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# ILLINOIS DEPARTMENT ON AGING

## FY 2017—FY 2019

## STATE PLAN ON AGING

## PUBLIC INFORMATION DOCUMENT



Bruce Rauner  
Governor

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# EXECUTIVE SUMMARY

## FY 2017-FY 2019 PRIORITIES OF THE ILLINOIS DEPARTMENT ON AGING

### **Rebalance Illinois' Long-Term Care System to Enhance Home and Community-Based Services for Older Adults and Their Caregivers**

People in need of long-term care need a range of different services, depending on the type and severity of their disabilities. The demand for alternatives to nursing home care has increased in recent years. Long-term care system change efforts also underscore the need to empower seniors to control and direct their own care. Choice and control are both key aspects of any consumer-directed service delivery system. Illinois policy-makers will consider how to satisfy the increasing need for long-term care services not only in terms of providing enough care, but also in terms of providing the type of services that older adults and family caregivers are likely to need and want with available resources.

The Balancing Incentive Program (BIP) was authorized under the Affordable Care Act to support states to modify the emphasis on allocating resources to institutional care to community-based long term services and supports. The overall goal of BIP is to expand access to Medicaid-funded home and community-based (HCBS) long term services and supports (LTSS) and to streamline program eligibility and service delivery to individuals needing LTSS services.

The Department of Healthcare and Family Services (HFS) is the state's designated agency for BIP development and implementation. HFS is closely collaborating with the Department on Aging and the Department of Human Services, the Governor's Office and stakeholders to implement the following three structural reforms in the LTSS system.

- No Wrong Door/Coordinated Entry Point;
- Conflict-Free Case Management Services; and
- Uniform Assessment Process

Through a grant from the Administration for Community Living (ACL), Illinois established a NWD Executive Committee, which included high-level administrative staff from the Department on Aging, Department of Healthcare and Family Services, Department of Human Services, and other state agencies. The NWD Executive Committee is in the process of developing a three-year State Plan that will be submitted to ACL by September, 2016. The NWD State Plan will include goals and objectives that will promote a coordinated system of multiple entry points across the State and across agencies.

### **Advocate for the Protection of the Rights of Older Adults and Persons with Disabilities**

The Illinois Department on Aging administers the statewide Adult Protective Services (APS) Program, under the authority of the Adult Protective Services Act (320ILCS 20/1 et seq.) to respond to reports of alleged mistreatment of any Illinois citizen 60 years or older and any adult with a disability age 18-59 who lives in the community at the time of the report.

The APS Act is locally coordinated through APS provider agencies, which are designated by the Regional Administrative Agencies (RAAs) and the Department on Aging. All Adult Protective

Services Caseworkers are trained and certified by the Department, which promulgates the Program's policies and procedures and oversees the monitoring of services through the RAAs.

The following are some of the major initiatives that the Adult Protective Services Program will undertake in the upcoming three years:

- Support the development and maintenance of regional abuse fatality review teams in each planning and service area, including representation from the coroner or medical examiner's office, State's Attorney's office, law enforcement, health care and social service.
- Maintain a statewide Adult Fatality Review Teams Advisory Council to provide coordination and oversight for regional fatality review teams and activities in the State.
- Facilitate the mandated minimum training standards for financial institutions for their current and new employees with direct customer contact through B\*SAFE on-site training and training of trainers.
- Provide collaborative training through coordination 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.

Mandated by the Federal Older Americans Act and the Illinois Act on the Aging, the Illinois Long-Term Care Ombudsman Program (LTCOP) is a resident-directed advocacy program which protects and improves the quality of life for residents in a variety of long-term care settings. Ombudsmen work to resolve problems of individual residents and to bring about changes at the local, state and national levels to improve care. Most residents receive good care in long-term care facilities; however, far too many experience violations of their rights including abuse, neglect, poor care, isolation and lack of choices and meaningful activities. Trained community ombudsmen regularly visit long-term care facilities, monitor conditions and care, and provide a voice for those unable to speak for themselves. Long-Term Care Ombudsmen make every reasonable effort to assist, empower, represent and intervene on behalf of the resident. Ombudsman work is directed by the resident.

The following are some of the major initiatives that the Long Term Care Ombudsman Program will undertake in the upcoming three years:

- Develop posters and brochures regarding the Ombudsman expansion to include individuals' rights regarding services provided by managed care organizations and waiver services.
- Develop best practices for Regional Ombudsman Programs to develop and implement M-Teams.
- Amend the IL Act on the Aging and the Specialized Mental Health Rehabilitation Act of 2013 to include Specialized Mental Health Rehabilitation facilities (SMHRFs) in Ombudsman jurisdiction.
- Amend the IL Nursing Home Care Act to close a loop hole regarding involuntary transfers and discharges.

### **Sustain and Expand the Community-Based Aging Network in Anticipation of the Continued Growth of the Aging Population**

The population age 85 and older is the fastest growing segment of the older population. The size of this age group will have a major impact on the service delivery system because these

individuals tend to be in poorer health and require more services than the young elderly. With the aging demographic boom, the need for in-home assistance (e.g., homemaker, adult day service, and home delivered meals) will dramatically increase. Current and future levels of federal and state funding for Aging Network services has struggled to keep pace with the need for services.

Enrollment in the Department on Aging's Medicaid Waiver Community Care Program (CCP) has significantly grown over the past ten years. In FY 2005, CCP serves approximately 41,000 older adults. CCP currently services 80,000 individuals. 35,000 of these individuals are Medicaid eligible and 45,000 individuals are non-Medicaid eligible. For participants who are Medicaid eligible, the State of Illinois receives a match of up to approximately \$200 million from the federal government which is returned to GRF. For individuals who are non-Medicaid eligible, CCP services are funded entirely through GRF.

CCP provides the same level of services and supports to individuals aged 60 and over regardless of their Medicaid eligibility status. Sustaining CCP as it exists today will cost an additional \$93.3 million in the next six years assuming the completion of the managed care transition by FY 2018. This program design is no longer financially sustainable for the State of Illinois.

In FY 2017, the Department on Aging will transition individuals who are non-Medicaid eligible to a new Community Reinvestment Program (CRP). Similar to other states, the Department on Aging's approach will maintain a service package for individuals that do not meet Medicaid eligibility requirements. The goals of CRP include the following:

1. Sustaining core services and supports to individuals aged 60 and above who demonstrate a need, regardless of their Medicaid eligibility status.
2. Leveraging all available resources to reduce dependence on public funds.
3. Increasing flexibility in how services to older individuals are delivered.
4. Preventing early admission to institutional care as a result of community based services while supporting individuals to remain safely at home.

CRP will continue to utilize the strengths of the Aging Network for intake, eligibility determination, and development of care plans; care coordination; service delivery; and oversight of service provider agencies. Non-Medicaid eligible clients will have their Determination of Need (DON) score applied to a new service cost maximum table to derive a new individual spending allocation. CRP will provide greater flexibility of services, and the Area Agencies on Aging will be used as the regional administrative organizations for the coordination of services.

### **Promote Healthy Aging and Family Support to Increase Prevention Options and Services**

Improved prevention efforts in medical care have promoted major increases in life expectancy in the U.S. Increases in life expectancy have caused a change in the leading causes of death among older individuals. The top three causes of death for older adults age 65 or older are heart disease, cancer, and stroke according to the Centers for Disease Control and Prevention. These diseases are often preventable. In order to address the health care needs of older adults, the Aging Network will need to develop and implement evidence-based programs on health promotion, disease prevention, and chronic disease self-management, and continue to provide educational and outreach services about Medicare preventive health services.

According to several surveys, 70% of older workers plan to work into their retirement years. The Department on Aging and Aging Network will continue to advocate for the interests of older

workers on statewide and local Workforce Investment Boards and Committees. Additionally, the Department on Aging and the Area Agencies on Aging will need to work with the private and public sector to develop additional employment opportunities for older workers.

With the aging of the baby boomer generation, it is anticipated that many older adults will seek meaningful civic engagement (volunteer) opportunities. Older adults are in an excellent position to volunteer. In many cases they may have the time as well as the experience and expertise to help in a variety of activities. The Aging Network and communities throughout Illinois will need to attempt to utilize these untapped resources.

### **Implement Quality Assurance Mechanisms and Promote Accountability for the Services Provided by the Aging Network**

The Grant Accountability and Transparency Act (GATA) became law on July 16, 2014 as Public Act 98-0706. The purpose of GATA is to establish uniform administrative requirements, cost principles, and audit requirements for state and federal pass-through awards to non-federal entities. The Act is significant because grants comprise approximately two-thirds of the Illinois State Budget. Fifty-two (52) state agencies currently have grant-making authority.

GATA encompasses the entire grant life cycle and provides uniformity and guidance for all grant-making agencies in state government. Illinois is the first state in the nation to require uniform rules for the full life-cycle of grants management. The Act serves to build capacity of the grantee community by mandating grant-related training, and providing guidance and support to correct occurrences of non-compliance with fiscal, administrative and programmatic requirements.

The Department will work with the Governor's Office of Management and Budget and other state agencies to maintain quality performance measures and Budgeting for Results indicators for long-term care and other community based services. The Department will also develop standards of quality for CCP services consistent with federal CMS guidelines and ensure related Quality Assurance monitoring activities.

Other initiatives address the following:

- Improve information technology infrastructure and reporting capabilities.
- Ensure timely determinations of provider reviews and client appeals, and management of client services to ensure effective operations and good customer service.
- Continue the administration of the procurement process for the Community Care Program and develop and maintain performance objectives for providers and grantees that are aligned with the Department on Aging's strategic priorities.
- Provide innovative online training options to the Aging Network and other staff development opportunities.

## **PURPOSE & DEVELOPMENT OF THE STATE PLAN ON AGING**

The three-year Illinois State Plan on Aging is the planning document that the Illinois Department on Aging produces to guide Older Americans Act-related programmatic activities and services for older adults, family caregivers and grandparents raising grandchildren and direct the statewide effort to transform the state's long-term care system for Illinois' frail elderly residents. The Plan establishes priorities and identifies Department on Aging initiatives in fulfilling its overall mission to serve and advocate for older Illinoisans and their caregivers.

In order to be eligible to receive funds under Title III of the Older Americans Act, Section 307 of the Act requires the State to submit to the Administration on Aging (AoA) a State Plan on Aging which meets the criteria established by AoA through federal regulations. Each State agency has been afforded the opportunity by AoA to develop its own format for the State Plan and to determine the effective duration of the Plan (i.e., two, three, or four years).

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, caregivers and persons with disabilities served through No Wrong Door sites. Key questions that were considered in the development of the State Plan included the following:

- What are Illinois' goals, initiatives and priorities for home and community based services?
- What is Illinois' current capacity (e.g., workforce, fiscal outlook, etc.) to meet those goals?
- What challenges will Illinois face and how are these being addressed through measurable objectives?

The Governor's Office has proposed a community-based human and health services delivery model to effectively link at risk populations with services to help them regain their physical and mental health and their economic self-sufficiency through employment. The human and health services transformation is based on "five pillars: prevention and population health, paying for value and outcomes, using data and analytics to provide targeted support, moving from institutional to community care, and building a cradle to career education system that leads to self-sufficiency." This initiative will assist Illinois' human and health services to offer access to "high quality, consumer-centered, community-based services through effective stewardship of public and private resources." This significant initiative has been used as a guiding principle in the development of the three-year State Plan on Aging.

The Illinois Department on Aging has elected to develop a three-year plan, which follows by two years the planning cycle established for Illinois' Area Agencies on Aging in the development and administration of their three-year Area Plans. The statewide initiative of continued work on the No Wrong Door System and health promotion activities and other Area Plan initiatives as outlined in the current Area Plans have been incorporated into this FY 2017-FY 2019 State Plan on Aging.

In recent years, significant Illinois Aging Network planning activities have occurred with the mandates of the state Older Adult Services Act. The State Plan on Aging represents planning commitments by the State regarding the Older Adult Services Advisory Act and the planning activities of the Older Adult Services Advisory Committee.

Additionally, the Department on Aging has established priorities as outlined in its draft FY 2016-FY 2019 Strategic Plan. These strategic priorities and initiatives have been also included in the FY 2017-FY 2019 State Plan on Aging.

The development of the FY 2017-FY 2019 State Plan on Aging has included additional planning activities to gather input in the development of goals and priorities of the Illinois Department on Aging, as outlined below:

- Using Balancing Incentive Program (BIP) planning meetings of the Illinois Department of Healthcare and Family Services and other state agencies to respond to federal initiatives and the state initiative to rebalance the long-term care system in Illinois.
- Working with the No Wrong Door (NWD) Executive Committee and the Lewin Group on the development of a three-year NWD State Plan.
- Using planning activities of the Older Adults Services Advisory Committee
- Participating in the Health and Human Services Transformation Committee planning meetings.
- Using planning activities of the 13 Area Agencies on Aging as documented by the Area Plans submitted to the Illinois Department on Aging.
- Sharing the Public Information Document (PID) with a wide group of organizations, associations and advisory groups in order to seek public input.
- Placing a copy of the PID on the Department's web site.
- Conducting three public hearings to receive final input on the draft State Plan on Aging.
- Finalizing the State Plan on Aging based on comments received during the hearings and follow-up written comments.

## **PRIORITIES, INITIATIVES, STRATEGIES & PERFORMANCE MEASURES**

<b>Priority #1: Rebalance Illinois' long term care system to enhance home and community-based services for older adults and their caregivers.</b>
<b>Initiative 1.1: Improve access to sustainable home and community-based services and person-centered options for older adults to prevent and delay institutionalization.</b>
<b>Strategies</b>
<ul style="list-style-type: none"> <li>• Coordinate with sister agencies in reviewing the Pre-Admission Screening and Resident Review (PASRR) process to ensure compliance with federal Medicaid regulations. Ensure individuals are aware of community-based service options prior to admission to an institutional setting.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with Lewin consultants and stakeholders on a review of existing Choices for Care process. Ensure coordination of Choices for Care process with the implementation of the Uniform Assessment Tool (UAT).</li> </ul>
<ul style="list-style-type: none"> <li>• Implement a sustainability plan for Pathways/ MFP post completion of the MFP Demonstration Project. Develop a plan to add MFP demonstration services to the Elderly Waiver to ensure rebalancing activities post MFP.</li> </ul>
<ul style="list-style-type: none"> <li>• Seek timely amendments and approval of the 1915(c) Medicaid Waiver to incorporate program enhancements, implement quality improvement strategies and reform measures to leverage available Federal Financial Participation.</li> </ul>
<ul style="list-style-type: none"> <li>• Evaluate existing Demonstration projects to determine their effectiveness and possible expansion opportunities for statewide implementation.</li> </ul>
<ul style="list-style-type: none"> <li>• Serve as the lead agency for the implementation of the Colbert Consent Decree. Continue rebalancing efforts related to the decree and review the cost neutral study once completed.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide ongoing funding for the Nursing Home Deflection &amp; ADRC enhancement pilot to reduce the placement of older persons and persons with disabilities in nursing homes through deflection to home and community services and through interventions that shorten stays in nursing homes. Analyze service utilization data to determine existing gaps in the community-based service system and possible additional waiver services.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to review service levels associated with the Senior HelpLine to ensure accessibility to program options and services.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to provide extensive training on home and community-based services, AIRS certification and recertification and apply person-centered planning philosophy and approach to the Senior HelpLine and BIP call center.</li> </ul>
<b>Initiative 1.2: Collaborate on and implement the No Wrong Door (NWD) integrated system for Illinois residents.</b>
<b>Strategies</b>
<ul style="list-style-type: none"> <li>• Collaborate with HFS, DHS, and stakeholders on the implementation of the BIP-related NWD activities, including conflict free case management (CFCM) and Uniform Assessment Tool (UAT) that will facilitate access to services for clients and caregivers across all populations and inform clients of their community-based service options.</li> </ul>
<ul style="list-style-type: none"> <li>• Establish an effective method to share information with and conduct cross training events with partners that serve persons with disabilities.</li> </ul>

<ul style="list-style-type: none"> <li>• Continue to promote AIRS training, certification and accreditation for both new and existing NWD partners.</li> </ul>
<ul style="list-style-type: none"> <li>• Strengthen and standardize partnership agreements and mutual referral protocols between aging, disability, behavioral health, housing, transportation and other services at the community level.</li> </ul>
<ul style="list-style-type: none"> <li>• Under the leadership of HFS, develop and implement a statewide outreach and marketing plan. Market the NWD brand with HFS, other state agencies and regional and local NWD sites.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop NWD standards through the BIP Interagency workgroup and stakeholders.</li> </ul>
<ul style="list-style-type: none"> <li>• Finalize and implement the three-year NWD State Plan with the NWD Executive Committee.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop effective education and training programs for NWD partners and the call center to ensure consistent delivery of information on waiver programs serving the 17 years of age and older populations.</li> </ul>
<ul style="list-style-type: none"> <li>• Execute the statewide Balance Incentive Program (BIP) call center and provide uniform information to clients and refer Initial Screens to waiver programs serving the 17 years of age and older populations.</li> </ul>
<ul style="list-style-type: none"> <li>• Improve transitions and data sharing between initial NWD entry point person-centered counselor and Medicaid eligibility staff, Medicaid case managers, and Medicaid or private managed care organizations.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop and institute standard policies and requirements for community-based organizations in the NWD system funded by state agencies.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue statewide advisory group with stakeholders from all populations, individuals and family members, providers, payers to inform and shape policy.</li> </ul>
<p><b>Initiative 1.3: Encourage policies to improve access and expand availability of housing with supportive services for older adults.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Collaborate with other state agencies and provide support for the ongoing maintenance of the housing locator system and statewide housing coordinators.</li> </ul>
<ul style="list-style-type: none"> <li>• Advocate for and secure adequate funding to maintain sustainable in-home assisted living and community-based options.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue involvement on Illinois Housing Development Authority (IHDA) Housing Task Force.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to assist with funding <a href="http://www.ILHousingSearch.org">www.ILHousing Search.org</a> housing locator</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to work with state partners on identifying housing subsidies and vouchers to increase the pool of affordable housing.</li> </ul>
<p><b>Initiative 1.4: Expand and improve transportation options for older adults and individuals with disabilities.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Participate as a member of the Rural Transit Assistance Center's (RTAC) Advisory Council and represent the needs of older adults and those with disabilities.</li> </ul>
<ul style="list-style-type: none"> <li>• Coordinate and assist the Illinois Department of Human Services with the ongoing functioning of their Social Services Block Grant (Donated Funds Initiative (DFI)) for senior transportation.</li> </ul>

<ul style="list-style-type: none"> <li>• Work with the Rural Transit Assistance Center (RTAC), Human Services Transportation Plan (HSTP) Coordinators, Illinois Department of Transportation (IDoT) and the 13 AAAs to coordinate the delivery of transportation services at the state and local levels across Illinois.</li> </ul>
<ul style="list-style-type: none"> <li>• Publicize and assist AAAs, their service providers and other community organizations providing transportation services to access available training and funding opportunities.</li> </ul>
<p><b>Initiative 1.5 Enhance IDoA’s website and include an information and assistance database by geographic area to link older adults and caregivers to services and benefits.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Analyze Enhanced Service Program (ESP) or other similar service inventory and client query options to improve online ability to counsel older adults and caregivers on available service options by geographic planning and service areas, and encourage wider usage of such technology across the Aging Network.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide linkages on the Department’s website to the HFS LTC web site.</li> </ul>
<p><b>Initiative 1.6: Sponsor and administer Alzheimer’s Disease and related dementia training and outreach initiatives for the Aging Network and caregivers.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Develop referral protocol for dementia-related resources and services.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop training for caregivers to decrease caregiver burden.</li> </ul>
<ul style="list-style-type: none"> <li>• Promote educational conferences, events and webinars to promote dementia education and sensitivity.</li> </ul>
<ul style="list-style-type: none"> <li>• Sustain and expand the Savvy Caregiver Program in all PSAs.</li> </ul>
<ul style="list-style-type: none"> <li>• Expand working relationships with Alzheimer’s Associations and the Illinois Cognitive Resource Network.</li> </ul>
<ul style="list-style-type: none"> <li>• Explore ways to provide caregiver support, including an expansion of respite services.</li> </ul>
<ul style="list-style-type: none"> <li>• Increase caregiver education and public education through the NWD system.</li> </ul>
<p><b>Performance Measures</b></p>
<p>Track # of individuals that are sustained in the community through MFP and Colbert post transition. Analyze recidivism rates on an annual basis.</p>
<p>Review and establish new termination codes for CCP in order to track participants that transition out of CCP to determine reasons for termination.</p>
<p>Track # of Initial Screens completed and referred to each waiver program and MH/SA programs.</p>
<p>Track % of Initial Screens that were contacted by NWD sites within designated timeframe.</p>
<p>Track MDS Section Q referrals that result in MFP and/or Colbert enrollment and transition.</p>
<p>Track % and # of older adults and those with disabilities who received Title III-B transportation services during the federal fiscal year compared to the previous federal fiscal year.</p>
<p>Track # of persons enrolled in the Nursing Home Deflection project.</p>
<p>Track # of persons enrolled in project that was able to return home after short nursing home stay.</p>
<p>Track # of family caregivers served with respite services.</p>
<p>Track # of family caregivers served with education and training services.</p>
<p>Track # of family caregivers enrolled in Savvy Caregiver.</p>

**Priority 2: Advocate for the protection of the rights of older adults and persons with disabilities.**

**Initiative 2.1 Protect older adults and persons with a disability by strengthening inter-agency collaboration to prevent abuse, neglect and exploitation, and increase public awareness.**

**Strategies**

- Support the development and maintenance of regional abuse fatality review teams in each planning and service area, including representation from the coroner or medical examiner's office, State's Attorney's office, law enforcement, health care and social service.
- Maintain a statewide Adult Fatality Review Teams Advisory Council to provide coordination and oversight for regional fatality review teams and activities in the State.
- Facilitate the mandated minimum training standards for financial institutions for their current and new employees with direct customer contact through B\*SAFE on-site training and training of trainers.
- Coordinate with utility and electric companies to alert older adults regarding telemarketing and home repair fraud.
- Provide training to law enforcement through involvement in the Office of Attorney General's 40 hour Elderly Service Officers' training curriculum.
- Provide collaborative training through coordination 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.
- Participate in the Illinois State Triad, a collaborative effort among law enforcement, community advocates and social services, to promote crime prevention for older adults.
- Participate in "Envision Illinois," a collaborative partnership in Illinois addressing domestic violence in the lives of people with disabilities and Deaf people throughout the State of Illinois.
- 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.

