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] 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 2021-FY 2023, 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've learned from the experience of facing 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 and 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 it is evident in best practice approaches, 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 adults 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 those 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 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

[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.

primary care visits were completed via telehealth. This is an increase from 0.1% of primary care visits prior to the public health emergency.[4] However, technology, like a tablet or iPad is not enough; we've 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 2021- FY 2023 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 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.

[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.

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 2021-FY 2023 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: Implement federally-mandated Person-Centered Planning requirements Statewide.

Goal 7: Protect older adults and persons with disabilities by strengthening interagency collaboration to prevent abuse, neglect and exploitation, and increase public awareness.

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

GOALS, OBJECTIVES, STRATEGIES & 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 of social determinants of health, and incorporating a focus on helping support people's unmet social needs. These goals (and the objectives, strategies and outcomes that support them) are provide the framework for the State Plan on Aging for FY 2021-FY 2023.

As required by ACL, the goals, objectives and strategies are included in each of ACL's four focus areas, plus a fifth focus 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—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.

<u>Goal 5</u>: 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.

<u>Goal 6</u>: Implement federally-mandated person-centered planning requirements statewide.

<u>Goal 7</u>: Protect older adults and persons with disabilities by strengthening interagency collaboration to prevent abuse, neglect and exploitation, and increase public awareness.

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

<u>Goal 1</u>: 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 Medicare preventive services including the use of evidence-based programs.

Strategy 1.1c: Conduct an evaluation of Tittle II-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.

<u>Outcomes for Objective 1.1:</u>

- 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.

<u>Goal 2</u>: 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: Address nutritional deficits and food insecurity, a significant social determinant of health, in older adults.

Strategy 2.1a: 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 2.1b: Increase the number of trainings available to MCOs and Care Coordination Units (CCUs) on the Home Delivered Meal (HDM) program, other AAA evidence-based nutrition programs, and apply a health equity approach to nutrition programming.

Strategy 2.1c: 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.

Strategy 2.1d: 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 2.1e: 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 2.1f: 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 2.1g: 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 2.1h: 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) for participants in the congregate and home delivered meal program.

Strategy 2.1i: 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 2.1j: Strengthen the Department's policies on nutrition screening/assessment for the Senior Nutrition Program and provide training(s) to the Aging Network on updates to the Department's policies.

Strategy 2.1k: 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 2.1l: 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.

Outcomes for Objective 2.1:

- MCOs will increase referrals for HDM by 25% over baseline.
- 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.

Objective 2.2: Expand and improve transportation options in order for older adults to maintain quality of life and independence.

Strategy 2.2a: 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 2.2b: 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 2.2c: 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 2.2d: Publicize and assist AAAs, their service providers, and other community organizations that provide transportation services to access available training and funding opportunities.

Strategy 2.2e: Provide tools and technical assistance on older adult transportation issues to local advocates.

Outcomes for Objective 2.2:

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

Objective 2.3: Ensure that older adults can secure accessible, safe, healthy, affordable, and inclusive housing that allows for aging in place and community integration.

Strategy 2.3a: IDoA and other Aging Network representatives will participate in the statewide working groups for progress development on the Illinois Housing Blueprint goals.

Strategy 2.3b: Inform policymakers about the gaps and recommendations for reducing gaps in housing with supportive services for older adults.

Strategy 2.3c: 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 2.3d: Advocate for and secure adequate funding to maintain affordable assisted living and other affordable and accessible community-based housing options.

Strategy 2.3e: 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 2.3f: Promote Senior Real Estate Specialist certification as part of advocating for age-friendly housing options.

Outcomes for Objective 2.3:

- 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 2.4: Promote healthy aging and social integration.

Strategy 2.4a: 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 2.4b: 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 2.4c: 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 2.4d: 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 2.4e: Promote volunteerism among older adults and their families and friends.

Strategy 2.4f: 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 2.4g: Senior center and adult day services sites will plan for and deliver remote and/or virtual activities and services.

Strategy 2.4h: 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 2.4:

- Outreach efforts from senior centers will grow by 2% in FY22 and FY23.
- 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 2.5: 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 2.5a: 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 2.5b: Provide training and supports to caregivers to decrease caregiver burden and caregiver stress, such as Savvy Caregiver Program, Stress Buster Program with AAAs.

