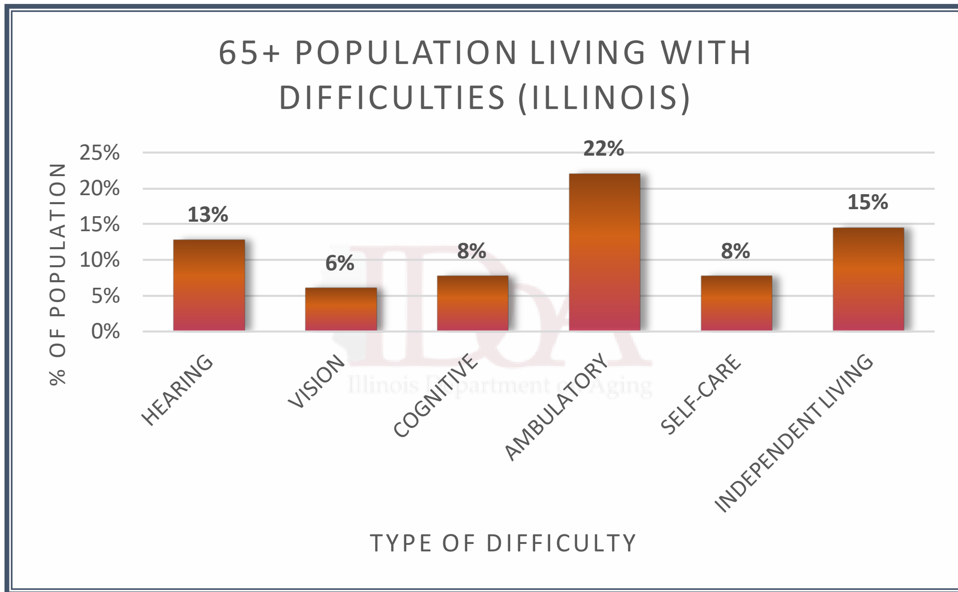
Source: 2012-2016 American Community Survey Special Tabulation, Table S21023



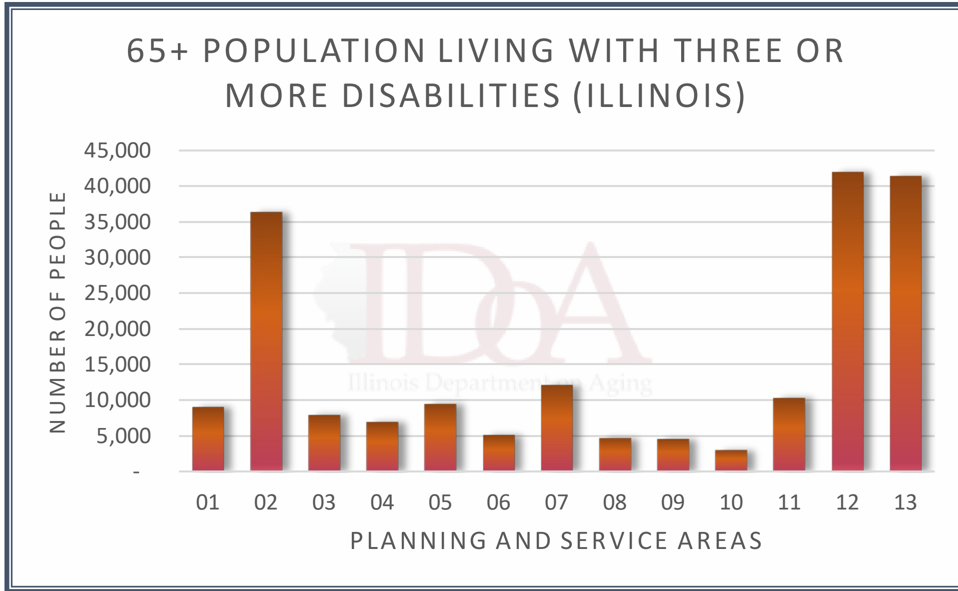
Source: U.S. Census Bureau 2018 Population Estimates, Table CC-EST2018-AllData-17