**Initiative: 2.2: 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.**

**Strategies**

- Enhance the assessment components of the statewide assessment instrument to increase the depth of the program's investigation and improve factors considered in case plan development.
- Systematically measure progress toward case plan goals throughout the program's involvement with an individual.
- Provide opportunities for on-going professional development for adult protective services caseworkers and supervisors through Department sponsored and Department recommended trainings scheduled throughout the state.
- Maintain support for the required multi-disciplinary teams for each adult protective services provider agency that provides professional guidance on complex cases.

<ul style="list-style-type: none"> <li>• Continue to support the availability of a 24 hour statewide abuse hotline, which allows the reporter to file the report with a reporting line that is staffed.</li> </ul>
<ul style="list-style-type: none"> <li>• Assure Adult Protective Service provider agencies are adequately trained on adopted rules, protocols and policies and procedures for the Adult Protective Services program's full implementation of services to individuals who self-neglect.</li> </ul>
<ul style="list-style-type: none"> <li>• Support the involvement of adult protective service provider agencies as facilitators on regional fatality review teams to foster communication among multiple agencies in developing a greater understanding of the incidence and causes of premature deaths and the methods for preventing those deaths.</li> </ul>
<p><b>Initiative 2.3: Strengthen authority and capacity of the LTC Ombudsman Program and maximize program services to meet the needs of older adults residing in LTC facilities and in the community.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Strengthen the LTCOP by revising the current State Rules to be in compliance with the new Federal Rules.</li> </ul>
<ul style="list-style-type: none"> <li>• Strengthen the LTCOP by revising the current Illinois Long-Term Care Policies and Procedures Manual to be in compliance with the new Federal Rules.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop best practices for Regional Ombudsman Programs to develop and implement M-Teams.</li> </ul>
<ul style="list-style-type: none"> <li>• Strengthen communication between the State Office and the Regional programs by developing a website with a portal for Ombudsman to access current forms, rules, policies and procedures, and training opportunities.</li> </ul>
<ul style="list-style-type: none"> <li>• Maximize benchmark directives.</li> </ul>
<ul style="list-style-type: none"> <li>• 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 (MMAI).</li> </ul>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<p><b>Initiative 2.4: Create a legislative and outreach plan to advance residents' rights</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Amend the IL Act on the Aging and the Specialized Mental Health Rehabilitation Act of 2013 to include SMHRFs in Ombudsman jurisdiction.</li> </ul>
<ul style="list-style-type: none"> <li>• Amend the IL Nursing Home Care Act to close a loop hole regarding involuntary transfers and discharges.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop posters and brochures regarding the Ombudsman expansion to include individuals' rights regarding services provided by managed care organizations and waiver services.</li> </ul>
<p><b>Initiative 2.5: Improve the credibility, value of services provided by the LTCOP.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Develop a Consumer Choice Website.</li> </ul>
<ul style="list-style-type: none"> <li>• Revise Monitoring and Assessment Tool.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to provide up-to-date training sessions for Ombudsmen.</li> </ul>
<ul style="list-style-type: none"> <li>• Maintain the Long-Term Care Advisory Group.</li> </ul>

<b>Performance Measures</b>
Establish regional fatality review teams active in each planning and service area in the State, with rosters that reflect participation by multi-disciplinary professionals. Representation from each active regional fatality review team reflected on the roster of the statewide fatality review team Advisory Council.
Develop statewide annual report data, compiled from aggregate data and recommendations of regional fatality review teams to develop education, prevention, prosecution, or other strategies, designed to improve coordination of services.
Request bi-annual reports from the Department of Financial and Professional Regulation, providing aggregate statistics on the required bank training programs.
Request training rosters submitted from completed B*SAFE on-site trainings.
Develop sample communication delivered to customers of utility and electric companies serving Illinois residents.
Develop Illinois Family Violence Coordinating Councils' model protocols and training curricula.
Expand statewide data collection elements, which result from enhanced assessment and measurement of progress toward case plan goals.
Review annual program case review results that reflect caseworkers' improved holistic assessments, and include active participation by victims in development of goals.
Review annual program case review results that reflect an increase in providers' understanding of the perpetrator's relationship with the victim throughout the case.
Review outcomes at case closure that reflect mitigated risk to the victim.
Review annual program data that reflects better outcomes for victims, through a reduction in subsequent intake reports.
Track increased service provision to individuals age 60 or older or adults with disabilities age 18-59 who self-neglect.
Develop statewide annual report data, compiled from aggregate data and recommendations of regional fatality review teams to develop education, prevention, prosecution, or other strategies, designed to improve coordination of services.
Revise the State Rules to incorporate the Long Term Care Ombudsman Program (LTCOP) expansion and the new Federal Rules.
Revise the Illinois Long-Term Care Policies and Procedures to incorporate the new Federal Rules, strengthening the independence of the program and clarifying programmatic and individual conflicts of interest.
Develop M-Team best practices for Regional Ombudsmen to discuss difficult cases with an experienced group of professionals from various areas of long-term care.
Develop a portal within the Consumer Choice and Ombudsman Resources Center website to allow all staff Ombudsmen to access current documents, rules, policies and procedures, policy clarifications, training materials and opportunities for training as well as an Ombudsman calendar of events.
Track the Long-Term Care Ombudsman program benchmarks.
Require Regional LTOPs to maintain or surpass 43 closed cases for every 1,000 beds.
Require Regional LTOPs to maintain or surpass 135 consultations to individuals for every 1,000 beds.
Track ombudsman data related to complaints and assistance with accessing community-based services.
Collaborate with Equip for Equality and other interested parties to tighten legislation on involuntary discharges.

Develop two separate brochures and posters – one for individuals receiving services under a managed care organization and are in the MMAI demonstration and the other for individuals receiving services under a waiver. Translate the posters and brochures into several different languages.
Develop the Consumer Choice Website for consumers seeking information regarding long-term care facilities. LTC facility management will complete a long questionnaire and will become “verified” by the State Ombudsman to be included in the website. From those questions, consumers can search for facilities based on the desires and or needs of the consumer. Within the website there will be a portal only for Ombudsmen use that includes updated forms, information, and events.
Revise the Monitoring and Assessment Tool to add compliance measures related to the new Federal and State Rules as well as the updated Illinois State LTCOP Policies and Procedures. This tool will be used by the State Office to determine the strength and needs of Regional Programs and provider agencies as well as the AAA involvement with the Regional Programs. Particular attention will be made to organizational and individual conflicts of interest.
Develop on-going training for the LTOP certification process as well as after post-certification.
Track performance of the deliverables of the MFP Grant through benchmarks and monthly reports of activities.
Develop benchmarks on MMAI cases, inquires and community education sessions.
Develop benchmarks for the expansion of Ombudsman waiver services.
<b>Priority 3: Sustain and expand the community-based Aging Network in anticipation of future growth.</b>
<b>Initiative 3.1: Sustain and maximize use of Medicaid waivers to leverage improved Federal Financial Participation for home and community-based services.</b>
<b>Strategies</b>
<ul style="list-style-type: none"> <li>Require that all CCP enroll in Medicaid or apply (non-Medicaid eligible clients will be enrolled in Community Reinvestment Program (CRP).</li> </ul>
<b>Initiative 3.2: Provide an alternative community-based program for older adults in Illinois that do not meet the CCP requirements but choose to receive services in their home and delay institutionalization.</b>
<b>Strategies</b>
<ul style="list-style-type: none"> <li>Collaborate with other State Agencies and the Lewin Group and work with piloting and implementation for the UAT levels 1 and 2.</li> <li>Complete the design and implementation of the Community Reinvestment Program (CRP) and work on the improvement of accessibility to Public Benefits for those eligible.</li> <li>Partner with 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 homes for short term stays can return to the community.</li> <li>Complete the design and implementation of the Community Reinvestment Program (CRP) and work on the improvement of accessibility to public benefits for those eligible.</li> <li>Work with the Older Adults Services Advisory Committee (OASAC) Evaluation workgroup to establish evaluation criteria for CRP. Collect data to demonstrate effectiveness of CRP in delaying premature institutionalization of participants.</li> </ul>

**Initiative 3.3: Sustain the implementation and expansion of Managed Long Term Care Services and Supports through Managed Care Organizations.**

**Strategies**

- Collaborate with the Departments of Healthcare and Family Services (HFS) and Human Services to implement Public Act 96-1501 (i.e., long term care rebalancing) to move eligible recipients for comprehensive medical benefits across LTC programs to risk-based integrated care options.
- Continue to provide technical assistance through the BEAM unit to MCOs, providers and Care Coordination Units (CCUs) to facilitate transfers between managed care and waiver programs.
- Provide specialized trainings to MCO staff as issues arise.
- Continue to work with the Regional LTC Ombudsman Programs to advocate on behalf of individuals receiving MCO services with the MMAI program. There are 10 Regional Ombudsman Programs that are in the MMAI service areas.
- Continue work with Regional LTC Ombudsman Programs to provide community education sessions to inform the public as well as stakeholders about the role of the Managed Care Ombudsman Program.
- Collaborate with the Regional LTC Ombudsman Programs, federal ACL as well as HFS to coordinate plans for better delivery of MCO services from every viewpoint.
- Work with Regional LTC Ombudsman Program to communicate care and system concerns to managed care organizations and federal and state agencies.

**Initiative 3.4: Acquire grants to improve long term care options for older adults, and identify new opportunities for the Aging Network.**

**Strategies**

- Assess areas and internal customer service gaps to improve efficiency of the grant management functions and processes.
- Identify available grants and advise Aging Network of partnership opportunities to enhance programs and services for older adults and caregivers.
- Apply for grant opportunities and develop relationships with social services, academic or other reputable organizations to identify research and demonstration project opportunities and collaborative partnerships to plan, administer, evaluate, and/or improve long term care services.
- Work with AAAs and service providers to strengthen their grant writing skills.

**Initiative 3.5: Implement Person-Center Planning on a statewide basis at all NWD sites.**

**Strategies**

- Comply with the federal HCBS Medicaid Waiver requirements specific to person-centered planning (PCP). Issue person-centered planning survey to Aging Network to determine existing gaps in PCP process. Review data from survey results to incorporate into PCP training. Add language to Elderly Waiver, CCP and CRP administrative rules, policies, training materials to ensure compliance with PCP requirements.
- Collaborate with other State Agencies and the Lewin Group, work with piloting and implementation for the UAT levels 1 and 2.
- Increase and expand NWD site staff capacity across organizations to provide one-on-one counseling using person-centered counseling for all populations.

<ul style="list-style-type: none"> <li>• Partner with 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 homes for short term stays can return to the community.</li> </ul>
<ul style="list-style-type: none"> <li>• Increase capacity of NWD sites to support private pay individuals through person-centered counseling processes to make best use of existing resources and access private services.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop standardized “toolkit” of resources, processes, formal guidance, and performance expectations to make available to all NWD sites providing person-centered counseling.</li> </ul>
<ul style="list-style-type: none"> <li>• Work with CLESE to develop and implement person-centered counseling principles for assessing and developing care plans for individuals with Limited English Speaking abilities.</li> </ul>
<p><b>Initiative 3.6: Maintain active involvement in the Veteran-Directed Home and Community Based Services Program, and promote and collaborate to expand the initiative.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Require additional and ongoing funding to maintain the Veteran-Directed home and community-based services.</li> </ul>
<ul style="list-style-type: none"> <li>• Identify potential Fiscal Management Service (FMS) providers in Illinois and assist Area Agencies on Aging with the procurement of FMS agreements for VIP.</li> </ul>
<ul style="list-style-type: none"> <li>• Partner with the Illinois Department of Veterans Affairs to develop strategies to increase the Aging Network's awareness of veterans' benefits and the utilization of benefits among the State's Veteran population.</li> </ul>
<p><b>Initiative 3.7: Administer the Benefit Access Program and improve public benefit outreach to older adults and persons with disabilities through the Aging Network.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Analyze ways to continue to simplify online enrollment in the 2-year rolling application for the Benefit Access Program, and continue collaborations with additional outside entities regarding electronic receipt of application data.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with the Area Agencies on Aging to maintain work performance targets by service area for participating Senior Health Insurance Program and Senior Health Assistance Program sites.</li> </ul>
<p><b>Initiative 3.8: Continue to expand Senior Health Insurance Program and Senior Health Assistance Program outreach to include the Benefit Access Program and all Medicare programs.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Continue to expand 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.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with Make Medicare Work Coalition, Latino Outreach Network, Centers for Independent Living, faith-based organizations, Coalition of Limited English Speaking Elderly (CLESE), Family Caregiver Resource Centers, federally qualified health centers and other organizations on scheduling enrollment events to provide one-on-one counseling.</li> </ul>

<b>Initiative 3.9: Ensure adequate program efficiency measures and streamlined access to sustainable public benefits.</b>
<b>Strategies</b>
<ul style="list-style-type: none"> <li>• 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.</li> </ul>
<b>Performance Measures</b>
Implement Level 1 Screening Tool and UAT.
Submit rules to JCAR, continue program development and obtain budget approval.
Work with HHS transformation workgroup timelines.
Coordinate with CCU's the completion of Medicaid applications for all CCP clients and coordinate transfer to CRP for Non-Medicaid clients.
Participate in ongoing National calls and provide Technical Assistance to AAA's as needed.
Coordinate with AAA's to select a new FMS provider.
Participate in periodic calls with AAA's to discuss outreach activities in efforts to expand the program.
Track # of BAA applications deemed eligible without attachments or staff review.
Track # of BAA applications deemed eligible with attachments and staff review.
Track # of Medicare beneficiaries assisted with Medicare Part D enrollments.
Track # of Medicare beneficiaries assisted through one-on-one counseling.
Track # of Medicare beneficiaries that are limited English speaking assisted with Medicare Part D enrollments.
Track # of Medicare beneficiaries that are limited English speaking assisted through one-on-one counseling.
Track performance measure used by ACL via National Performance Reporting (NPR) [total client contacts, total public and media events/audience reached, total low income beneficiaries counselled, total Medicare disabled beneficiaries counselled, client contact made - less than 10 minutes in duration, substantial client contact – over 10 minutes in duration, total enrollments (all), total Medicare Part D enrollments].
<b>Priority 4: Promote Healthy Aging and Family Support to increase Prevention Services</b>
<b>Initiative 4.1: Promote healthy and active lifestyles among older adults</b>
<b>Strategies:</b>
<ul style="list-style-type: none"> <li>• Promote health and wellness programs through senior centers, hospitals, health clubs and YWCA/YMCA to increase physical activity and improve nutrition.</li> </ul>
<ul style="list-style-type: none"> <li>• Partner with Senior Olympics to expand on health and volunteer opportunities for Senior Corps Programs.</li> </ul>
<ul style="list-style-type: none"> <li>• Partner with Senior Olympics, senior centers, hospitals, health clubs and YWCA/YMCA to increase physical activity and improve nutrition for Senior Corps Programs.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide nutrition education by licensed dietitian during annual training as it relates to the adult meal pattern requirements of USDA for the Child and Adult Care Food Program.</li> </ul>
<ul style="list-style-type: none"> <li>• Advocate for increased federal state administrative expense funds to support nutrition education training expenses to promote increased fruits &amp; vegetables (dependent upon pending meal pattern changes) and healthier choices for snacks.</li> </ul>
<ul style="list-style-type: none"> <li>• Evaluate activities at the time of the review to identify if exercise is included on a daily or a weekly basis of adult day service (ADS) clients.</li> </ul>

<ul style="list-style-type: none"> <li>• Continue to expand outreach opportunities including informative exhibits and free health screenings for older adults.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with Medicare programs to continue to encourage older adults to participate in preventive service options and to continue to counsel older adults on Medicare preventive services.</li> </ul>
<ul style="list-style-type: none"> <li>• Conduct an evaluation of the provision of Title III-D and Title III-B evidence-based health promotion programs (that comply with the Highest-Level Criteria) in the 13 Planning and Service Areas (PSA).</li> </ul>
<ul style="list-style-type: none"> <li>• Explore and implement evidence-based and consumer-directed caregiver health promotion programs and best practices.</li> </ul>
<ul style="list-style-type: none"> <li>• Work with the Department of Human Services (DHS), Area Agencies on Aging (AAAs), Aging Network service providers and Local County Public Health agencies on the Senior Farmers Market Nutrition Program (SFMNP).</li> </ul>
<p><b>Initiative 4.2: Expand employment, volunteer and training opportunities for older adults in the private and public sectors.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Continue to meet existing Senior Community Service Employment Program (SCSEP) performance measures in addition to new measures established by the U.S. Department of Labor.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to evaluate whether regional SCSEP Grantees are meeting placement goals on a quarterly basis.</li> </ul>
<ul style="list-style-type: none"> <li>• Coordinate with the SCSEP National Contractors to achieve optimal equitable distribution of authorized SCSEP slots allocated annually by the U.S. Department of Labor.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with Local Workforce Investment Area Boards, Illinois Department of Employment Security (IDES) offices, Comprehensive (and satellite) One-Stop Centers, and Veteran offices to promote employment opportunities for older adults.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop and implement a new SCSEP State Plan per the U.S. Department of Labor requirements (every four years).</li> </ul>
<ul style="list-style-type: none"> <li>• Coordinate with the Workforce Innovation and Opportunity Act (WIOA) to enhance SCSEP services to the older worker.</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with the sixteen (16) partner programs under WIOA to ensure older workers are targeted and have access to services under WIOA, specifically available at the Comprehensive and Satellite One-Stop Centers.</li> </ul>
<ul style="list-style-type: none"> <li>• Serve on the WIOA State Interagency Work Group and represent the SCSEP program, older workers, and IDoA.</li> </ul>
<ul style="list-style-type: none"> <li>• Coordinate with activities with the Illinois JobLink system, a web-based job search and training resource developed and managed by Illinois Department of Employment Security (IDES).</li> </ul>
<ul style="list-style-type: none"> <li>• Coordinate with IDES and obtain administrative access (as applicable) for regional SCSEP Grantees and obtain an Inter-Agency Agreement (SDA).</li> </ul>
<ul style="list-style-type: none"> <li>• Continue collaboration with the Federal Corporation for National and Community Service (CNCS) to provide Senior Companion, RSVP and FGP services.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue collaboration with the Federal Corporation for National and Community Service (CNCS) to provide and expand Senior Companion volunteer opportunities for low income seniors over the age of 60.</li> </ul>

<b>Performance Measures:</b>
Track # of older adults assisted with Medicare Part D enrollments.
Track # of older adults assisted with Medicare Savings Program applications.
Track # of older adults assisted with Extra Help applications.
Track # of older adults educated about Medicare prevention benefits.
Track # of older adults reported participating in physical exercise/activity.
Track # of volunteer opportunities for Senior Corps Programs to assist with Senior Olympics.
Track # of older adults participating in the Senior Farmers Market Nutrition Program (SFMNP).
Track # of low income seniors and minorities educated about healthy eating.
Expand Senior Farmers Market Program to serve at least one county in each planning and service area (PSA)
Assist interested AAAs to apply for federal demonstration grant opportunities to develop evidence-based health promotion programs for Caregivers and Grandparents Raising Grandchildren.
Track # of participants enrolled in SCP.
Track # of older adults enrolled in RSVP and FGP.
Track # of older adults enrolled in SCSEP.
Track % of SCSEP participants entering unsubsidized employment.
Track # of partnerships with the Comprehensive and/or Satellite One-Stop Centers.
Track # of current MOU Agreements and identify the applicable MOUs in the 25 Local Workforce Investment Areas (citing Comprehensive One-Stop Centers only).
Track # of older workers who were provided services at the Comprehensive and/or Satellite One-Stop Centers.
Track # of referrals made to the Comprehensive and/or Satellite One-Stop Centers.
Track # of SCSEP participants accessing the IL JobLink system.
Track # of SCSEP active job searches conducted in the IL JobLink system.
Track # of SCSEP participants who achieved successful employment through the IL JobLink system.
Track # of individuals who attended outreach events that included IDoA participation.
Track # of individuals who attend SHIP sponsored events.
<b>Priority 5: Implement quality assurance mechanisms and promote accountability for the services provided to the aging network.</b>
<b>Initiative 5.1: Improve IDoA's information technology infrastructure and data collection and reporting capabilities.</b>
<b>Strategies:</b>
<ul style="list-style-type: none"> <li>• Complete Medicaid waiver reporting requirements and provide access to CCC/CCP forms through a web-based system.</li> <li>• Emphasize and encourage importance of the federal NPR reporting system in order to track client contacts related to SHAP/MIPPA and SHIP.</li> <li>• Consolidate all reporting requirements and use the NPR system as the primary method of reporting SHIP, SHAP and MIPPA activities.</li> <li>• Provide the Aging Network a searchable database that includes an array of client information. This will provide efficiency for IDoA and the Aging Network.</li> <li>• Provide a database that will allow providers to upload case file information that will enable the IDoA to expand its ability to compile reportable data and statistics.</li> </ul>

<ul style="list-style-type: none"> <li>• Ensure required data collected to date is analyzed and feedback and compliance measures are provided to each Care Coordination Unit.</li> </ul>
<ul style="list-style-type: none"> <li>• Develop a centralized web-based grants management and reporting system for Older Americans Act and related services</li> </ul>
<p><b>Initiative 5.2: Ensure timely determination of provider reviews and client appeals, and management of client services to ensure effective operations and good customer service.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Create an improved system for reporting critical incidents that will include a status tracking system for incidents and responses.</li> </ul>
<ul style="list-style-type: none"> <li>• Restructure the Office of Community Care System to provide a progressive monitoring system for provider reviews.</li> </ul>
<ul style="list-style-type: none"> <li>• Maintain a tracking system for the annual status calls to each CCU as required by rule.</li> </ul>
<ul style="list-style-type: none"> <li>• Establish an evaluation process for the Electronic Verification System (EVV) for CCP in-home service to ensure appropriate delivery and utilization of service hours.</li> </ul>
<p><b>Initiative 5.3: Provide innovative online training options to the Aging Network and other staff development opportunities.</b></p>
<p><b>Strategies</b></p>
<ul style="list-style-type: none"> <li>• Provide up-to-date information on current and new IDoA programs to the Aging Network.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to research websites for additional program information.</li> </ul>
<ul style="list-style-type: none"> <li>• Provide on-line training for the Aging Network and IDoA staff for certification or re-certification.</li> </ul>
<ul style="list-style-type: none"> <li>• Continue to work with Central Management Services (CMS) to provide DVDs and webinars for continued education for the Aging Network.</li> </ul>
<ul style="list-style-type: none"> <li>• Work closely with other divisions to meet their needs for training and information.</li> </ul>
<ul style="list-style-type: none"> <li>• Work closely with other state agencies to provide training for the educational needs of the Aging Network and IDoA staff.</li> </ul>
<p><b>Initiative 5.4: Develop and maintain performance objectives and targets for providers and grantees that are aligned to IDoA's strategic priorities.</b></p>
<p><b>Strategies:</b></p>
<ul style="list-style-type: none"> <li>• Work with Governor's Office of Management and Budget (GOMB) and other state agencies to maintain quality performance measures and Budgeting for Outcome indicators for LTC services.</li> </ul>
<ul style="list-style-type: none"> <li>• Establish standards of quality for CCP consistent with federal Centers for Medicare and Medicaid Services (CMS) guidelines and ensure related quality assurance monitoring activities by the Department.</li> </ul>
<ul style="list-style-type: none"> <li>• Work with the Illinois Older Adult Services Advisory Committee, Illinois CCU Council, CCPAC and other stakeholders to periodically report and/or monitor policy proposals and service outcomes.</li> </ul>
<ul style="list-style-type: none"> <li>• Maintain quality reporting of service efforts and accomplishments and a strong commitment to transparency (through mechanisms which include the Public Accountability Report, AAAs Area Plans, and Annual Reports, among other means).</li> </ul>
<ul style="list-style-type: none"> <li>• Analyze data that is compiled in the new database to ensure performance objectives are being met by all CCUs and providers. Establish corrective actions for findings.</li> </ul>

**Initiative 5.5: Maintain current statewide contingency plans and training events to respond to disaster declarations and client access to services.**

**Strategies**

- Partner with IEMA, the American Red Cross (ARC) and the Department of Public Health (IDPH) to access available, ongoing disaster training for the 13 AAAs annually.
- Coordinate with the ARC and IEMA to develop a “Mutual Aid” agreement with I4A so they can assist other AAAs in Illinois that need assistance with disaster situations.
- Coordinate with ARC and IDPH to train AAAs and their service providers about FNSS and how to effectively incorporate these services in their disaster plans.
- Evaluate the AAAs’ current disaster plans to assure that they will assist the ARC in assessing the functional needs of evacuees.
- Partner with IEMA, the American Red Cross (ARC) and the Department of Public Health to access available, ongoing disaster training for Senior Corps Programs annually.