Strategy 2.5c: Collaborate with advocacy organization including the Alzheimer's Association and the Illinois Cognitive Resource Network to increase public awareness, education, and sensitivity.

Strategy 2.5d: Identify service and support gaps and explore opportunities to increase caregiver support through respite and dementia gap filling services.

Strategy 2.5e: Fund and support the Alzheimer's disease and related dementias (ADRD) programs available in all PSAs.

Strategy 2.5f: Work with Aging Network partners to build a dementia-capable workforce.

Strategy 2.5g: 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 2.5h: Analyze data from FY20 ADRD program and make necessary changes to improve services and adopt best practices across all Planning and Service Areas.

Strategy 2.6i: 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.

Outcomes for Objective 2.5:

- Two full dementia trainings will be offered for professionals and para professionals in FY21. Three full dementia trainings will be offered for professionals and para professionals in FY22 and FY23.
- 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.

Objective 2.6: Expand employment, volunteer, and training opportunities for older adults in the private and public sectors.

Strategy 2.6a: Evaluate whether regional Senior Citizen Supported Employment Program (SCSEP) grantees are meeting placement goals on a quarterly basis.

Strategy 2.6b: 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 2.6c: 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 2.6d: IDoA will have representation on the Workforce Innovation and Opportunity Act (WIOA) State Interagency Workgroup.

Strategy 2.6e: 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 2.6f: 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 2.6 g: 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 2.6:

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

Strategy 2.7a: Educate AAA's about Age-Friendly Communities and the role they can play in their area.

Strategy 2.7b: 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 2.7c: Evaluate existing age-friendly communities in Illinois to understand and disseminate best practices and lessons learned.

Outcomes for Objective 2.7:

- 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."

Objective 2.8: Expand programming to reduce social isolation and loneliness.

Strategy 2.8a: Provide training and education opportunities to AAAs, CCUs and other Aging Network partners to become educated for signs of social isolation and loneliness.

Strategy 2.8b: Work with AAAs to implement the UCLA loneliness scale.

Strategy 2.8c: Research and monitor best practices to guide implementation of programming to reduce isolation and loneliness.

Strategy 2.8d: Work with academic partner to evaluate social isolation and loneliness data collected from evidenced-based programs.

Strategy 2.8e: Investigate availability of funding from Illinois Broadband Council for internet and WIFI.

Strategy 2.8f: Work with AAAs to maintain and expand programs to reduce social isolation and loneliness, such as volunteers and senior calling programs.

Outcomes for Objective 2.8:

- 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 and WIFI for older adults.
- Number of new programs initiated to reduce social isolation and loneliness.

Objective 2.9: Integrate into healthcare and other services the provision and connection to services for older adults to meet their social needs.

Strategy 2.9a: Evaluate capacity of AAAs (via training and program development) to conduct health promotion and prevention screenings.

Strategy 2.9b: 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).

Strategy 2.9c: 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 2.9d: Grow capacity of the Aging Network (via training, program development, and seeking grants) to provide disease prevention and health promotion education.

Outcomes for Objective 2.9:

- 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.

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: Incentivize IDoA-contracted Care Coordination Units to assist older adults with the initial Medicaid application with the implementation of the blended rate.

Strategy 3.1c: Identify barriers to completing and submitting Medicaid applications and work with HFS to overcome these barriers.

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

Strategy 3.1f: Provide education and outreach to Aging Network and older adults about the Medicaid look-alike coverage for undocumented older adults.

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 Sub-committee.
- Evaluate IDoA 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 Administration 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, 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 3.3j: 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 technical assistance through the IDoA Benefits, Eligibility, Assistance, and Monitoring (BEAM) unit to MCOs, Aging Network providers, and Care Coordination Units (CCUs) to facilitate more efficient participant transfers between managed care and waiver programs.

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

Strategy 3.3f: 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 at least 375 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 monthly.

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

Strategy 3.4a: 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 3.4b: 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 3.4c: 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 3.4d: 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 3.5e: 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, other precautions that are necessary in order ensure continuity of services.