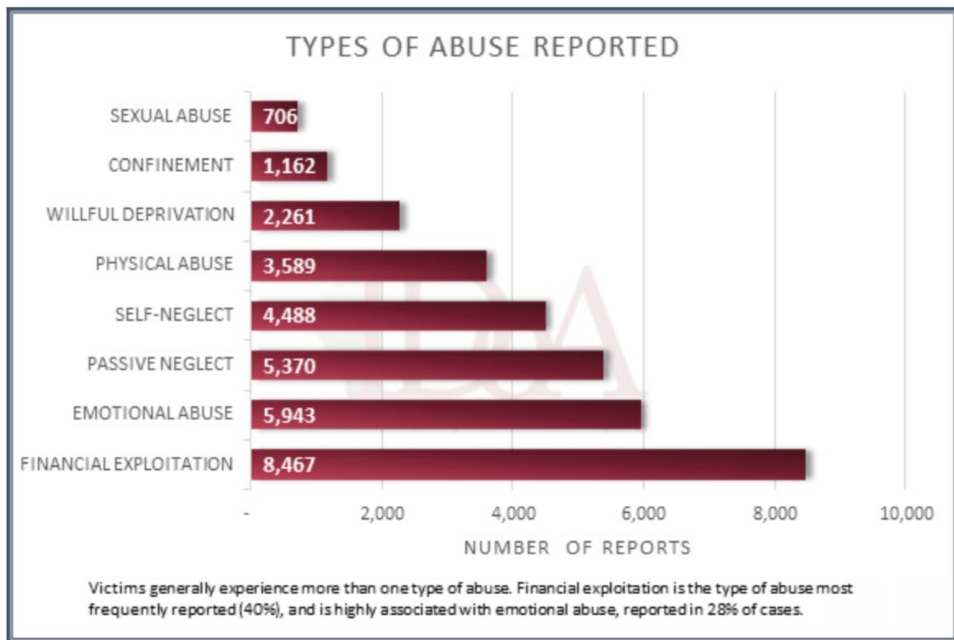
Source: 2012-2016 American Community Survey Special Tabulation (Table S21010B)



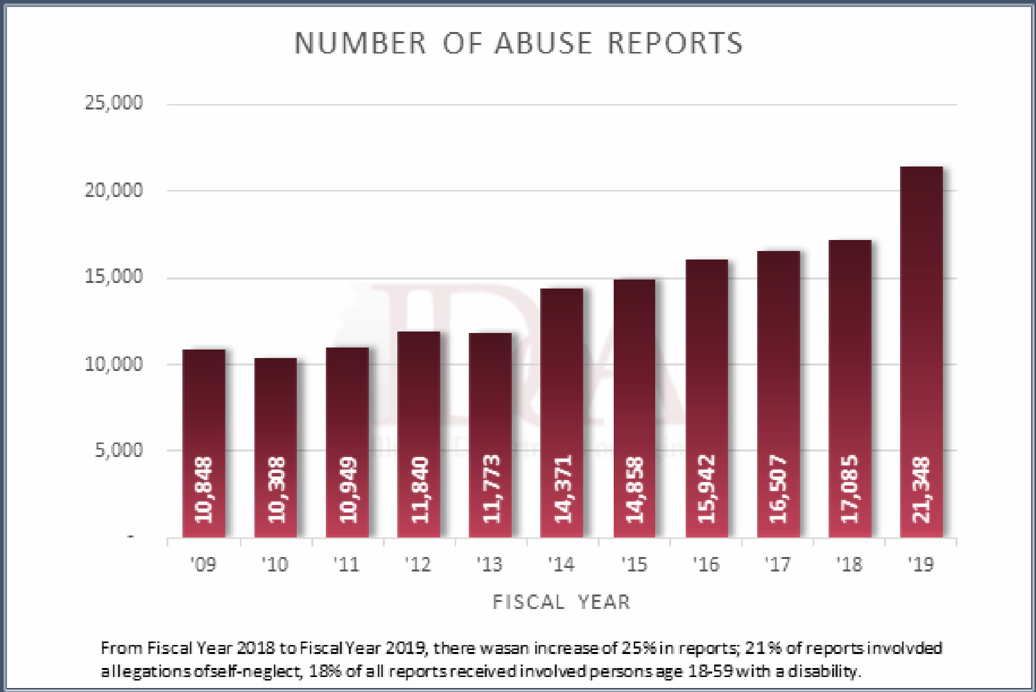
Source: 2018 American Community Survey, 1 Year Estimate, Table S1810