**Initiative 5.6: Conduct periodic rate and other cost efficiency studies of home and community-based services.**

**Strategies**

- Conduct rate study on home delivered meals in Illinois.
- Conduct an evaluation on the CRP program.

**Initiative 5.7: Implement the Grant Accountability and Transparency Act (GATA) per the requirements of the Governor’s Office of Management and Budget.**

- Verify GATA pre-qualification requirements of grantees.
- Use the uniform grant application and uniform grant agreement.
- Conduct training of Aging Network grantees on GATA.
- Conduct merit based reviews of grant applications per GATA requirements.
- Develop performance measures for all grants.

**Performance Measures**

- Address Quality Assurance (QA) goals in waiver as identified.
- Conduct rate study in FY 17 to determine actual cost of providing home delivered meals (HDM).
- Use information from the HDM rate study in development of FY 18 state budget proposal.
- Conduct training sessions for the AAAs and their service providers to be provided by IEMA, Illinois Department of Public Health and the ARC locally.
- Facilitate and work with the ARC to organize and provide PSA-wide training with the AAAs and their service providers to assess the functional needs of evacuees in ARC shelters.
- Enter into an inter-agency mutual aid agreement with IEMA, ARC, and I4A.
- Conduct training sessions for Senior Corps to be provided by IEMA, IDPH and the ARC locally.
- Track # of new users added to the NPR system with permissions to enter client contacts.
- Track # of client contacts entered into the NPR system.
- Provide an updated CCP manual to all CCUs and providers.
- Update the CCP training materials and provide updated training to all CCUs and providers.
- Implement new department initiatives and wavier requirements into training materials.
- Generate performance reports from the Training Tracker system.
- Meet required timeline for reviews as required per grant cycle.
- Produce reports to show more accurate participant documentation to determine trends in multiple demographics.
- Provide accurate analyses of improved quality assurance measures.

# THE AGING NETWORK IN ILLINOIS

## THE ILLINOIS DEPARTMENT ON AGING

The Illinois Department on Aging was created by the State Legislature in 1973 for the purpose of improving the quality of life for Illinois' senior citizens by coordinating programs and services enabling older persons to preserve their independence as long as possible. It is the single State agency in Illinois authorized to receive and dispense Federal Older Americans Act funds, as well as specific State funds, through Area Agencies on Aging and community-based service providers.

The legislative mandate of the Illinois Department on Aging is to provide a comprehensive and coordinated service system for the State's approximately 2.5 million older persons, giving high priority to those in greatest need; to conduct studies and research into the needs and problems of the elderly; and to ensure participation by older persons in the planning and operation of all phases of the system. In fulfilling its mission, the Department on Aging responds to the dynamic needs of society's aging population through a variety of activities including:

- Planning, implementing and monitoring integrated service systems;
- Coordinating and assisting the efforts of local community agencies;
- Advocating for the needs of the State's elderly population; and
- Cooperating with Federal, State, local and other agencies of government in developing programs and initiatives.

The Illinois Department on Aging's administrative structure reflects the major areas of activity required to fulfill the agency's legislative mandate and overall mission. In addition to the Executive Office, the other organizational units in the Department are the Division of Community Relations and Outreach, the Division of Finance and Administration, the Division of Information Technology, the Division of Planning, Research & Development, the Division of Home and Community Services and the Division of Transition & Community Relations.

The **Executive Office** provides leadership in administering Department programs and is responsible for implementing the Department's strategic plan. The Executive Office consists of five administrative support units: the Offices of General Counsel, Legislative Affairs, Chief Internal Auditor, Public Information, and Human Resources. Along with developing strategic objectives and policies on quality long-term care and other health care needs, the Executive Office serves as an advocate on behalf of seniors and their caregivers to the state and federal governments, as well as providers and advocates comprising the Aging Network.

The **Division of Planning, Research and Development** is responsible for monitoring and analyzing the Community Care Program utilization and spending, overseeing the implementation of quality improvement strategies and compliance with Medicaid waiver regulations, and leading the Department's efforts to reform long-term-care. Specific areas of responsibility include: forecasting and cost analysis; strategic planning and performance metric reporting; program design and evaluation; and managing the overall Home and Community Based Service Medicaid waiver for the Community Care Program. The Division is also charged

with the development and monitoring of demonstration projects that test alternative home and community based service delivery models, maintaining public and private partnerships, identifying private and government funding opportunities for new programs and services, and working collaboratively with Department staff and external stakeholders to respond to funding opportunities.

The **Division of Home and Community Services** is responsible for all field and administrative support functions for the Department's Community Care Program, Older Americans Act services and other state funded services. These programs include: homemaker, adult day service and case management services, as well as information and assistance, transportation, home-delivered meals, congregate meals, support to senior centers and other services mandated under Title III and Title VII of the federal Older Americans Act. The Division works to protect the rights of older adults through the Office of Adult Protective Services and the Office of the State LTC Ombudsman. This Division also includes the Office of Training and Development, which provides programmatic and technical training to case coordination units, Department staff and members of the Aging Network throughout the state.

The **Division of Finance and Administration** reaches all areas of the Department providing needed internal support for carrying out the day-to-day internal functions of the Department such as preparing and monitoring the annual budget, processing procurement agreements in accordance with the Illinois Procurement Code, maintaining the Department's equipment inventory and vehicles, and performs a variety of fiscal and accounting duties including preparing payroll, working with auditors and completing a variety of reports to the federal government and other state agencies.

The **Division of Community Relations and Outreach** develops and carries out the Department's statewide information, education and advocacy initiatives; plans and oversees statewide events that educate the public and the Aging network about programs and services that affect older adults and their families by promoting the Department's mission; directs and oversees all assistance and advocacy performed by the Senior Helpline through its toll-free call center. The Division designs marketing strategies for special projects; develops and implements outreach efforts at the Illinois State Fair, health fairs and other special events. Additionally, the Senior Health Insurance Program (SHIP) provides free statewide health insurance confidential counseling and advocacy for Medicare beneficiaries relating to Medicare, private health insurance and related health plans as well as outreach efforts to pre-retirees, Medicare beneficiaries and caregivers. SHIP activities align with IDoA's mission to help older adults and persons with disabilities maintain their health and independence while remaining in their homes and communities.

The **Division of Benefits, Eligibility Assistance & Monitoring** administers the Benefit Access Program. The Benefit Access Program offers a license plate discount through the Secretary of State's office and free transit rides for Seniors and Persons with Disabilities through local transit authorities. The Division provides technical assistance advisement to CCP and managed care organizations and program monitoring and fraud prevention.

The **Division of Information Technology (DIT)** is responsible for the support of all Illinois Department on Aging information systems and technology. This support includes the maintenance and upkeep of all current and legacy systems and the development and/or deployment of any new systems that are approved by IDoA Management. DIT is also responsible for all data transfers between all HHS sister agencies and non-HHS Illinois State

agencies. DIT is also responsible for creating and deploying all requested reporting that is needed to support the Agency and the Aging Network.

The **Division of Transitions and Community Relations** was established in January 2014 to expedite the implementation of the Colbert Consent Decree. The Office uses a collaborative and community-based approach to transition Colbert Class members living in nursing facilities to an integrated and least restrictive environment. Colbert Class members are then provided with services and supports that are necessary to live independently in the community. The Office is responsible for monitoring and evaluating the development and implementation of this innovative service delivery system which combines the services of health including mental health, housing and social services. As the number of Class Members living independently increases, the Office will ensure that there are adequate post transition services and supports to stabilize the Class Member. The Office will also identify any necessary regulatory changes that govern nursing facility residents and to enhance the quality of life of nursing home residents as well as provide effective oversight and enforcement of all applicable regulations and laws.

### **ILLINOIS COUNCIL ON AGING**

The Illinois Act on the Aging mandates that the Department on Aging establish and maintain a state level advisory body to concern itself with supporting the well-being of senior citizens in Illinois. The Illinois Council on Aging was created to promote advocacy on behalf of senior citizens in response to the Illinois Act on the Aging. The Council works with the Director of the Illinois Department on Aging, as well as Area Agencies on Aging, service providers, and advocate groups to help improve the lives of senior citizens. The Council also provides guidance to the Governor and the General Assembly by advising them on the concerns, problems, and services provided to the elderly in our State.

Duties of the Illinois Council on Aging, as specified in State law, include review and comment on the State Plan on Aging prepared by the Department; review and comment on disbursement by the Department of public funds to provider agencies; preparation and submittal to the Governor, the General Assembly, and to the Director an annual report on programs and services for the elderly; recommending candidates to the Governor for the appointment of the Director for the Department on Aging; consulting with the Director regarding operations of the Department; and conducting public hearings and generally representing the interests of older persons in Illinois.

Twenty-three citizen members on the Council are chosen by the Governor. They represent all parts of the State and reflect the economic, ethnic, sexual, racial, rural and urban characteristics of the people age 60 years and older in Illinois. Of these men and women, the majority are over the age of 60.

Eight additional Legislative members representing the Illinois Senate and House serve on the Council. These members are appointed by the President of the Senate and Speaker of the House, respectively.

### **AREA AGENCIES ON AGING**

The State of Illinois is divided into 13 Planning and Service Areas (PSAs). There is one Area Agency on Aging designated by the Department on Aging located within each Planning and Service Area. In Illinois, twelve (12) not-for-profit agencies and one unit of local government (city of Chicago) serve as Area Agencies on Aging. Each Area Agency on Aging is responsible for planning, coordinating, and advocating for the development of a comprehensive and

coordinated system of services for the elderly and caregivers within the boundaries of the individual Planning and Service Area.

The Illinois Department on Aging, in accordance with the Older Americans Act, has decentralized the planning process by delegating planning responsibilities to the Area Agencies on Aging. This assures that programs developed by, and services funded by, the Area Agencies on Aging are integrated into the three-year planning cycle followed by the Department on Aging. This cycle begins with an assessment of the needs of local older adults, family caregivers and grandparents raising grandchildren for services. Through a process of public hearings, surveys, research and the assistance of the Area Agencies' advisory councils, these needs are ranked in order of importance and matched with available resources.

The proposed funding distribution, budget, and other planning information are then incorporated into an Area Plan on Aging following a format prepared by the Department on Aging. Also, included in the plan is an outline of proposed Area Agency on Aging activities for the coming years. Following public hearings on the proposed Area Plan, the Plan is submitted to the Department on Aging for review and approval. Area Agencies on Aging are permitted to amend their Area Plans annually in response to changing needs, priorities and funds available. Federal Older Americans Act and State General Revenue funds are allocated to the Area Agencies on Aging upon approval of the Area Plan or Area Plan annual amendments by the Department on Aging.

The Area Agencies on Aging in Illinois are not, as a rule, direct service providers. They contract with local providers for services that have been identified as needs through the planning process. The Area Agencies on Aging are responsible for monitoring, evaluating, planning for services, and providing technical assistance as needed. In addition, the Area Agencies on Aging function as advocates for older persons and are the primary disseminators of information relating to aging issues within their respective Planning and Service Areas.

## **SERVICE PROVIDERS**

Community-based service providers represent a key segment of the Aging Network in Illinois because they provide the programs and direct services to older persons. The success that the Aging Network has had in linking older persons with needed services is one tangible result of cooperation and coordination between the Department, the Area Agencies on Aging and local service providers.

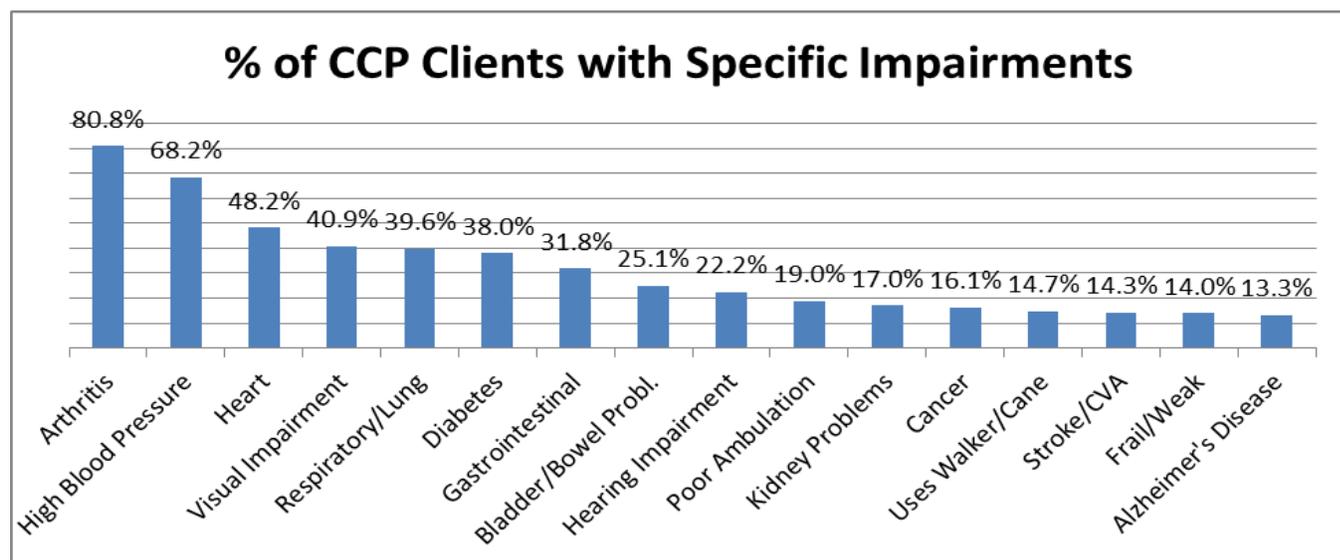
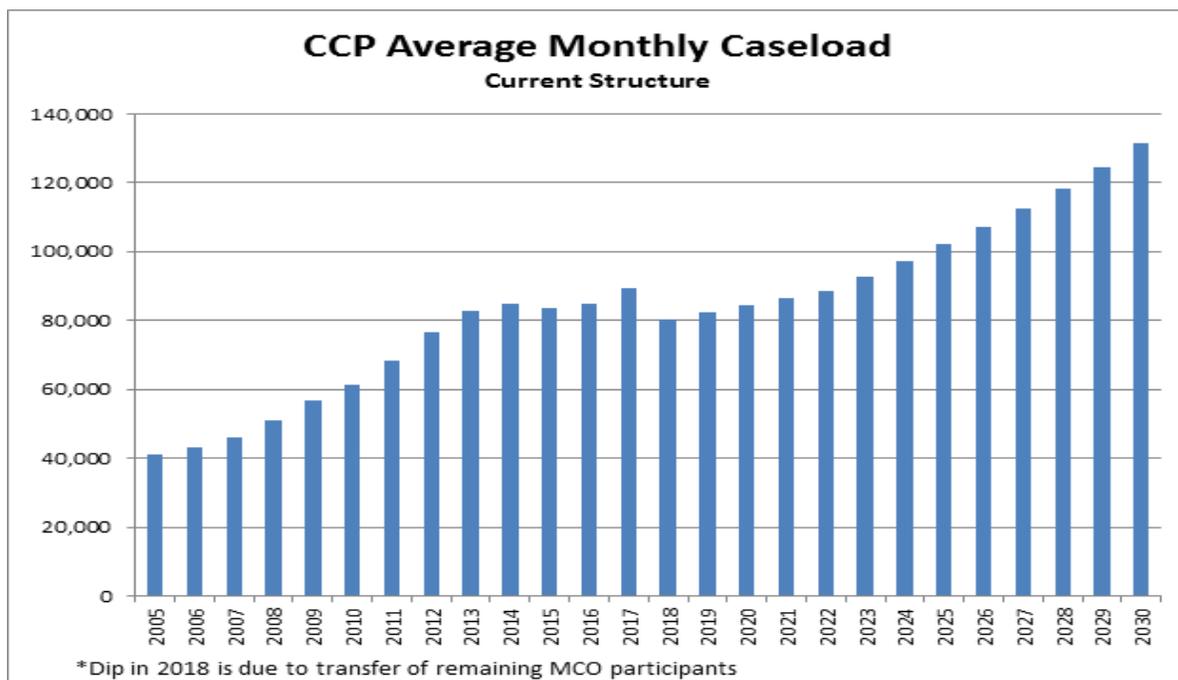
Care Coordination Units (CCUs), created in 1983, function as gatekeepers to the State long-term care system by coordinating and integrating community-based long-term care services available throughout the entire aging network for and on behalf of frail and vulnerable older persons. Approximately thirty-six (36) agencies, including senior centers, health departments, visiting nurse associations, and social service agencies, have been designated as Care Coordination Units (CCUs). Care managers, employed by CCUs, assess older persons' needs, determine eligibility for specified services, develop care plans with the consent of the older person and/or their family, coordinate service delivery and generally manage service needs on a regular basis. The CCUs are supported through a combination of State general revenue funds and Title III federal funds.

The direct service delivery system consists of agencies funded with Title III and State funds through the Area Agencies on Aging and through the Department on Aging with Community

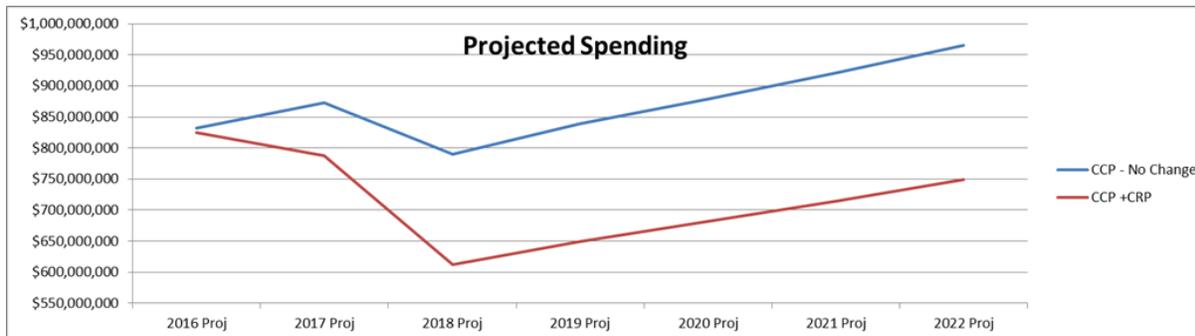
Care Program appropriations. Many agencies receive both Title III and Community Care Program funding.

## COMMUNITY CARE PROGRAM & COMMUNITY REINVESTMENT PROGRAM

Established in 1979 by Public Act 81-202, the Illinois Department on Aging's Community Care Program (CCP) helps senior citizens to remain in their own homes by providing in-home and community-based services. Enrollment in CCP has significantly grown over the past 10 years due to the aging of the population in Illinois. During FY 2016, it is estimated that more than 80,000 older adults will receive services through CCP. Services offered through CCP include case management, adult day service, emergency home response, and homemaker services.



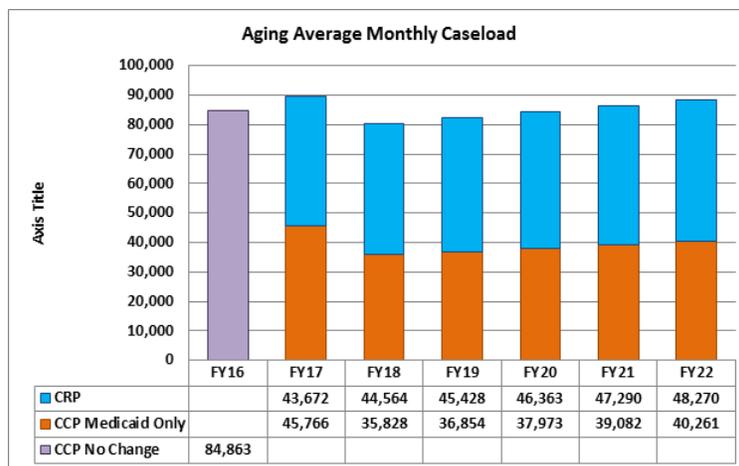
CCP provides the same level of services and supports to individuals aged 60 and over regardless of their Medicaid eligibility status. Sustaining CCP as it exists today will cost an additional \$93.3 million in the next six years assuming the completion of the managed care transition by FY 2018. This program design is no longer financially sustainable for the State of Illinois.