Outcomes for Objective 3.4:

- 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.

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: 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).

Strategy 3.5c: 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 disorders 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 MAT, 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 screenings and mental health and substance use disorder healthcare 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 that seek 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:

- Increased % of screenings for mental health and substance use disorders.
- Increased # (from baseline) of referrals to mental health treatment by CCUs and AAAs.
- Increased # (from baseline) of referrals to substance use disorder treatment by CCUs and AAAs

- Decreased % of deaths of older adults attributed to mental illness or substance use disorders.

<u>Goal 4</u>: 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: Implement IDoA rate study recommendations (for care coordination, in-home services, EHRS, ADS and ADS transportation) in coordination with Care Coordination Units (CCUs), the Department of Healthcare and Family Services, contracted providers, and federal CMS.

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

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

<u>Outcomes for Objective 4.1:</u>

- Identify the OASAC recommendations that IDoA can implement and provide technical assistance through its advisory committees.
- Establish at least one pilot programs focused on geriatric specialists established 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.

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, taking into account 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 (CCU), 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.

Outcomes for Objective 4.3:

- 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.
- 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.

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 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 federal 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.

Outcomes for Objective 5.1:

- 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 Federal CMS to add services to the Waiver

Objective 5.2: Continue to communicate and raise awareness across the state, the Aging Network, and other 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 and ensure all online and print materials are accessible for people with disabilities.

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; and re-design of the Department's website inclusive of services and supports through sister Departments 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 risk.

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 5.34c: Work with Area Agencies on Aging, Care Coordination Units, and other 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.

Outcomes for Objective 5.4

- Increased % of older adults utilizing assistive technology.
- Increased funding available for assistive technology.

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 and nursing homes.

Strategy 6.1a: Continue to partner with Care Coordination Units, the Illinois Department of Healthcare and Family Services, the Illinois Department of Human Services, 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: Work with Illinois Department of Healthcare and Family Services and Department of Human Services as they re-design the federal Pre-Admission Screening & Resident Review (PASRR) requirements to ensure that it is aligned with the Choices for Care screen requirement.

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 6.1e: Develop process for Area Agency on Aging to create person-centered, customized care plans for caregivers to ensure that all services and supports are in place and explore options to prevent caregiver burnout.

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

- Twelve annual trainings will be provided to Aging Network in all areas of the state
- All AAAs will report on their plan and implementation strategies to meet the person-centered planning mandate in each of their OAA services
- Toolkit will be developed, disseminated to participants and caregivers, and evaluated by them as to effectiveness, and for improvement
- Quarterly training for Choices for Care screeners

Goal 7: Protect older adults and persons with disabilities by strengthening interagency collaboration to prevent abuse, neglect and exploitation, and increase public awareness.

Objective 7.1: Protect older adults and persons with a disability 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. The Task Force is commissioned to address barriers to prosecution, review current alder abuse practices in Illinois, review best practices in other states, ensure that prevention strategies have plans to be responsive to emergencies such as pandemics, and create a long-term plan for Illinois related to elder abuse.

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. Use the information gleaned from the Fatality Review Teams to improve program delivery and training.

Strategy 7.1e: Use the information gleaned from the Fatality Review Teams are used 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. Office 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. The project is directed by the Illinois Department of Human Services, Illinois rape crisis centers, disability service agencies, and self-advocates.

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 will be demonstrated by the number of trainings offered.
- 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 thus 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 then 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 the Adult Protective Services 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 prior to the training and after the 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 coordinating entities to ensure current 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 coordinating entities and as a result if the number of multiple reports for individuals declines.
- 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 Protect 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 be in compliance with the new 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 dually eligible for Medicaid and Medicare Alignment Initiative (MMAI).

Strategy 7.4g: Continue to provide Ombudsman services to 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.

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 LGBT seniors and persons with disabilities, and 3) anti-racism training.

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.

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.

Objective 7.6: Create a 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: Negotiate with nursing home associations to ameliorate their concerns.

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 as easy as possible 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:

- New/Updated IDoA Dashboard.
- New Case Management Information System.
- New Benefit Access Application.
- New electronic Community Care Program Information System.
- 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 certifications, (and re-certifications where appropriate) 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