Source: 2012-2016 American Community Survey Special Tabulation, Table S210DIS09

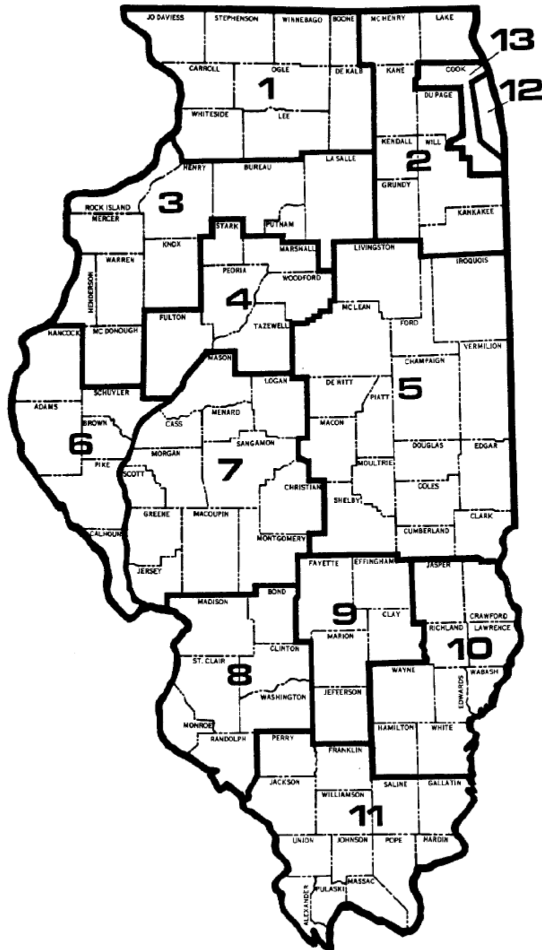


Source: 2019 Adult Protective Services Report



Source: 2019 Adult Protective Services Report

APPENDIX F



Planning and Service Areas

1. **Northwestern Illinois Area Agency on Aging** Grant Nyhammer, Executive Director & General Counsel 1111 South Alpine Road, Suite 600
   Rockford, IL 61108
   815/226-4901; FAX: 815/226-8984;
   1-800-542-8402 (nine county area ONLY)

2. **AgeGuide**
   Marla Fronczak, CEO
   Main Office:
   1910 S. Highland Ave., Suite 100
   Lombard, Illinois 60148
   630/293-5990; 800/528-2000; Fax: 630/293-7488
   Fiscal Office
   100 College Dr, Building 5
   Kankakee, Illinois 60901

3. **Western Illinois Area Agency on Aging**
   Barbara Eskildsen, Executive Director
   729 - 34th Avenue
   Rock Island, IL 61201-5950
   309/793-6800; FAX: 309/793-6807;
   1-800-322-1051 (I & A)

4. **Central Illinois Agency on Aging, Inc.**
   Keith Rider, President & CEO
   700 Hamilton Boulevard
   Peoria, IL 61603-3617
   309/674-2071; FAX: 309/674-3639;
   309/674-1831 (TDD); 1-877-777-2422

5. **East Central Illinois Area Agency on Aging, Inc.**
   Susan Real, Executive Director
   1003 Maple Hill Road
   Bloomington, IL 61704-9327
   309/829-2065; FAX: 309/829-6021;
   1-800-888-4456 (I & A) (sixteen county area ONLY)

6. **West Central Illinois Area Agency on Aging**
   Michael Drew, Director
   Mailing Address:
   P. O. Box 428, Quincy, IL 62306-0428
   (Non-U.S. Post Office deliveries):
   639 York Street, Suite 333, Quincy, IL 62301
   217/223-7904; FAX: 217/222-1220;
   1-800-252-9027 (I & A) (Voice & TDD)

7. **AgeLinc**
   Carolyn Austin, Executive Director
   2731 S. MacArthur Blvd
   Springfield, IL 62704
   217/787-9234 (Voice & TTY); FAX: 217/787-6290;
   1-800-252-2918 (I & A) (217, 309 & 618 area codes ONLY)

8. **AgeSmart Community Resources**
   Joy Paeth, Chief Executive Officer
   801 W State St
   O'Fallon, IL 62269
   618/222-2561; FAX: 618/222-2567;

9. **Midland Area Agency on Aging**
   Tracy Barczewski, Executive Director
   434 South Poplar
   Centralia, IL 62801-1420
   618/532-1853; FAX: 618/532-5259;
   1-877-532-1853

10. **Southeastern Illinois Agency on Aging, Inc.**
    Shana Holmes, Chief Executive Officer
    516 Market Street
    Mt. Carmel, IL 62863-1558
    618/262-2306; FAX: 618/262-4967;
    1-800-635-8544 (618 area code ONLY)

11. **Egyptian Area Agency on Aging, Inc.**
    Becky Salazar, Executive Director
    200 East Plaza Drive
    Carterville, IL 62918-1982
    618/985-8311; FAX: 618/985-8315;
    1-888-895-3306

12. **Senior Services Area Agency on Aging**
    Chicago Department of Family and Support Services
    Brandie Knazze, First Deputy
    1615 West Chicago Avenue, 3rd Floor
    Chicago, IL 60622
    312/743-0155; FAX: 312/744-8168;
    312/744-6777 (TTY)

13. **AgeOptions, Inc.**
    Diane Slezak, President & CEO
    1048 Lake Street, Suite 300
    Oak Park, IL 60301
    708/383-0258; 708/ 524-1653 (TTY)
    708/524-0870 FAX

_ Denotes Change

(Rev. 09/10/2020)

State of Illinois, Department on Aging
One Natural Resources Way, #100
Springfield, Illinois 62702-1271
www.illinois.gov/aging

Senior HelpLine (8:30am – 5:00pm, Monday – Friday):
1-800-252-8966, 1-888-206-1327 (TTY)

Adult Protective Services Hotline (24-Hour):
1-866-800-1409, 1-888-206-1327 (TTY)

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in compliance with appropriate State and federal statutes. If you feel you have been discriminated against, call the Senior HelpLine at 1-800-252-8966, 1-888-206-1327 (TTY).

Printed by Authority of the State of Illinois IL-402-1301 (12/20)