In FY 2017, the Department on Aging will transition individuals who are non-Medicaid eligible to a new Community Reinvestment Program (CRP). Similar to other states, the Department on Aging’s approach will maintain a service package for individuals that do not meet Medicaid eligibility requirements. The goals of CRP include the following:

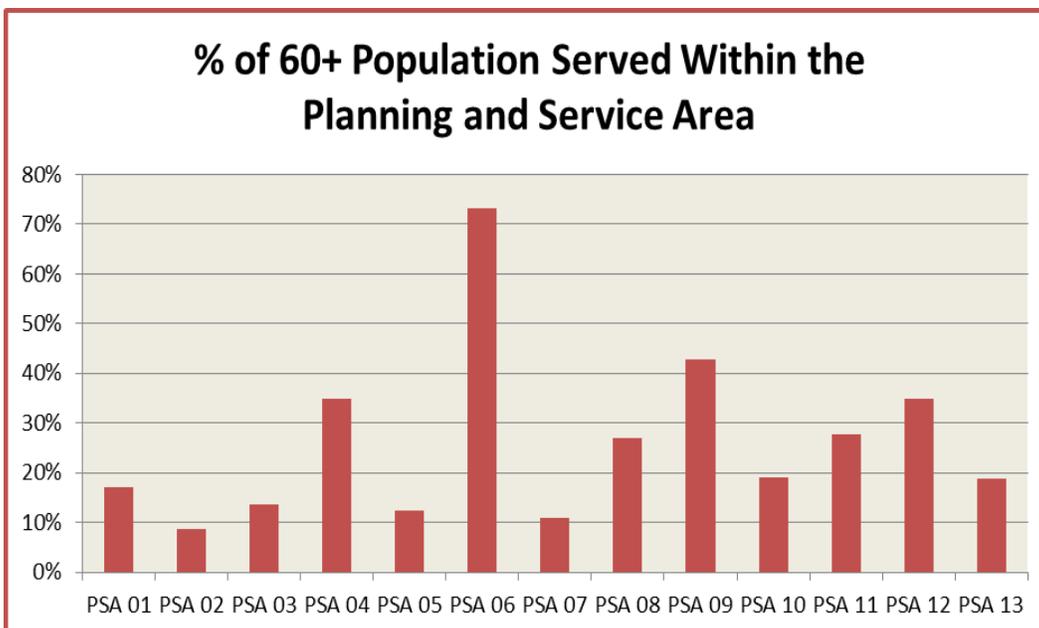
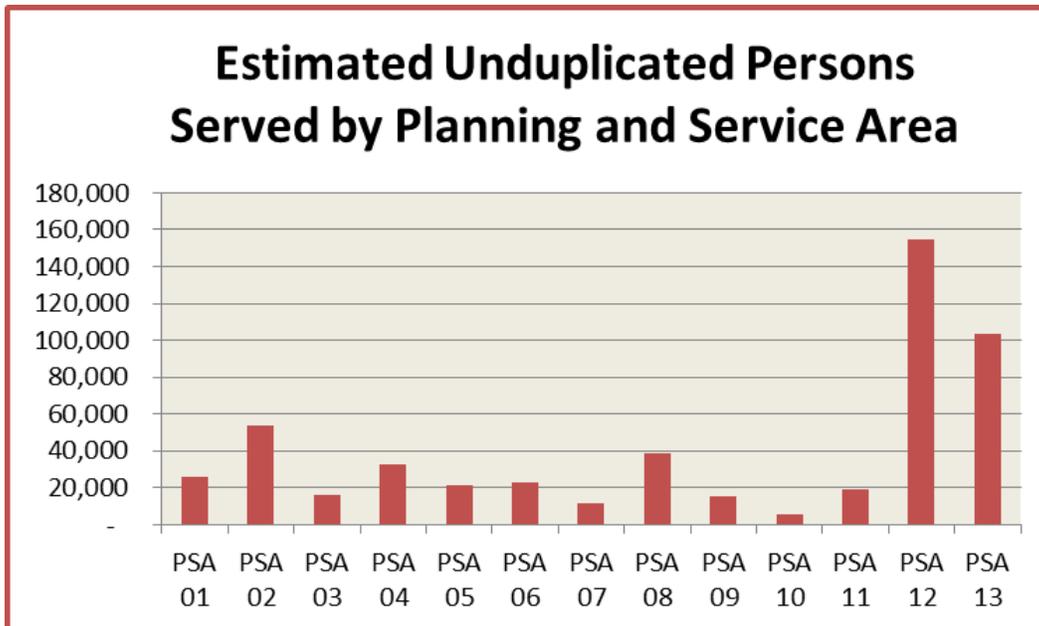
1. Sustaining core services and supports to individuals aged 60 and above who demonstrate a need, regardless of their Medicaid eligibility status.
2. Leveraging all available resources to reduce dependence on public funds.
3. Increasing flexibility in how services to older individuals are delivered.
4. Preventing early admission to institutional care as a result of community based services while supporting individuals to remain safely at home.

CRP will continue to utilize the strengths of the Aging Network for intake, eligibility determination, and development of care plans; care coordination; service delivery; and oversight of service provider agencies. Non-Medicaid eligible clients will have their Determination of Need (DON) score applied to a new service cost maximum table to derive a new individual spending allocation. CRP will provide greater flexibility of services, and the Area Agencies on Aging will be used as the regional administrative organizations for the coordination of services.



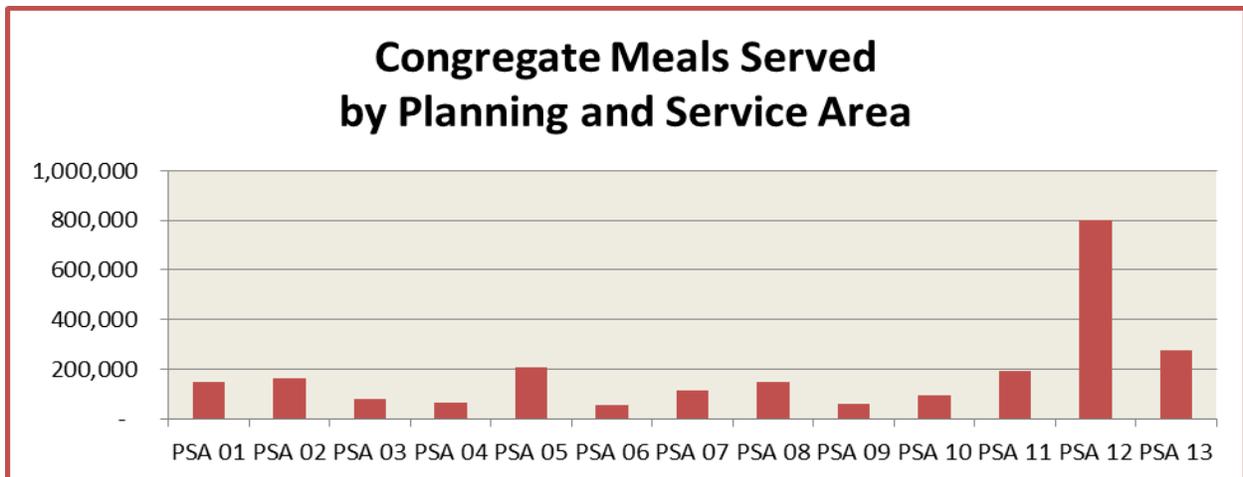
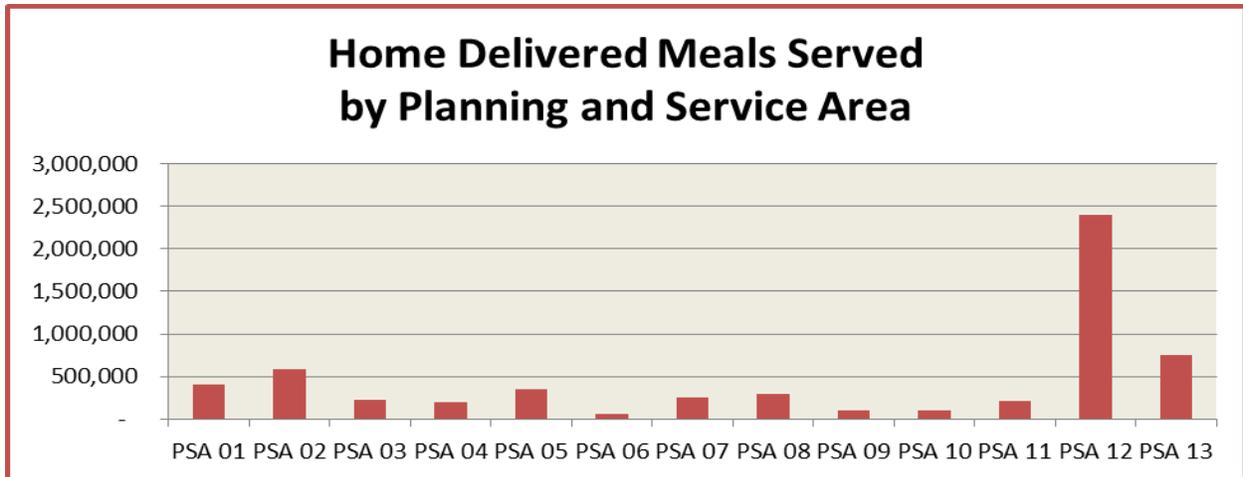
## OLDER AMERICANS ACT SERVICES

During FY 2015, it is estimated that approximately 240 service providers under Title III of the Older Americans Act served more than 521,450 older adults, family caregivers and grandparents raising grandchildren. These services include information and assistance, outreach, congregate meals, home delivered meals, transportation, legal assistance, respite care, home health, residential repair, senior center activities and health promotion and disease prevention. The following chart represents the number of persons served by Planning and Service Area in FY 2015. The second chart represents the percentage of age 60+ population served in each Planning and Service Area.

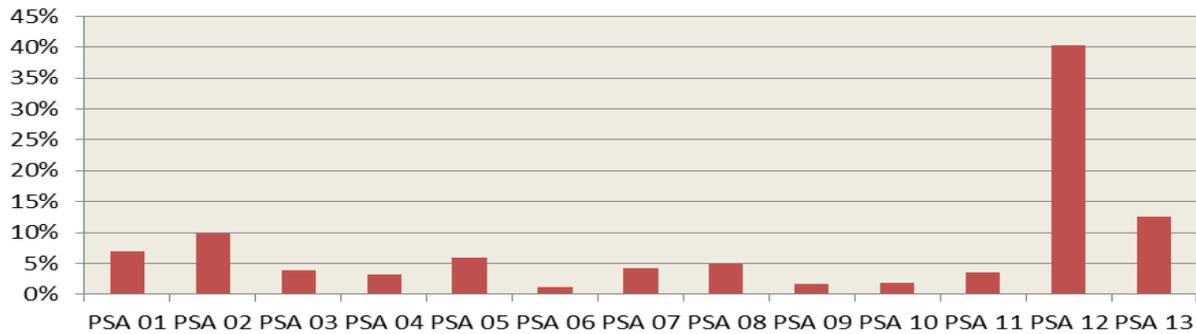


## Nutrition Services

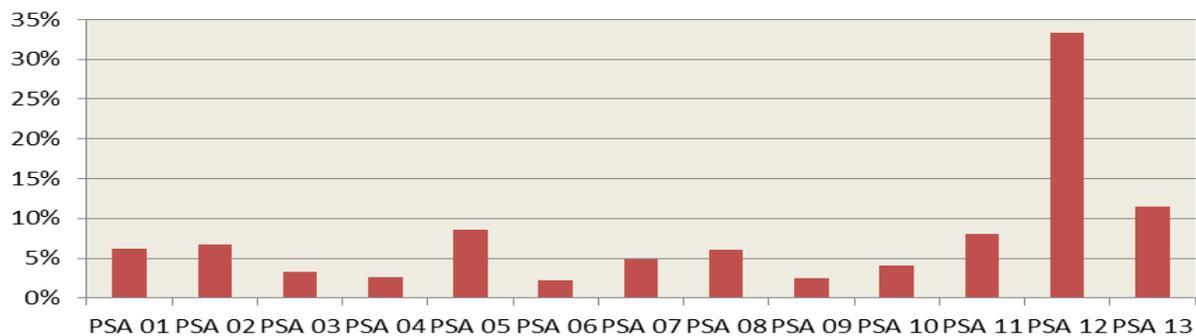
In FY 2015, more than 2.4 million congregate meals were served to approximately 82,940 older persons at 428 meal sites located throughout the State. Approximately 33,350 homebound elderly received an estimated 5.9 million home delivered meals. The following charts outline the number of home delivered meals and congregate meals provided by Planning and Service Area in Illinois during FY 2015 and the percentage of the statewide meals provided by each Planning and Service Area.



### % of State-wide Home Delivered Meals Provided by Each Planning and Service Area

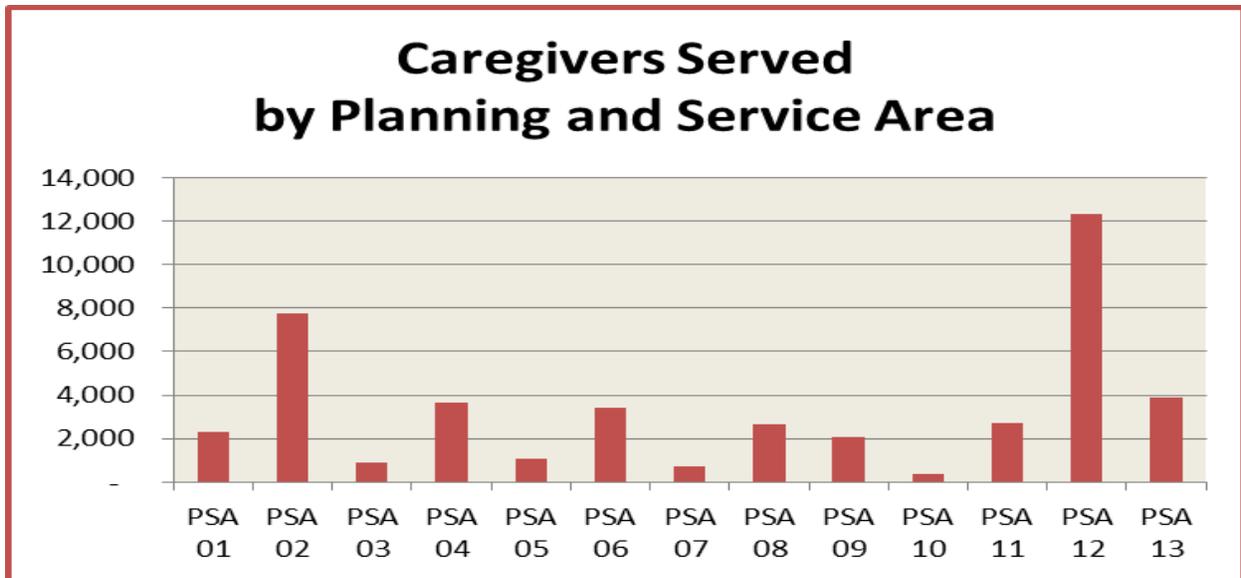


### % of Statewide Congregate Meals Served by Each Planning and Service Area



### Family Caregiver Support Program

The National Family Caregiver Support Program provides a core of support services to caregivers of elderly adults and grandparents raising grandchildren. These services include information, assistance, counseling, support groups, respite, and supplemental services. The Area Agencies on Aging are mandated to develop and implement Family Caregiver Resource Centers that can serve as a local point of entry to a broad range of services to caregiving families. The Family Caregiver Resource Centers have the capacity to provide access to information, training, support groups, counseling, resource libraries, respite care and supplemental services to family caregivers and grandparents raising grandchildren. In FY 2015, it is estimated that more than 40,330 family caregivers and grandparents raising grandchildren were served. The following chart outlines the number of caregivers served by Planning and Service Area in FY 2015.



### Disease Prevention & Health Promotion Services

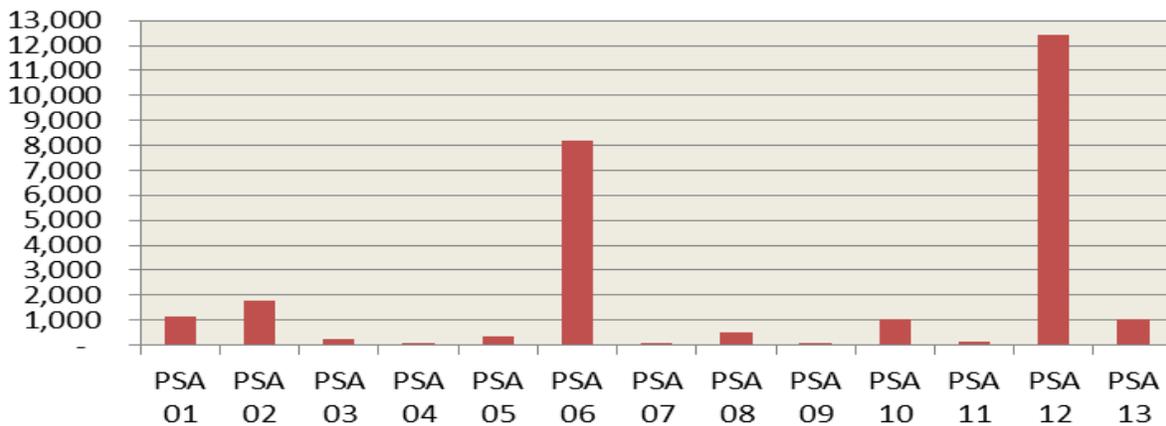
Title IIID of the OAA was established in 1987. It provides grants to States and Territories based on their share of the population aged 60 and over for programs that support healthy lifestyles and promote healthy behaviors. Priority is given to serving elders living in medically underserved areas of the State or who are in greatest economic need.

Evidence-based programs are now required for Title IIID-funded activities. This change followed a decade of progress by the aging services network to move their efforts toward implementing disease prevention and health promotion programs that are based on scientific evidence and demonstrated to improve the health of older adults. The Federal FY-2012 Congressional appropriations law included, for the first time, an evidence-based requirement. In response to that new requirement, ACL developed an evidence-based definition to support the transition.

Beginning October 1, 2016, Title IIID funds will only be able to be used on health promotion programs that meet the highest-level criteria of an evidence-based program.

The following chart outlines the number of caregivers served by Planning and Service Area in FY 2015.

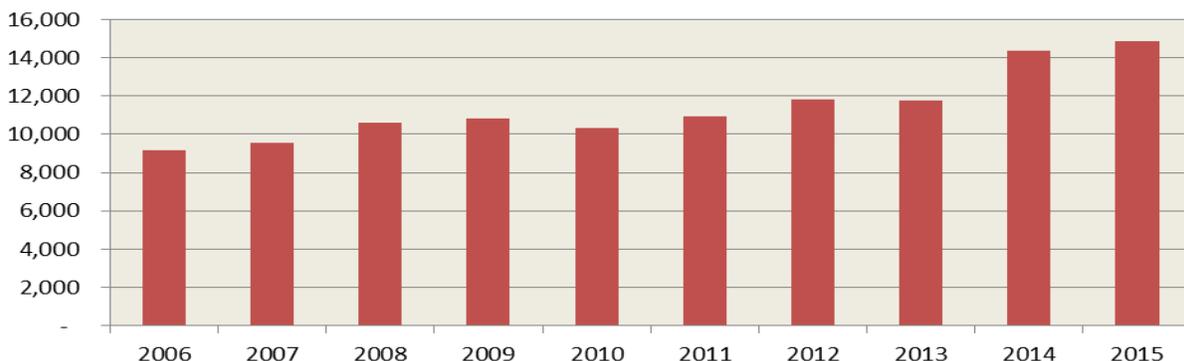
## Persons Served by Disease Prevention & Health Promotion Services by Planning and Service Area



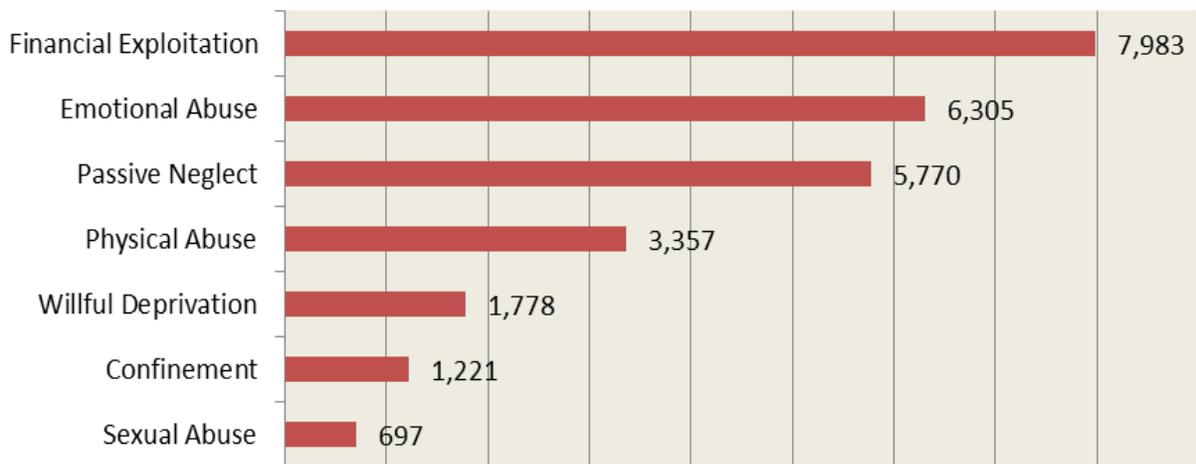
### ADULT PROTECTIVE SERVICES PROGRAM

The Adult Protective Services Program (formerly the Elder Abuse and Neglect Program) became available statewide on April 1, 1991. It operated in accordance with the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), which was signed into law in 1988. The Act was amended to become the Adult Protective Services Act on July 1, 2013. The Adult Protective Services Act directs the Department to establish an intervention program to respond to reports of alleged abuse, neglect, and exploitation (ANE) of older adults and adults with disabilities who live at home at the time of the report, and to work with the individual in resolving the abusive situations. The Adult Protective Services Program is locally coordinated through 42 provider agencies that conduct investigations and work with older adults and persons with disabilities in resolving abusive situations. In FY 2016, it is estimated that the Adult Protective Services Program will receive approximately 16,140 reports of abuse, neglect and exploitation. This represents an increase of 9% since FY 2015.

### Number of Abuse Reports



## Types of Abuse Reported



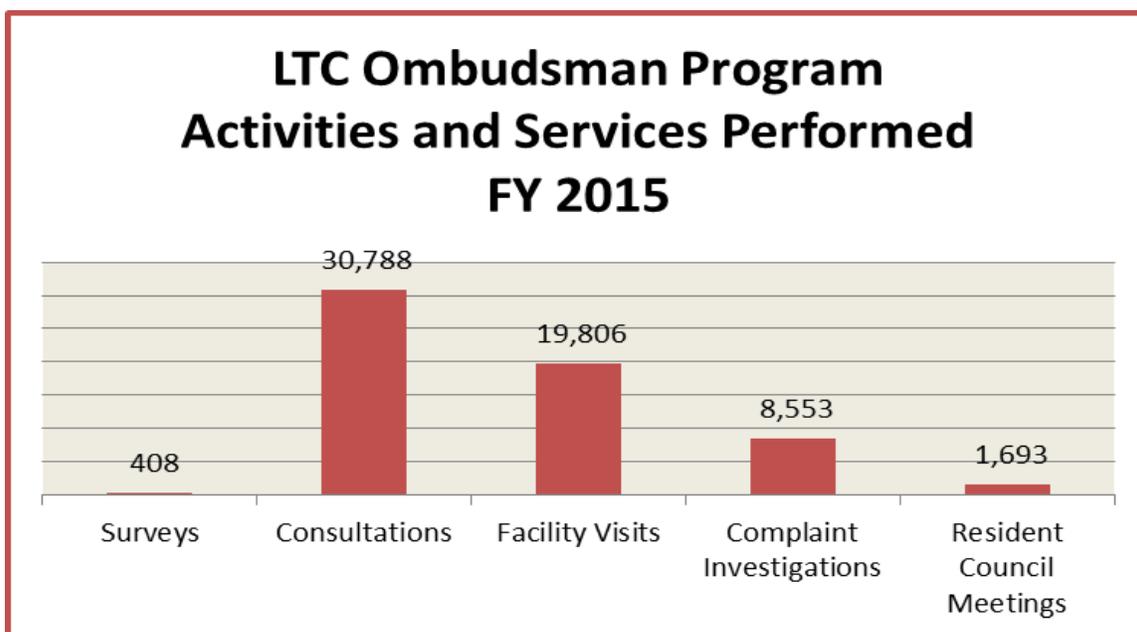
Victims generally experience more than one type of abuse.

## LONG TERM CARE OMBUDSMAN PROGRAM

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 a number of 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. The following chart outlines the service activities performed in FY 2015.

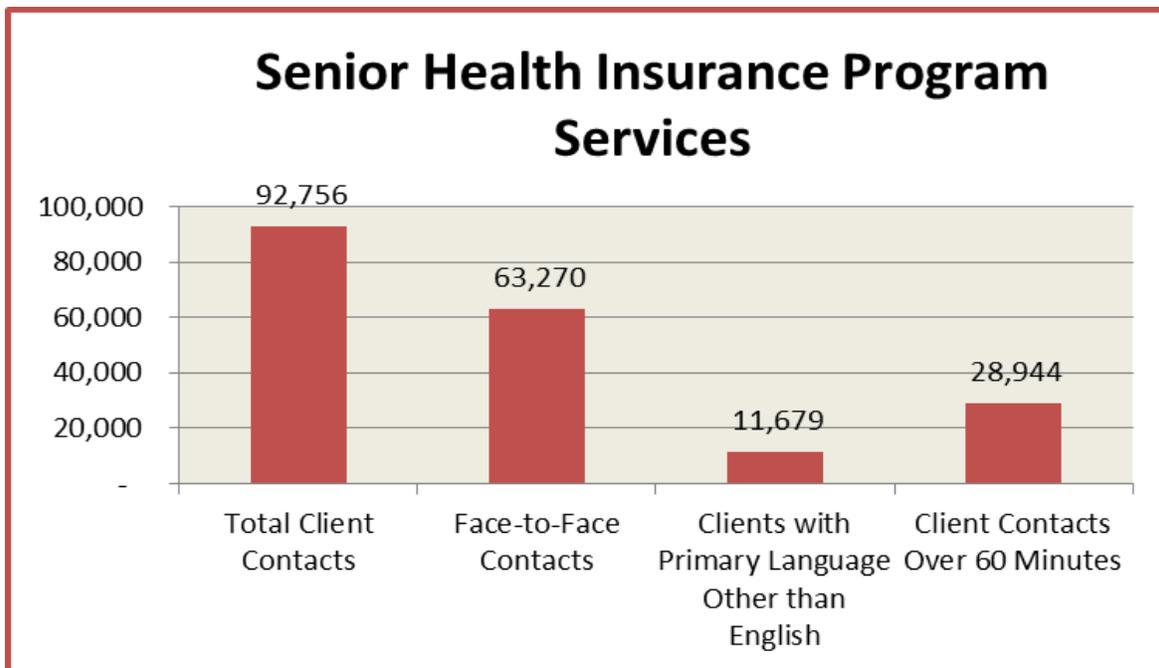
In 2013, the Illinois Act on the Aging was amended to expand Ombudsman services into the community. Ombudsmen are now able to advocate on behalf of older persons and persons with disabilities ages 18-59 residing in their own homes or community-based settings, relating to matters which may adversely affect 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.



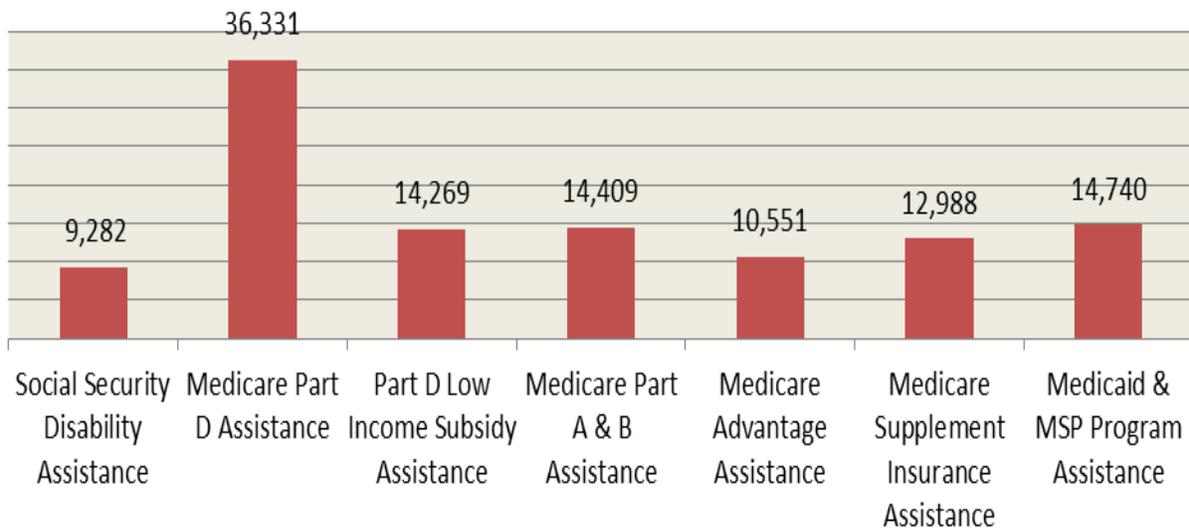
## SENIOR HEALTH INSURANCE PROGRAM

The Senior Health Insurance Program (SHIP) is a **free** statewide health insurance counseling service for Medicare beneficiaries and their caregivers. SHIP was initiated in the fall of 1988 within the Illinois Department of Insurance. SHIP currently has 250 offices throughout the state staffed by a total of over 1,110 counselors. All offices use state certified counselors who are supported by local sponsoring organizations that offer services to Medicare beneficiaries. SHIP also provides a toll-free line for the Medicare beneficiaries and their caregivers. In April 2013, SHIP transferred from the Illinois Department of Insurance to the Illinois Department on Aging pursuant to Executive Order 13-1. SHIP activities align with the Illinois Department on Aging's mission to help older individuals maintain their health and independence while remaining in their homes and communities.

The mission of SHIP is to educate the citizens of Illinois about Medicare, Medicare supplement; Medicare advantage plans and long term care insurance. Individuals receive this information through public forums, presentations to various community organizations, senior citizen centers, radio, television and various publications. SHIP provides accurate and objective counseling, assistance and advocacy relating to Medicare, private health insurance and related health plans. Counseling of the individual client focuses on specific information or assistance provided in one-on-one confidential sessions with certified counselors. Individual counseling sessions provide an effective way to objectively approach specific problems with claims and provide insurance policy analyses. The following charts outline services provided by SHIP in 2015.



## # of Clients Served by SHIP Assistance Category





## AREA AGENCIES ON AGING

<p><b><u>PSA 01</u></b>  <b>Northwestern Illinois Area Agency on Aging</b></p> <p>Grant Nyhammer, Executive Director          1111 South Alpine Road, Suite 600          Rockford, IL 61108          Phone: 815/226-4901 Fax: 815/226-8984          1-800-542-8402 (9 county area only)          Web: <a href="http://www.nwilaaa.org">www.nwilaaa.org</a>          E-Mail: <a href="mailto:gnyhammer@nwilaaa.org">gnyhammer@nwilaaa.org</a></p>	<p><b><u>PSA 04</u></b>  <b>Central Illinois Agency on Aging</b></p> <p>Keith Rider, President &amp; CEO          700 Hamilton Boulevard          Peoria, IL 61603-3617          Phone: 309/674-2071 Fax: 309/674-3639          1-877-777-2422 309/674-1831 (TTY)          Web: <a href="http://www.ciaoa.net">www.ciaoa.net</a>          E-Mail: <a href="mailto:krider@ciaoa.net">krider@ciaoa.net</a></p>
<p><b><u>PSA 02</u></b>  <b>Northeastern Illinois Area Agency on Aging</b></p> <p>Lucia West Jones, Executive Director          Mailing Address:          P.O. Box 809, Kankakee, IL 60901-0809          Non-U.S. Post Office Deliveries:          Kankakee Community College          River Road, West Campus - Building 5          Kankakee, IL 60901          Phone: 815/939-0727 Fax: 815/939-0022</p> <p>Field Office:          245 West Roosevelt Road, Building No. 6,          Suites 41-43          West Chicago, IL 60185          Phone: 630/293-5990 Fax: 630/293-7488          1-800-528-2000 (calls will be directed to proper source)          Web: <a href="http://www.ageguide.org">www.ageguide.org</a>          E-Mail: <a href="mailto:info@ageguide.org">info@ageguide.org</a></p>	<p><b><u>PSA 05</u></b>  <b>East Central Illinois Area Agency on Aging</b></p> <p>Susan Real, Executive Director          1003 Maple Hill Road          Bloomington, IL 61704-9327          Phone: 309/829-2065 Fax: 309/829-6021          1-800-888-4456 (I&amp;A for sixteen county area only)          Web: <a href="http://www.eciaaa.org">www.eciaaa.org</a>          E-Mail: <a href="mailto:SREAL@eciaaa.org">SREAL@eciaaa.org</a></p>
<p><b><u>PSA 03</u></b>  <b>Western Illinois Area Agency on Aging</b></p> <p>Barbara Eskildsen, Executive Director          729 - 34<sup>th</sup> Avenue          Rock Island, IL 61201-5950          Phone: 309/793-6800 Fax: 309/793-6807          1-800-322-1051 (I&amp;A)          Web: <a href="http://www.wiaaa.org">www.wiaaa.org</a>          E-Mail: <a href="mailto:beskildsen@wiaaa.org">beskildsen@wiaaa.org</a> or  <a href="mailto:FirstStopForSeniors@wiaaa.org">FirstStopForSeniors@wiaaa.org</a></p>	<p><b><u>PSA 06</u></b>  <b>West Central Illinois Area Agency on Aging</b></p> <p>Lynn Niewohner, Director          Mailing Address:          P.O. Box 428, Quincy, IL 62306-0428          Non-U.S. Post Office Deliveries:          639 York Street, Room 204, Quincy, IL 62301          Phone: 217/223-7904 Fax: 217/222-1220          1-800-252-9027 (I&amp;A) (Voice &amp; TTY)          Web: <a href="http://www.wciagingnetwork.org">www.wciagingnetwork.org</a>          E-Mail: <a href="mailto:lynn@wciagingnetwork.org">lynn@wciagingnetwork.org</a></p>

<p><b><u>PSA 07</u></b>  <b>Area Agency on Aging for Lincolnland</b>  Julie Hubbard, Executive Director  3100 Montvale Drive  Springfield, IL 62704-4278  Phone: 217/787-9234 (Voice &amp; TTY) Fax: 217/787-6290  1-800-252-2918 (I&amp;A for 217, 309 &amp; 618 area codes only)  Web: <a href="http://www.aginglinc.org">www.aginglinc.org</a>  E-Mail: <a href="mailto:jhubbard@aginglinc.org">jhubbard@aginglinc.org</a></p>	<p><b><u>PSA 11</u></b>  <b>Egyptian Area Agency on Aging</b>  John M. Smith, Executive Director  200 East Plaza Drive  Carterville, IL 62918-1982  Phone: 618/985-8311 Fax: 618/985-8315  1-888-895-3306  Web: <a href="http://www.egyptianaaa.org">www.egyptianaaa.org</a>  E-Mail: <a href="mailto:egyptianaaa@egyptianaaa.org">egyptianaaa@egyptianaaa.org</a></p>
<p><b><u>PSA 08</u></b>  <b>AgeSmart Community Resources</b>  Joy Paeth, Chief Executive Officer  2365 Country Road  Belleville, IL 62221-2571  Phone: 618/222-2561 Fax: 618/222-2567  1-800-326-3221  Web: <a href="http://www.AgeSmart.org">www.AgeSmart.org</a>  E-Mail: <a href="mailto:jpaeth@AgeSmart.org">jpaeth@AgeSmart.org</a></p>	<p><b><u>PSA 12</u></b>  <b>Senior Services Area Agency on Aging  Chicago Department of Family &amp; Support Services</b>  Joyce Gallagher, Executive Director  1615 West Chicago Avenue, 3<sup>rd</sup> Floor  Chicago, IL 60622  Phone: 312/744-4016 Fax: 312/744-8168  312/744-6777 (TTY)  Web: <a href="http://www.cityofchicago.org/aging">www.cityofchicago.org/aging</a>  E-Mail: <a href="mailto:mary_joyce.gallagher@cityofchicago.org">mary_joyce.gallagher@cityofchicago.org</a></p>
<p><b><u>PSA 09</u></b>  <b>Midland Area Agency on Aging</b>  Tracy Barczewski, Executive Director  Mailing Address:  P.O. Box 1420, Centralia, IL 62801-1420  Non-U.S. Post Office Deliveries  434 South Poplar, Centralia, IL 62801-1420  Phone: 618/532-1853 Fax: 618/532-5259  1-877-532-1853  Web: <a href="http://www.midlandaaa.org">www.midlandaaa.org</a>  E-Mail: <a href="mailto:tracy@midlandaaa.org">tracy@midlandaaa.org</a></p>	<p><b><u>PSA 13</u></b>  <b>AgeOptions, Inc.</b>  Jonathan Lavin, President &amp; CEO  1048 Lake Street, Suite 300  Oak Park, IL 60301  Phone: 708/383-0258 Fax: 708/524-0870  708/524-1653 (TTY)  1-800-699-9043 (Suburban Cook County area only)  Web: <a href="http://www.ageoptions.org">www.ageoptions.org</a>  E-Mail: <a href="mailto:jon.lavin@ageoptions.org">jon.lavin@ageoptions.org</a></p>
<p><b><u>PSA 10</u></b>  <b>Southeastern Illinois Agency on Aging</b>  Shana Holmes, Executive Director  516 Market Street  Mt. Carmel, IL 62863-1558  Phone: 618/262-2306 Fax: 618/262-4967  1-800-635-8544 (618 area code only)  Web: <a href="http://www.seiaoa.com">www.seiaoa.com</a>  E-Mail: <a href="mailto:seiaoa_shana@frontier.com">seiaoa_shana@frontier.com</a></p>	

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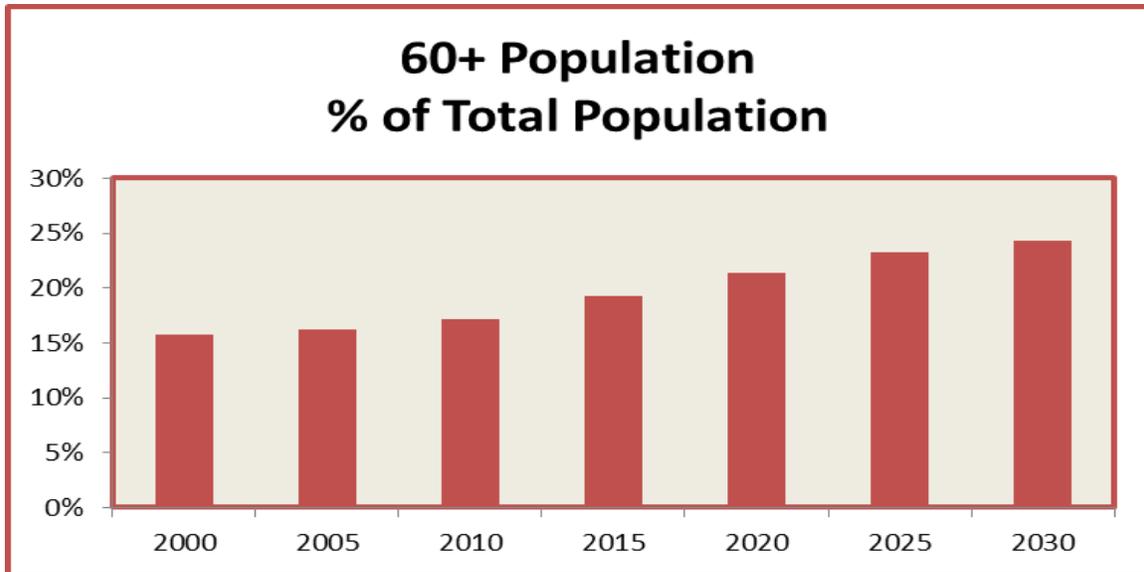
# **APPENDIX A**

## **THE AGE 60+ POPULATION IN ILLINOIS**

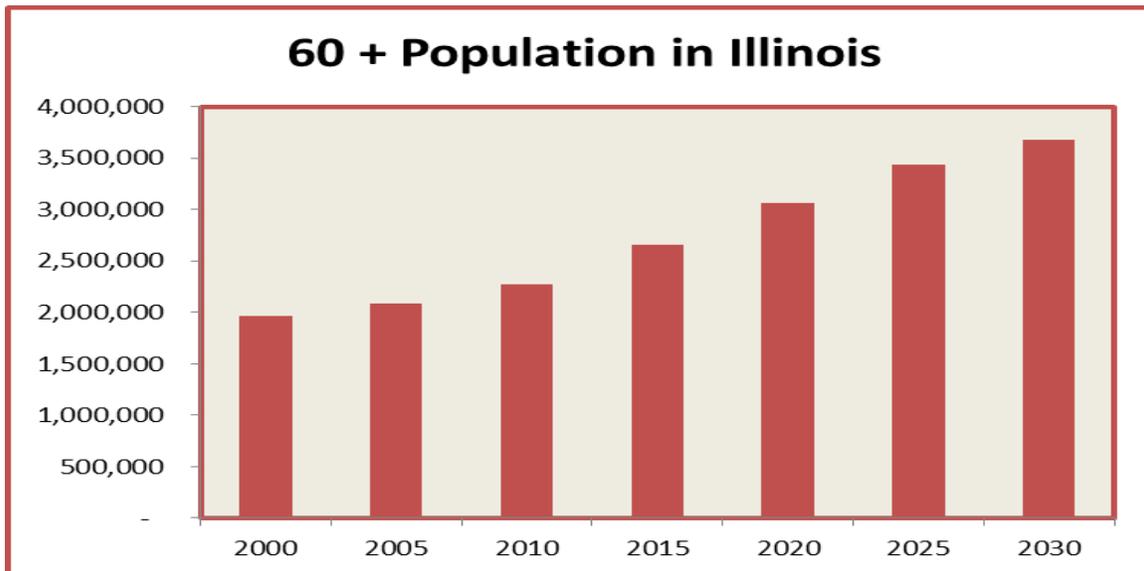
# THE AGE 60+ POPULATION IN ILLINOIS

## GROWTH OF THE AGE 60+ POPULATION

Since 2000, Illinois' older population has grown from 1.9 million to 2.5 million. It now represents 19.6% of the population in Illinois. By 2030, it is estimated that the age 60+ population will increase to 3.6 million and will represent 24% of Illinois' population.

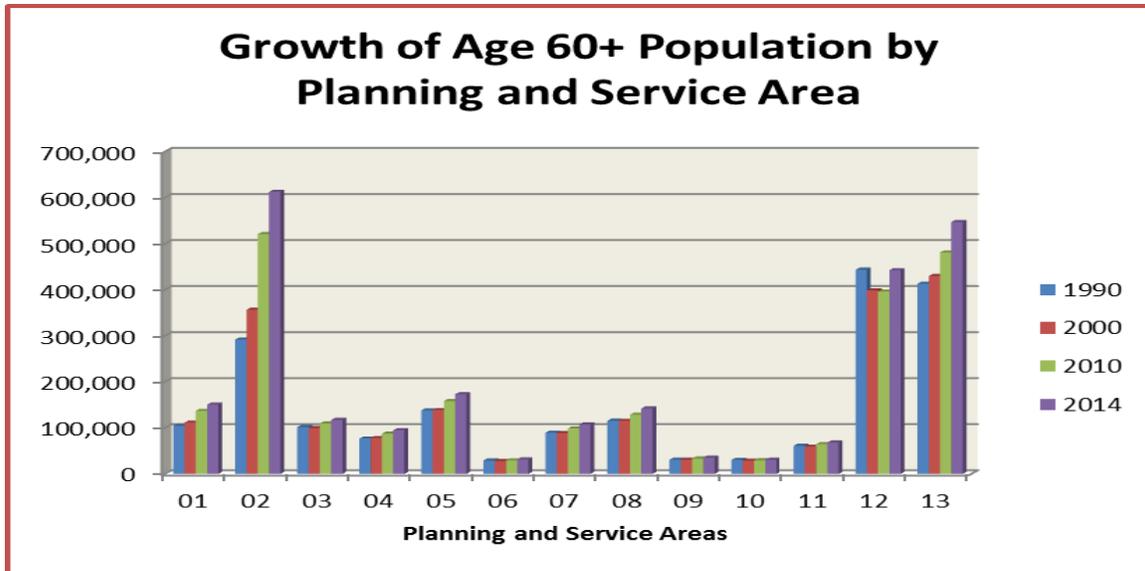


Source: U.S. Census Bureau and Illinois Department of Commerce & Economic Opportunity (2012).



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

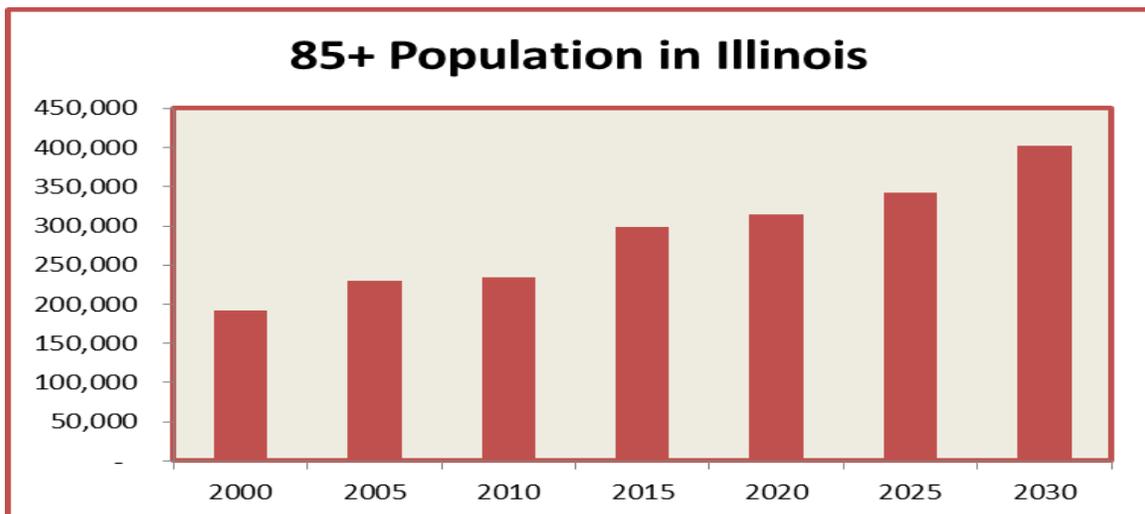
The following chart outlines the age 60+ population by Planning and Service Area based on the 1990, 2000 and 2010 Census and 2014 Census Population Estimates. PSA 01 (Rockford area), PSA 02 (collar counties), and PSA 13 (suburban Cook County) experienced the most significant growth in the age 60+ population.



Source: 1990, 2000, 2010 Census and 2014 Population Estimates.

### GROWTH OF THE AGE 85+ POPULATION

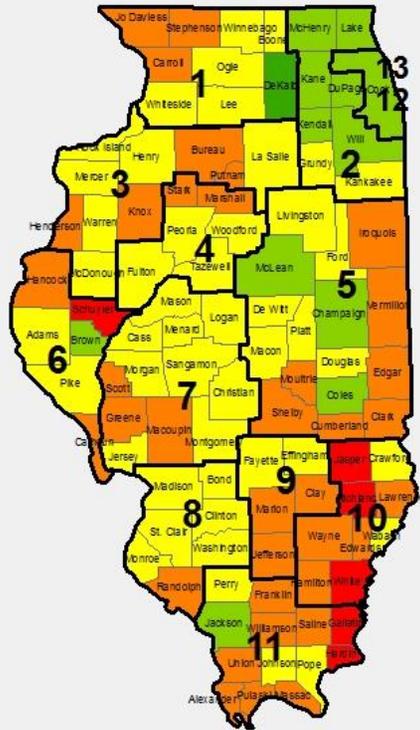
The population age 85 and older is currently the fastest growing segment of the older population. The size of this age group is important for the future of the long-term care system because these individuals tend to be in poorer health and require more services than the young elderly. In 2000, 192,346 of the 60+ population in Illinois was age 85+. In 2010, it increased to 234,912. In 2030, it is projected to be 402,311, which is an increase of 109% from 1990. With the demographic boom, the need for in-home assistance (e.g., homemaker, adult day service, and home delivered meals) will dramatically increase.



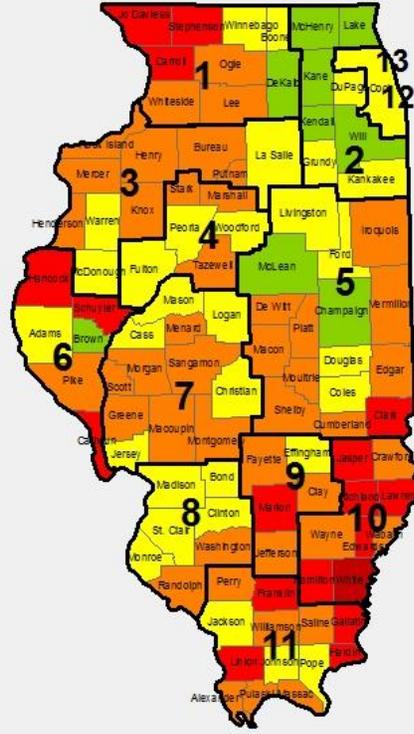
Source: U.S. Census Bureau and Illinois Department of Commerce & Economic Opportunity (2012).

## Illinois Population 60+ By County

2015



2020



2030



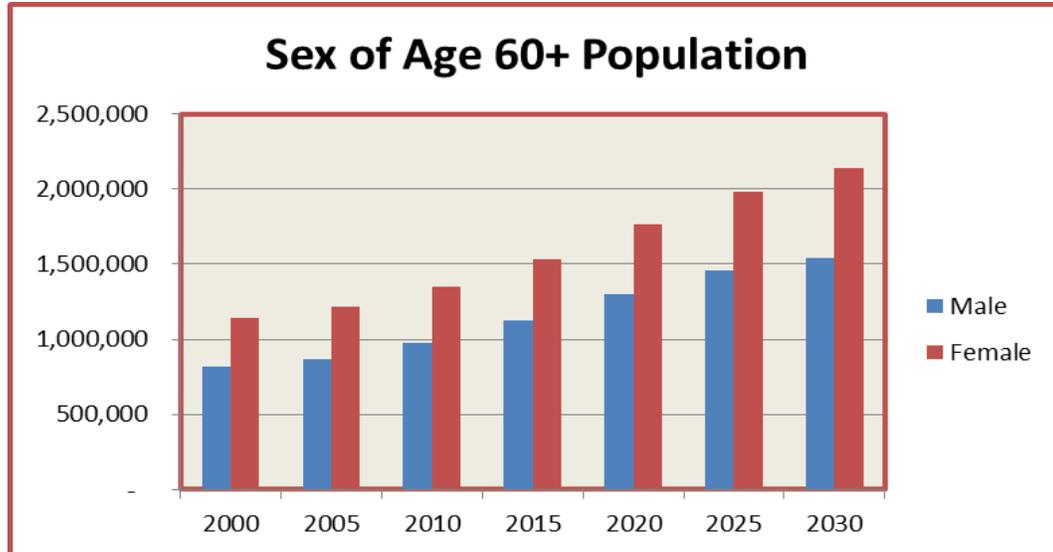
Data Source: Census Bureau 2015  
 Illinois Department on Aging  
 Jean Bohnhoff, Director  
 March 29, 2016

## GROWTH OF THE AGE 60+ POPULATION BY COUNTY

The maps outline the age 60+ population as a percentage of the overall population by county. The Illinois map for 2030 outlines that a significant number of counties in Illinois will have a higher percentage of older adults from 2015 to 2030.

## OLDER POPULATION BY GENDER

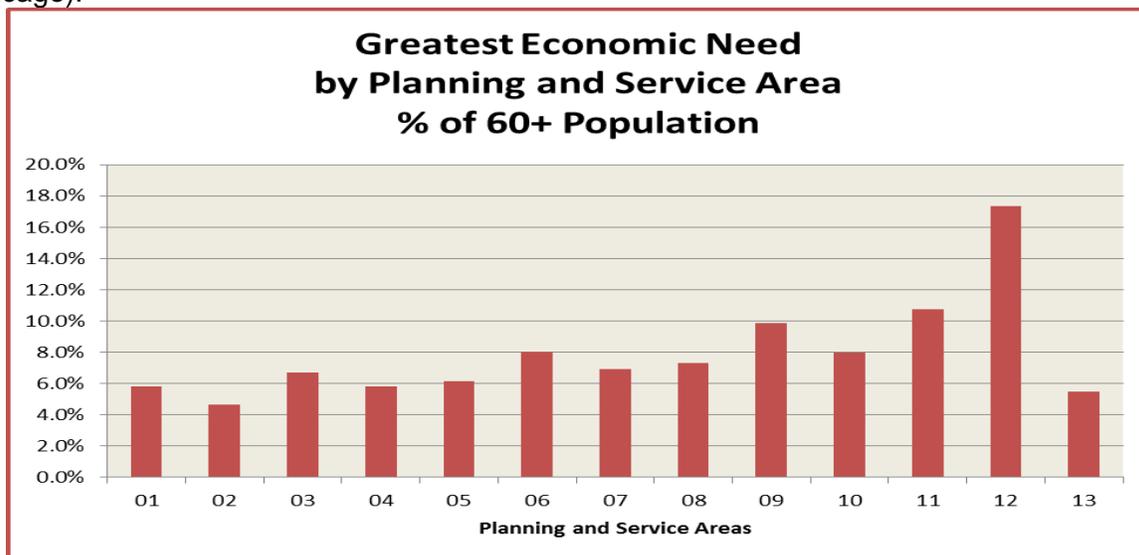
In Illinois older women represent 56% of the older population. As the older population grows, women will continue to represent a larger percentage of the general older population.



Source: Illinois Department of Commerce & Economic Opportunity (2012).

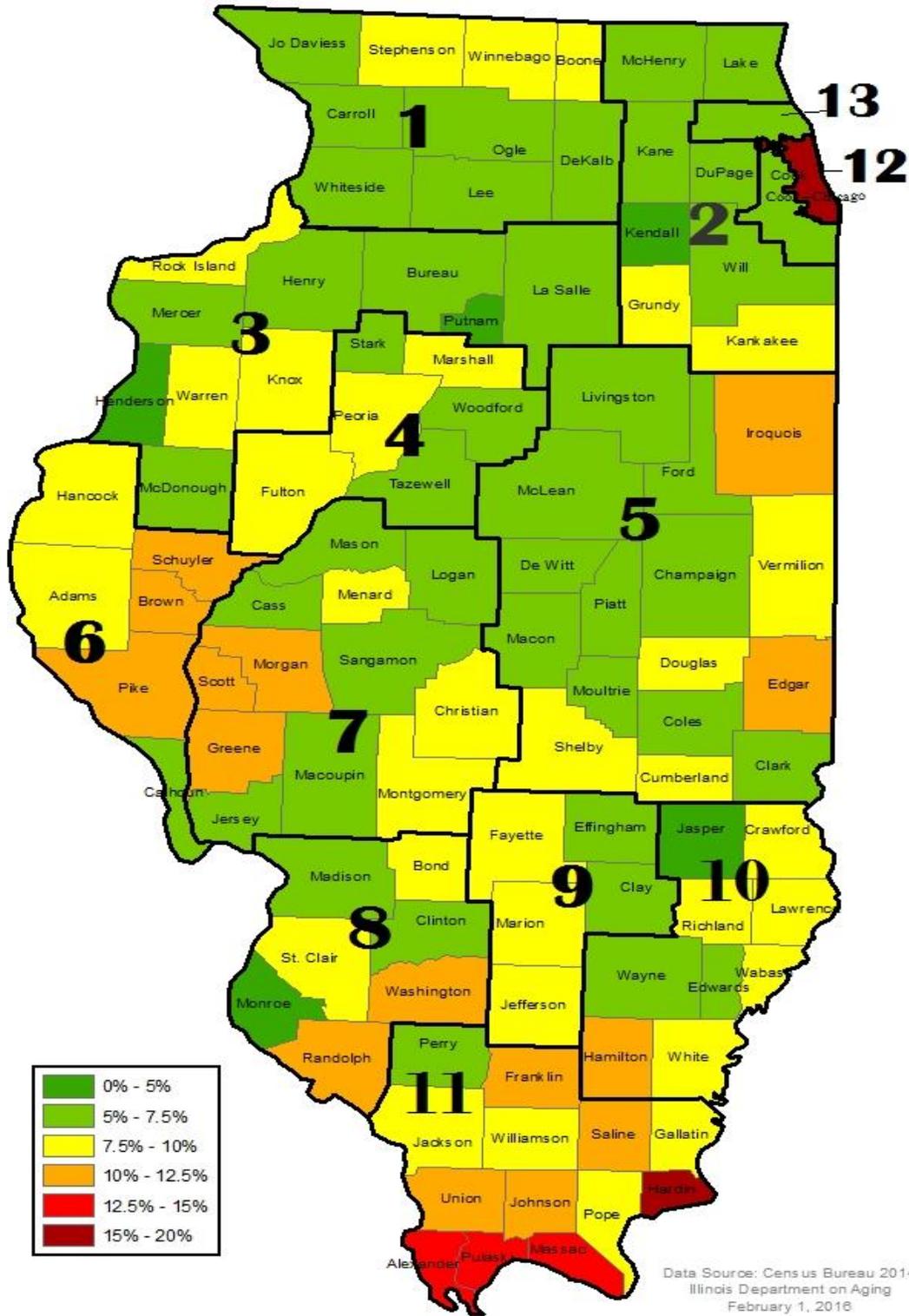
## POVERTY RATES AND INCOME OF THE OLDER POPULATION

Based on the 2010-2014 American Community Survey, approximately 8% of older adults in Illinois live in poverty. Poor older adults have limited opportunities to escape poverty. Without Social Security, an additional 36% of older Illinoisans would fall into poverty (AARP Public Policy Institute, 2012). The following graph outlines the percentage of older adults in greatest economic need by Planning and Service Area. Poverty rates among older adults are significantly higher in PSA 09 (Centralia area), PSA 11 (southern Illinois) and PSA 12 (City of Chicago).

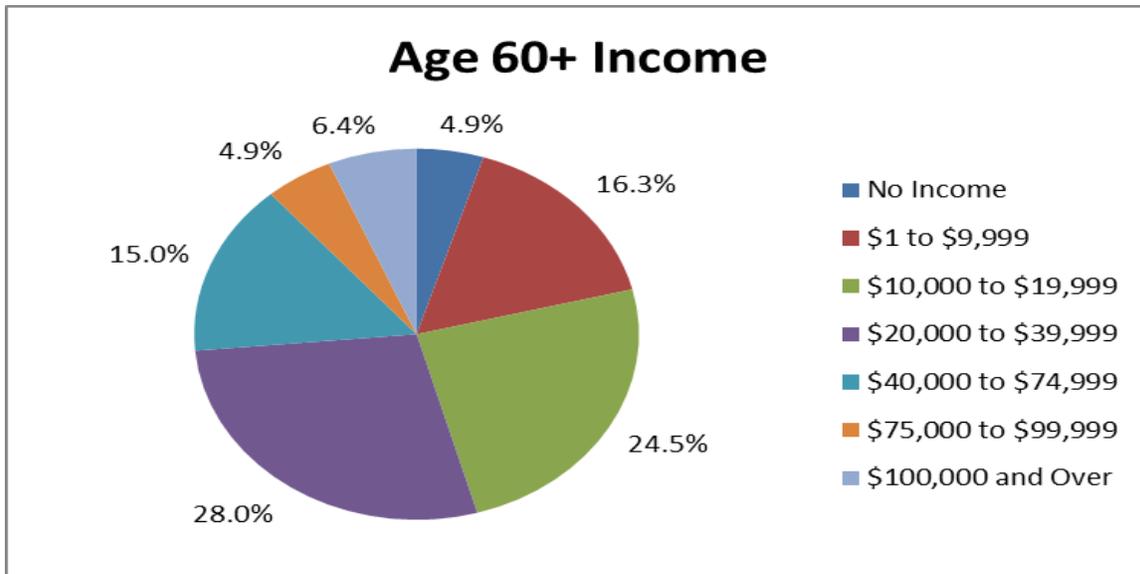


Source: 2010-2014 American Community Survey 5 Year Estimates, Table B17020.

# % of Age 60+ Below Poverty Level



Based on the 2009-2013 American Community Service, 4.9% of older adults in Illinois have no income and 16.3% have income between \$1 to \$9,999. Another 24.5% have income between \$10,000 to \$19,999. Thus, 45.7% of older adults have income less than \$20,000 per year.

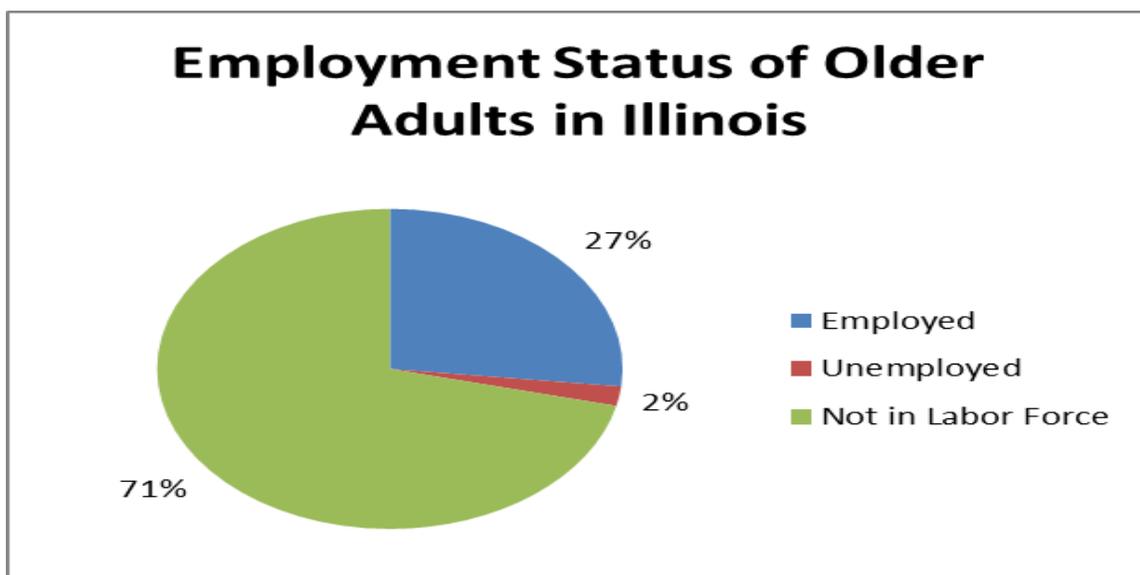


Source: Aging Special Tabulation, 2009-2013 American Community Survey 5 Year Estimates, Table S21032.

According to an AARP study, 22% of older adults in Illinois rely on Social Security for 90% of their family income. The average monthly benefit was only \$1,348 in 2014. (AARP Public Policy Institute, 2015).

## **EMPLOYMENT**

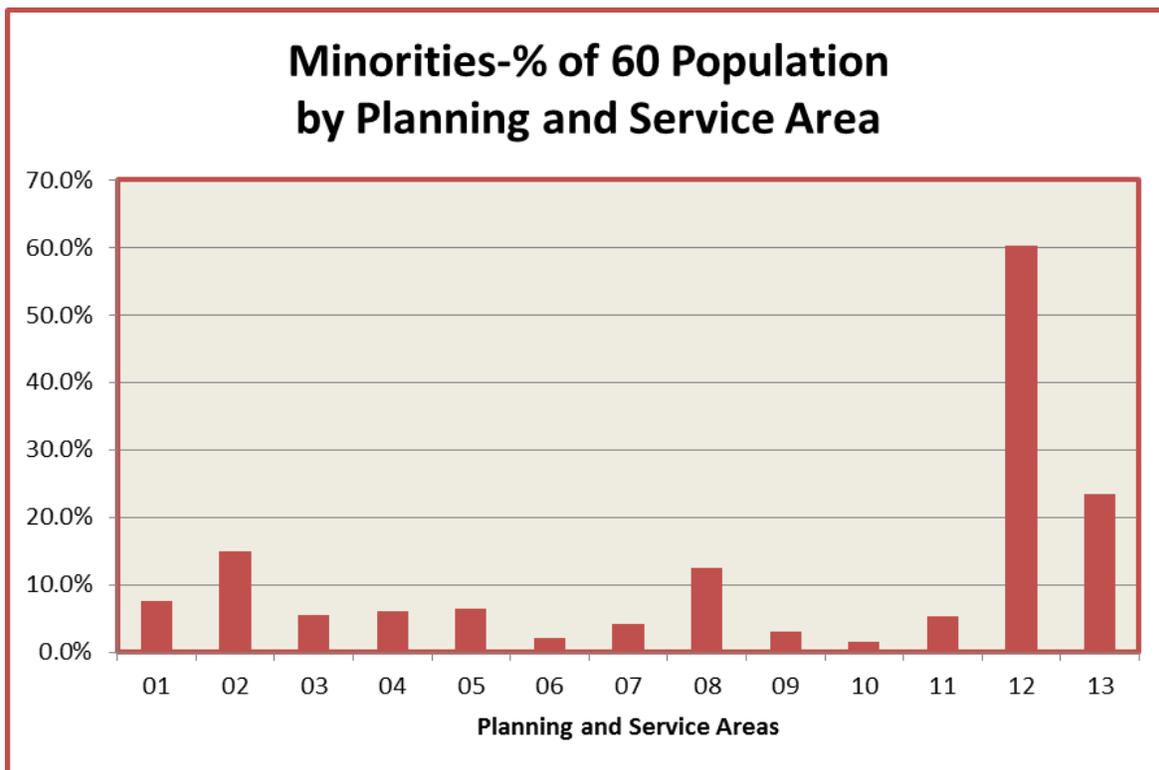
Based on the 2009-2013 American Community Survey, 27% of older adults are employed, 2% are unemployed, and 71% are not in the labor force.



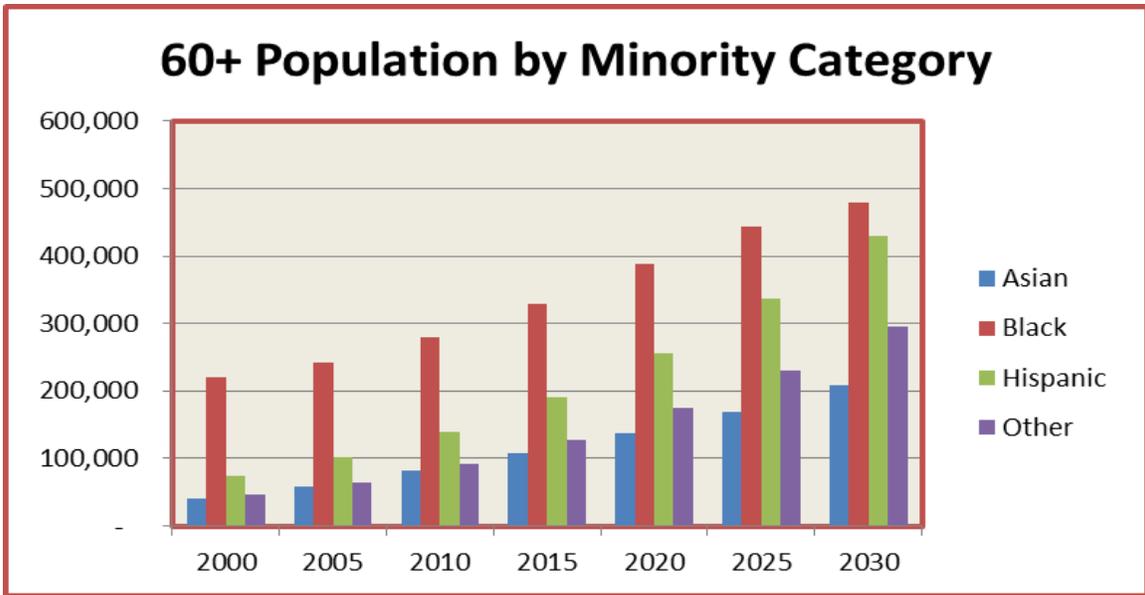
Source: Aging Special Tabulation, 2009-2013 American Community Survey 5 Year Estimates, Table S21023.

## **DIVERSITY OF THE OLDER POPULATION**

The population of older adults is becoming culturally and linguistically more diverse. Based on the 2014 Census Population Estimates, over 25% of the age 60+ population were minority in 2014. Based on the results of the 2014 Census Population Estimates, the number of minorities age 60 and older who reside in Illinois increased by 83% between 2000 and 2014. These trends will continue in the future. The Aging Network will need to develop services that will meet the diverse needs of the older population. The following graphs outline the percentage of the age 60+ population that are minorities in each Planning and Service Area and the future growth of the minority population in Illinois.



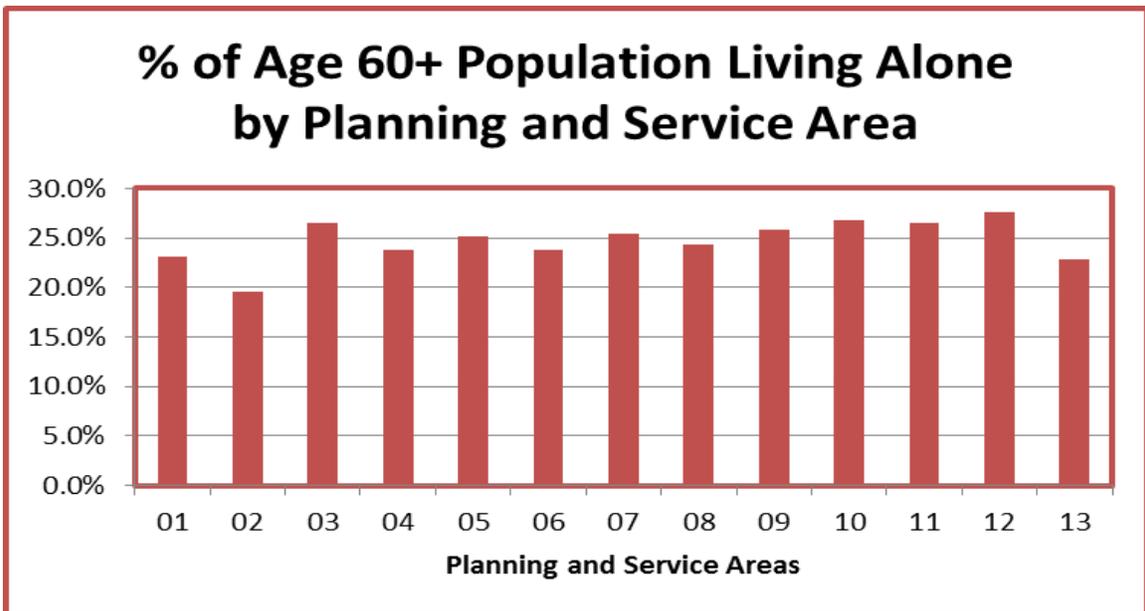
Source: Census Bureau 2014 Population Estimates, Table CC-EST2014-AllData-17.



Source: Illinois Department of Commerce & Economic Opportunity (2012).

### LIVING ARRANGEMENTS OF THE OLDER POPULATION

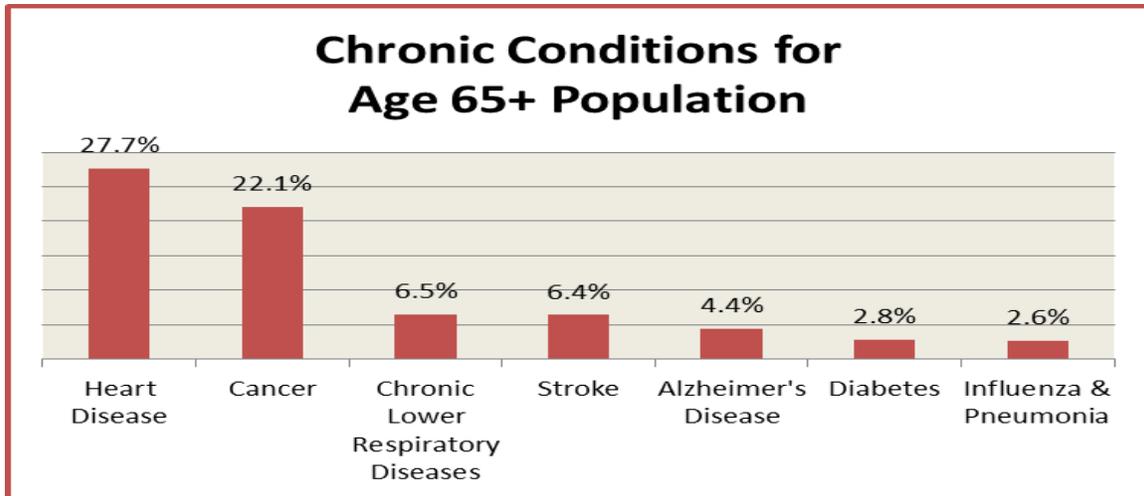
Based on the 2009-2013 American Community Survey, approximately 24% of all non-institutionalized older adults in Illinois live alone. For older females, the number of older adults residing by themselves increases as they become older. The following graph outlines the percentage of the age 60+ population living alone by Planning and Service Area.



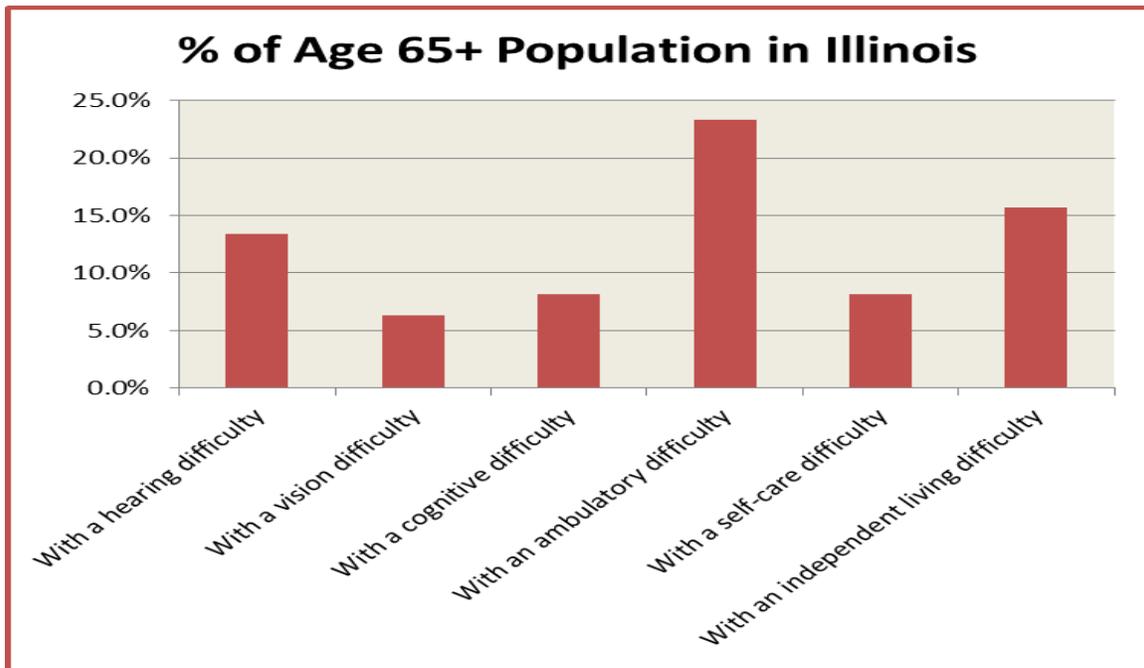
Source: Aging Special Tabulation, 2009-2013 American Community Survey 5 Year Estimates, Table S21010A.

## CHRONIC DISEASES, DISABILITIES & HEALTH ISSUES AMONG THE OLDER POPULATION

Chronic diseases such as heart disease, stroke, cancer, and diabetes are among the most common and expensive health conditions. Chronic health condition has an adverse impact on quality of life, contributing to declines in function and the inability to remain living in the community.

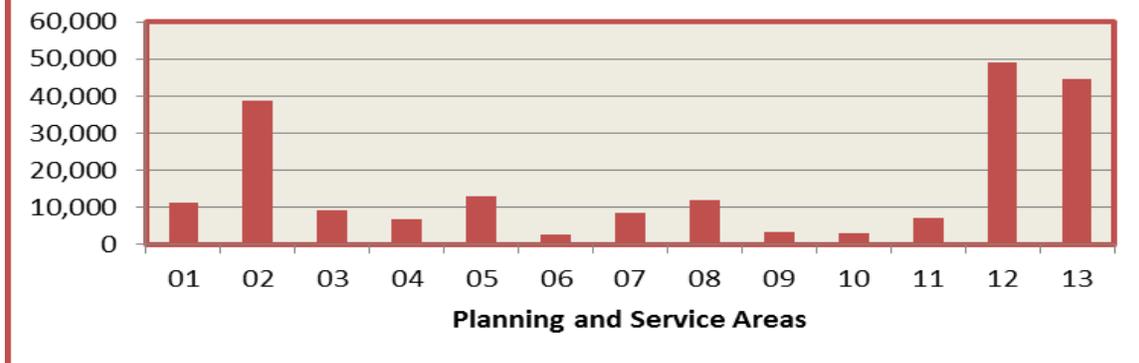


Source: CDC, The State of Aging & Health in America, 2013.



Source: 2010-2014 American Community Survey, 5 Year Estimates, Table S1810.

## Age 65+ Population with 3 or More Disabilities by Planning and Service Area



Source: Aging Special Tabulation, 2009-2013 American Community Survey, 5 Year Estimates, Table S210DIS09.

### National Report Card on Healthy Aging: How Healthy Are Older Adults in the United States?

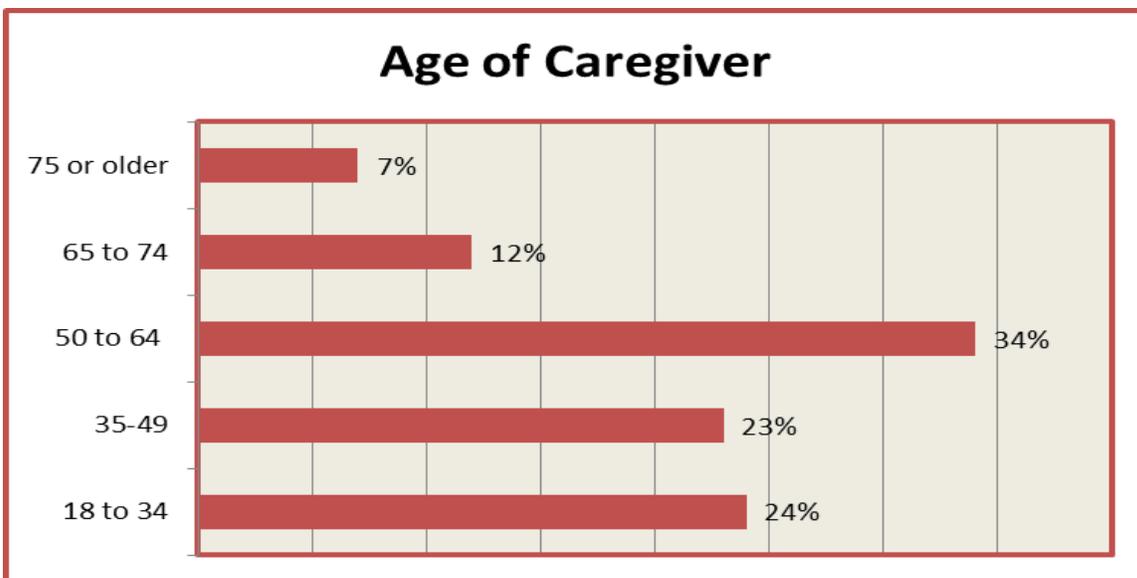
Indicator	Illinois Data	U.S. Data	Healthy People 2020 Target
<b>Health Status</b>			
Physically Unhealthy Days	5.4 mean # of days	5.4 mean # of days	N/A
Frequent Mental Distress	6.0%	6.9%	N/A
Oral Health-Tooth Retention	59.2%	59.6%	N/A
Disability	37.2%	37.9%	N/A
<b>Health Behaviors</b>			
No Leisure-Time Physical Activity within Past Month	34.3%	31.4%	32.6%
Eating $\geq$ 2 Fruits Daily	44.8%	41.8%	N/A
Eating $\geq$ 3 Vegetables Daily	26.3%	29.6%	N/A
Obesity	25.1%	24.3%	30.6%
Current Smoking	8.5%	8.3%	12.0%
Taking Medicine for High Blood Pressure	94.1%	94.0%	77.4%
<b>Preventive Care and Screening</b>			
Flu Vaccine in past Year	65.6%	66.9%	90.0%
Ever had pneumonia vaccine	61.9%	68.1%	90.0%
Mammogram within Past Two Years	80.5%	82.9%	70.0%
Colorectal Cancer Screening	69.3%	73.1%	70.5%
<b>Injuries</b>			
Fall Injury within Past Year	32.1%	31.7%	N/A

Source: Centers for Disease Control and Prevention, Healthy Aging-Location Summary and Centers for Disease Control and Prevention, The State of Aging & Health in America, 2013

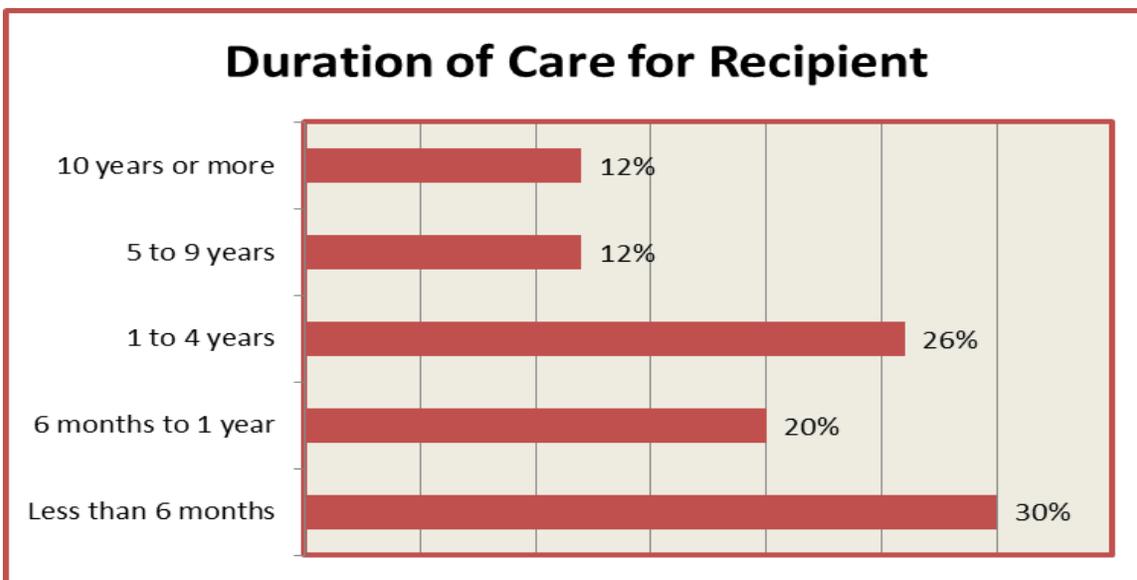
## **FAMILY CAREGIVING**

The informal caregiver is the foundation of support for the frail older person living in the community. Nearly one out of every four U.S. households is involved in providing assistance to older family members and other older adults. Family members and friends provide approximately 80% of all home care. On average caregivers spend 24.4 hours per week

providing care to family members and friends (National Alliance for Caregiving & AARP, 2015). In Illinois, there are an estimated 1.5 million family caregivers providing an estimated 1.4 million hours of care to family members during any given year at a total economic value of \$18.5 million (AARP Public Policy Institute, 2015 Update).



Source: AARP Public Policy Institute, Caregiving in the U.S.

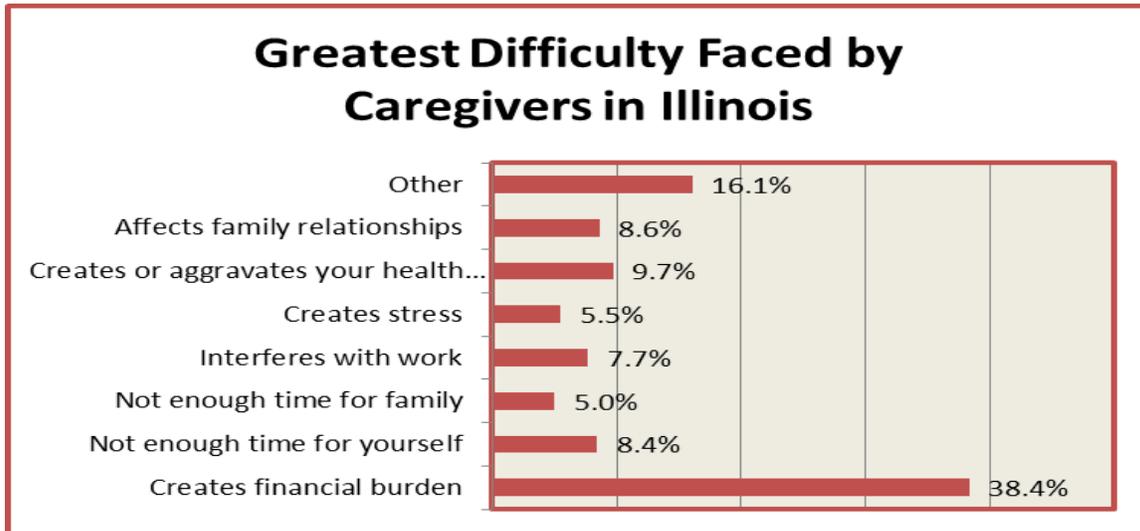


Source: AARP Public Policy Institute, Caregiving in the U.S.

Based on the 2013 Illinois Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Illinois Department of Public Health, more than 800,000 have provided care three or more years. The average amount of caregiver time expended on providing care was 18 hours per week.

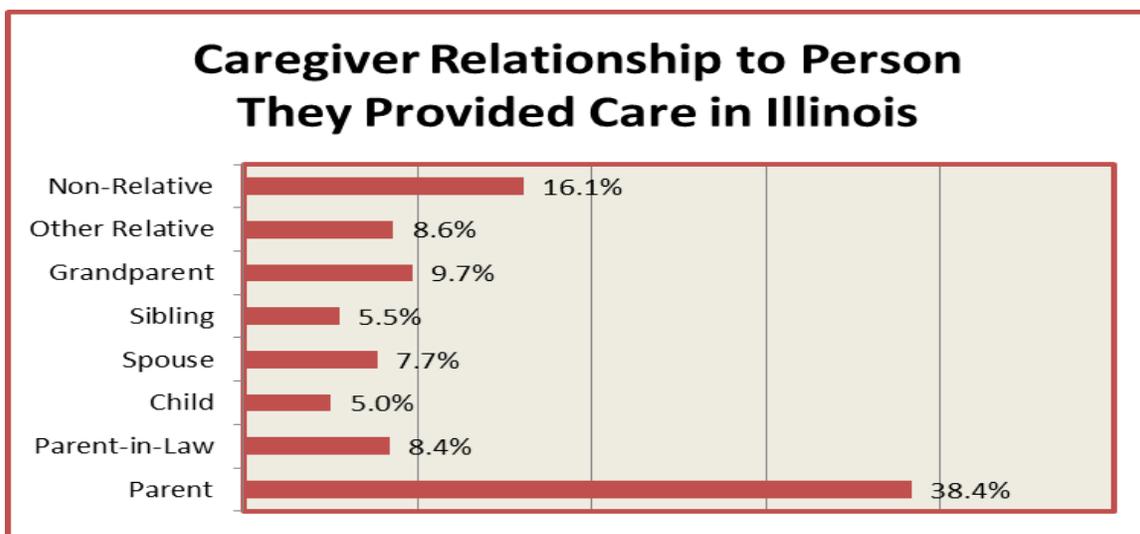
Based on the 2013 Illinois Behavioral Risk Factor Surveillance System (BRFSS) sponsored by the Illinois Department of Public Health, when caregivers in Illinois were given a list of difficulties

often experienced by caregivers and asked which one was the greatest difficulty they have faced, the difficulty reported most was the stress it creates (24.4%). A combined 14 percent of caregivers felt lack of time for themselves (10.7%) or family (3.7%) was most difficult. Approximately 6 percent felt the effect it had on family relationships was the greatest difficulty.



Source: 2013 Illinois Behavioral Risk Factor Surveillance System.

According to BRFSS, in 2013, 20 percent of adults in Illinois had provided care or assistance to a friend or family member within the past 30 days. Approximately 80 percent (83.3%) of caregivers provided care or assistance to a relative. Seventy percent provided care to a family member or friend 65 years of age or above. The majority of caregivers provided care to individuals declared to have a major diagnosis of a physical problem (47.3%) rather than mental problem (22.7%). Most often the person for whom the caregiver provides care or assistance is a parent (38.4%) or non-relative (16.1%).

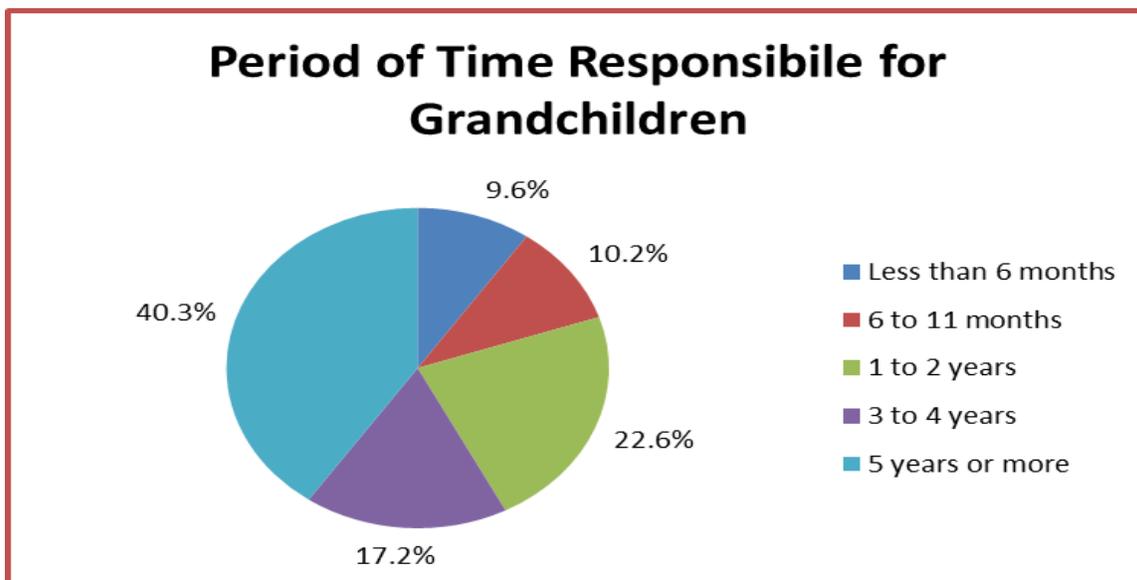


Source: 2013 Illinois Behavioral Risk Factor Surveillance System.

Caregivers can spend years providing care to a friend or family member. More than 20 percent of caregivers had spent more than five years providing care to one person. According to BRFSS, in 2013, an estimated 121,334 hours were spent by caregivers in Illinois providing assistance to someone with Alzheimer’s disease or dementia. Approximately 8 percent of caregivers were spouses providing an estimated 19,292 hours spent providing care by spouses, leaving less time for employment. To compound the complexity of caregiving, spouses serving as caregivers are not eligible for disability benefits for providing such care, reducing household earnings to create a large financial burden.

### **GRANDPARENTS RAISING GRANDCHILDREN**

Researchers and public policy makers began to comment on an increase in the number of grandchildren living in grandparent-maintained households in the early 1990’s. This trend has increased in the past two decades and the greatest growth has occurred among grandchildren living with grandparents with no parent present. In Illinois, there are 274,891 grandparents residing with their grandchildren and 97,103 are responsible for them (U.S. Census Bureau, 2010-2014 American Community Survey). Over 40% of grandparents responsible for their grandchildren have been providing care for five years or more. The increase of grandchildren in these living arrangements has been attributed to the growth in drug use among parents, teen pregnancy and divorce causing the rapid rise of single-parent households, mental and physical illness, AIDS, crime, child abuse and neglect, and incarceration of parents. The Aging Network will continue to develop intervention skills that focus on the needs of families as well as the needs of older adults.



Source: 2010-2014 American Community Survey 5 Year Estimates, Table B10050.

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- U.S. Bureau of the Census. *2014 Population Estimates*, Table CC-EST2014-AllData-17.
- U.S. Bureau of the Census. *2010-2014 American Community Survey 5-Year Estimates, Tables B17020, Table S1810, and Table B10050*.
- U.S. Bureau of the Census (2011). *2010 Census Summary File 1*.

# **APPENDIX B**

## **OLDER AMERICANS ACT**

## **HISTORICAL INFORMATION ON THE OLDER AMERICANS ACT**

The Older Americans Act (OAA) was enacted in 1965. The Act's purpose was to give older Americans increased opportunities for participating in the benefits of American society.

The Older Americans Act specifies that all older persons are eligible for services regardless of income. Generally, older persons are defined as those individuals who are age 60 and over. Preference must be given to those with the greatest economic or social need, with special attention to low-income minorities and older adults residing in rural areas. States and Area Agencies on Aging cannot use income screening to determine eligibility for services.

However, as funds become more limited, options for targeting services to the most vulnerable continue to be explored and implemented. The Area Agencies on Aging continue to assure that wide ranges of services are offered in their planning and service areas.

The following highlights some of the major changes to the Act over the past 40 years:

**1965** - The Act was enacted and contained a ten-point set of broad policy objectives aimed at improving the lives of older persons. Those objectives are to assure older persons:

- An adequate income in retirement;
- The best possible physical and mental health;
- Obtaining and maintaining suitable housing;
- Full restorative services for those who require institutional care;
- Opportunity for employment;
- Retirement in health, honor and dignity;
- Participating and contributing to meaningful activity;
- Efficient community services;
- Immediate benefit from proven research knowledge;
- Freedom, independence and the free exercise of individual initiative;
- Full participation in the planning and operation of community-based services;
- Protection against abuse, neglect and exploitation.

**1972** - The Nutrition Program for the Elderly Act was signed into law authorizing \$100 million for a national nutritional services program for the elderly.

**1973** - The Act was amended to require State Units on Aging (SUAs) to divide their states into planning and service areas (PSAs) and to designate Area Agencies on Aging (AAAs) to administer programs for the elderly in those PSAs. AAAs were assigned the chief responsibility for planning, coordinating, developing, and pooling resources to assure the availability and provision of a comprehensive range of services in the PSA.

**1975** - The Act was amended to allow the Commissioner to make direct grants to Indian tribes. Priority services were also mandated.

**1978** - The Act was amended to consolidate Title III - Social Services, Title V - Multipurpose Senior Center, and Title VII - Nutrition Services into one Title III with separate allocations for Title III-B - Social Services, Title III-C-1 - Congregate Meals, and Title III-C-2 - Home-Delivered Meals.

**1981** - The Act was amended to streamline and improve the efficiency of programs, increase flexibility to meet local needs, and increase the participation of older persons in the operation of the programs intended to serve them.

**1984** - The Act was amended to direct funding of National priority services (access, in-home, legal).

**1987** - The Act was amended to increase the focus placed on serving low-income minority older persons. Extensive outreach efforts were required to inform older persons in greatest need of their eligibility to receive benefits such as Supplemental Security Income (SSI), Medicaid, and Food Stamps. A new Title III-D was created which provides funds for in-home services. Ombudsman programs at the state level were strengthened and expanded.

**1992** - The Act was amended to increase the focus of providing preventive health services through Title III-F, with priority to areas of the state that are medically underserved and where there are a large number of persons in greatest economic need. A New Title VII was created, which provides a separate allotment for carrying out vulnerable elder rights protection activities, including the ombudsman program, the prevention of elder abuse, neglect, and exploitation, and benefits counseling.

**2000** - The Older Americans Act was reauthorized by Congress in the fall of 2000 for a five-year period. The amended Act contained new provisions for the National Family Caregiver Support Program and renamed Title III-D from *In Home Services* to *Disease Prevention and Community Services* with corresponding programmatic changes.

**2006** - The Older Americans Act was reauthorized by Congress for a five-year period. The amendments retained the targeting provisions for older adults in greatest economic and social need with special attention to minorities and older individuals residing in rural areas, and added a new focus on older individuals with limited English proficiency. The amendments also focused on the principles of consumer information for long-term care planning, evidence-based health promotion and prevention programs, and self-directed community-based services to older individuals at risk of institutionalization.

**2016** The U.S. House of Representatives passed S. 192. On March 21, 2016, the House passed S. 192, the Older Americans Act Reauthorization Act of 2016, by unanimous voice vote. On April 19, President Obama signed the Older Americans Reauthorization Act of 2016 into law. The reauthorization reflects priorities, including provisions that provide better protection for vulnerable older adults; streamline and improve program administration; improve nutrition services; align senior employment services with the workforce development system; create new support for modernizing multipurpose senior centers; highlight the importance of addressing economic needs; require that health promotion and disease prevention initiatives be evidence-based; and, promote chronic disease self-management and falls prevention.

## **OLDER AMERICANS ACT CLASSIFICATIONS**

The State Plan on Aging represents planning commitments by the State regarding Title III (Grants for State and Community Programs on Aging) and Title VII (Vulnerable Elder Rights Protection Activities) of the Older Americans Act. The following services are funded under Title III and Title VII.

### **Title III-B Supportive Services and Senior Centers**

- **Access Services** - Assisted Transportation, Individual Needs Assessment, Information & Assistance, Outreach, and Transportation.
- **In-Home Services** - Adult Day Care, Chore Housekeeping, Friendly Visiting, Home Health, Homemaker, Respite, and Telephone Reassurance.
- **Community Services** - Counseling, Education, Employment Assistance, Legal Assistance, Multipurpose Senior Center, and Recreation.

### **Title III-C Nutrition Services**

Under Title III-C-1, the Department on Aging is allotted funds for congregate nutrition services. Congregate meals are served in group settings such as senior centers, schools, churches, or other community settings. Title III-C-1 funds may also be used to provide nutrition education and other appropriate nutrition services for older persons.

Under Title III-C-2, the Department on Aging is allotted funds for Home Delivered Meal nutrition services. Home Delivered Meals are delivered to homebound older persons. Title III-C-2 funds may also be used to provide nutrition education and other appropriate nutrition services for older persons.

### **Title III-D Disease Prevention and Health Promotion Services**

These funds are currently used for a variety of health related services at the local level often in conjunction with local health departments. Programs include routine health screening, mental health screening, gerontological counseling, medication management, home injury control, physical fitness and health risk assessments. In FY 2017, the Area Agencies on Aging have incorporated evidence-based health promotion programs in their FY 2016-FY 2018 Area Plans.

### **Title III-E National Family Caregiver Support Program**

The Family Caregiver program provides five basic service categories to family caregivers of older adults and grandparents raising grandchildren, including: information about services; assistance in accessing services; counseling, support groups and training/education; respite care; and, supplemental services.

### **Title VII Vulnerable Elder Rights Protection Activities**

Title VII establishes programs to carry out vulnerable elder rights protection activities. The programs involved are the Long Term Care Ombudsman Program, elder abuse prevention activities and the legal assistance development program.

**APPENDIX C**

**ELDER RIGHTS PLAN**

# ELDER RIGHTS PLAN

## BACKGROUND INFORMATION

Older persons and adults with disabilities have the right to live free from abuse, neglect or exploitation. They also have the right, unless they have been adjudicated to lack mental capacity, to make their own decisions about where and how they will live, and with whom. Unfortunately, some individuals, both those who live at home and those who reside in long-term care facilities, are at risk of mistreatment by others. The Department on Aging operates two programs, the Long-Term Care Ombudsman Program (LTCOP) and the Adult Protective Services Program (APS) to ensure that vulnerable older adults are not mistreated and are able to exercise their rights. Both of these programs are designed to inform individuals of their civil, legal, and human rights and to assist them with exercising those rights. As such, they reflect the Department's longstanding commitment to the rights of older persons.

In 2013, the Illinois Act on the Aging was amended to expand Ombudsman services into the community. Ombudsmen 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.

On July 1, 2013 the Illinois Department on Aging assumed responsibility for the investigation of cases of suspected abuse, neglect and financial exploitation of adults with disabilities, age 18-59, who reside in the community. Illinois followed nationally-recognized best practices by creating a single Adult Protective Services agency in the State.

The Long-Term Care Ombudsman Program and the Adult Protective Services Program have Advisory Groups consisting of Area Agencies on Aging and provider agencies. The Advisory Groups have served as important vehicles to obtain the views of Area Agencies on Aging, adult protective services provider agencies and Regional Long-Term Care Ombudsman Programs.

The Department on Aging has also sought the input of the Illinois Council on Aging and the Illinois Long-Term Care Council. The Illinois Council on Aging is the state level advisory body to the Department on Aging, as mandated by the Illinois Act on the Aging. The Illinois Council on Aging was created to promote advocacy on behalf of older adults in response to the Illinois Act on the Aging. The Illinois Long-Term Care Council was formed in 2006 to advise the Department on Aging on matters pertaining to the quality of life and quality of care in the continuum of long-term care. Both Councils provide guidance to the Governor and the General Assembly by advising them on the concerns, problems, and services provided to older adults in our State. Representatives of the Illinois Council on Aging also serve on the Adult Protective Services Advisory Committee.

As advocacy-based programs, the success of the Adult Protective Services Program and the Long-Term Care Ombudsman Program in serving older adults is often based on the ability to refer and persuade other agencies or entities to be responsive to the problems of the older adults.

The Department on Aging regularly works with other state agencies and associations such as the Department of Healthcare and Family Services, the Department of Public Health, the Department of Human Services, the Law Enforcement Training and Standards Board, the State Police, the Office of Attorney General, the Illinois Association of Chiefs of Police, the Illinois Sheriff's Association, the Illinois Criminal Justice Information Authority, the Illinois Family Violence Coordinating Councils, the Illinois Coalition Against Domestic Violence and others in order to collaborate on issues of elder rights.

The Department on Aging has worked with other agencies and associations to improve response to older victims of mistreatment. For example, the Illinois State Triad, of which the Department on Aging is an active member, has implemented "B\*SAFE" (Bankers and Seniors Against Financial Exploitation). "B\*SAFE" is a project responsible for training bank customer service personnel to identify, report, and prevent financial abuse of older persons and adults with disabilities.

The State Triad also holds an annual statewide conference on crimes against the elderly for law enforcement officers and aging advocates, and provides specialized training to certify "Elderly Services Officers" two to three times a year.

The Department on Aging encourages adult protective services provider agencies and LTC Ombudsman Programs to make appropriate referrals to law enforcement. The Long-Term Care Ombudsman Program makes appropriate referrals to law enforcement and regulatory agencies if the resident gives permission or consent to the LTCOP to act.

In some cases, Adult Protective Services Program caseworkers will have knowledge of criminal behavior directed at older adults by family, household members, or others. Under specific circumstances, the caseworker is required to report the matter to law enforcement agencies and/or the State's Attorney's Office. These circumstances include, but are not limited to death, brain damage, bone fracture, and sexual assault. The older adult has the right to decide whether or not they wish to report the crime to the authorities in less serious cases. If the abuse or neglect against an individual with mental capacity was a misdemeanor or does not immediately threaten serious harm to the individual, the older adult has the right to decide whether they wish to report the crime to the authorities.

Adult Protective Services Program caseworkers are required to immediately report, to law enforcement and the coroner or medical examiner, any death of an older adult or an adult with disabilities that may be the result of abuse or neglect. The Department on Aging has also established abuse fatality review teams in each of its planning and service areas for the purposes of identifying and reviewing suspicious deaths, facilitating communications among officials responsible for autopsies and inquests and the individuals involved in reporting or investigating abuse and neglect and individuals involved in providing services, evaluating the means by which the death could have been prevented; and making recommendations that may help reduce the number of deaths caused by abuse and neglect.

The Department on Aging has worked with domestic violence advocates to increase referrals and recognition of elder abuse and abuse of adults with disabilities as another form of family violence through additional presentations at local Family Violence Coordination Councils and the statewide Illinois Family Violence Coordinating Council Steering Committee.

The Department on Aging also sponsors an Adult Protection and Advocacy Conference (APAC) each year for Adult Protective Services workers and Ombudsmen. Experts from all around the

country present to aging and disability advocates, medical professionals, Adult Protective Services workers, Ombudsmen, and legal service providers on the multiple facets of the aging and disabilities networks.

The Department on Aging included an assurance in this document outlining that the State will not supplant pre-existing funds to carry out each of the vulnerable elder rights protection activities as required by Title VII of the Older Americans Act. The Department on Aging reviews Area Plan budgets to ensure that Area Agencies on Aging do not supplant pre-existing funds to carry out elder rights protection activities.

## **LONG-TERM CARE OMBUDSMAN PROGRAM**

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 17 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, approximately 200 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 a number of 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.

The Long-Term Care Ombudsman Program works to protect and promote the rights and quality of life for long-term care residents. The program strives to ensure that existing state and federal laws as well as rules and regulations are adhered to and that resident and family voices are heard during drafting or revision of laws or rules through the advocacy service components of the program.

Complaint investigations are the program's number one priority followed by consultations and inquiries, providing regular presence visits to facilities, community education, and conducting systems advocacy. Regular presence ensures that residents have information about their rights, while investigative services focuses on the health, safety, welfare, and the rights of residents.

Ombudsmen are resident-directed. This means that Ombudsmen must follow the direction of the resident, regardless of who brought forward a complaint. If at any point during the complaint investigation, the resident expresses that he or she does not want the LTCO to take further action on a complaint involving the resident; Ombudsmen must discontinue work on the complaint.

In 2014, the Long-Term Care Ombudsman Program Standards were revised and are now called the Illinois Long-Term Care Ombudsman Program Policies and Procedures. Policies and procedures with regards to the Home Care Ombudsman expansion were added and several sections were updated and strengthened. With the new Federal Rule for the Ombudsman program coming into effect July 1, 2016, there is a need for additional revisions to be in compliance with the new Federal Rules.

The Long-Term Care Ombudsman Program strives for visibility in the community. Awareness of the program has been a struggle for years. A new brochure titled “You Have Rights” was developed in 2015 to replace the former “You Have a Voice” brochure. In addition, the “You Have a Voice” poster was revised and renamed “You Have Rights”. The posters are distributed to all long-term care facilities and the brochures are given to residents, family members, and members of the community. The State Office is also in the process of developing two additional posters and brochures to explain the rights of individuals receiving services under a managed care organization or receiving services at home under a Medicaid waiver.

The Long-Term Care Ombudsman Program will continue to work with state, local and civic organizations to improve service coordination and increase volunteer recruitment. As the projected increase of residents due to the “baby boomer” generation, more nursing home advocates will be needed to effectively advocate and educate residents and family members.

In the past, the state-wide ratio for Ombudsman per bed has been much lower than the recommended 1:2,000 beds. With the addition of the LTC Provider Fund Grant, the state-wide program is now at this recommended ratio. Also with the addition of the Provider Fund Grant, the State Office developed state-wide and regional benchmarks. The Illinois benchmarks were set after completion of a limited comparison of state LTCOP benchmark measures by the National Ombudsman Resource Center on behalf of the Illinois LTCOP. The Office used the recommendations for future continuous quality improvements from the July 2013 benchmark report findings as the basis for creating the current benchmarks for the Illinois LTCOP. The benchmarks reflect the minimum requirement for the following activities: Closed Cases, Consultations to Individuals, Regular Presence Visits, Facility Staff In-Services, Community Education Sessions, and Resident Council Meetings.

While the Home Care Ombudsman expansion activities are tracked, there are no current benchmarks for this program. The reason for no current benchmarks is because it is a new program and there was no data in which to determine appropriate expectations of activities. Once the program evolves and statistics can be pulled, the Office will make a determination of appropriate benchmarks for the expansion.

Every three years, the 17 Regional Ombudsman programs are monitored and evaluated by the Office of State Long-Term Care Ombudsman. Program evaluation includes interviews with the Area Agency on Aging, the provider agency, Regional, Community and Volunteer Ombudsmen. The assessments also include observing ombudsmen during facility visits, and reviewing case and complaint investigation documentation.

Evaluation of the LTCOP is in accordance with the principles of quality improvement and program effectiveness. The LTCOP activities and complaint data are compared to the respective Annual Services Plan.

Regional programs are required to submit an Annual Services Plan and quarterly program reports to their respective AAA and to the Office. The Ombudsman Program Annual Service Plans support a more centralized statewide program while recognizing different regional resident issues and priorities. Contents of the plan include activities to meet or exceed the service components of the statewide Ombudsman Program. Regional Ombudsman programs provide strategies to help achieve the statewide initiative, “promote safety and good care within licensed nursing facilities” as well as providing local initiatives and strategies to address them.

It is the responsibility of the State Long-Term Care Ombudsman (SLTCO) to designate provider agencies. In order to be eligible for designation by the SLTCO as a provider agency, an entity must:

- Be a public or nonprofit entity;
- Not be an agency or organization responsible for licensing or certifying long-term care services;
- Not be an association (or an affiliate of an association) of providers of long-term care or residential services for older persons;
- Have no financial interest in a long-term care facility;
- Have demonstrated capability to carry out the responsibilities of the provider agency;
- Not be part of an agency which limits the ability of an ombudsman to be objective and independently investigate and resolve complaints;
- Have a clearly definable unit to function as the Regional LTCOP;
- Have sufficient staff to perform all duties and responsibilities of the Regional LTCOP which shall include a designated individual, known as the Regional Ombudsman, who has the overall responsibility for the activities of the Regional LTCOP and at a minimum have one full time equivalent staff person for every 2,000 licensed long-term care facility beds.

The Department does not impose any restrictions on the eligibility of entities for designation as local Ombudsman programs in addition to the criteria set forth in Section 712(a)(5)(C) of the Older Americans Act.

Conflicts of interest exist in the LTCOP when other interests intrude upon, interfere with, or threaten to negate the ability of the LTCOP to independently investigate and resolve complaints without compromise on behalf of long-term care facility residents.

Based on the provision of the Older Americans Act and the Illinois Act on the Aging, all records of the Illinois Long-Term Care Ombudsman Program are confidential and are disclosed only in limited circumstances specifically provided by applicable law. Other than the resident, only the State Ombudsman has the authority to disclose Ombudsman records.

The Resident's Right to Know Act became law on January 1, 2009, which amended the Illinois Act on the Aging, the Nursing Home Care Act (NHCA), and the Consumer Fraud and Deceptive Business Practices Act. The law requires each licensed, long-term care nursing facility to complete an annual Consumer Choice Information Report that includes information about the facility's quality of care, services and security issues related to the residents and the staff of the facility. This important information will assist families in choosing a facility or monitoring a facility where a family member might currently reside. The Office of State Long-Term Care Ombudsman is responsible for developing a data base of consumer choice information reports completed by facilities and making this information accessible to the public on the internet by means of a hyperlink labeled "Resident's Right to Know" on the IDoA home page. The Office has the authority to maintain the database and ensure that information provided by the facility is accurate.

Since March 2010, the Long-term Care Ombudsman Program (LTCOP) has placed greater emphasis and involvement to increase the outreach and education efforts to transition older adults out of long-term care facilities. Due to the ongoing regular presence of ombudsmen in facilities and the 24-hour access provisions, ombudsmen are best equipped to identify residents interested in a referral to the Money Follows the Person Project (MFP). Ombudsmen build

relationships, trust and familiarity with residents, therefore, ensuring factual conversations centered on MFP. Since Ombudsmen are resident directed, referrals are made to the MFP program based on residents' wishes.

From its initial involvement, the LTCOP has made a significant number of MFP referrals to the Department on Aging, Department of Mental Health and Department of Rehabilitation Services. By conducting ongoing regular presence visits, conducting public education activities, and attending Resident and Family Council meetings, Ombudsmen have made significant strides in reaching and educating both residents and family members. However, a lack of mental health services offered in the community has been a significant challenge with successful transitions statewide.

As Illinois continues to push to rebalance the long-term care system, it is important for the LTCOP to remain involved in the MFP referral process. Armed with firsthand knowledge about the residents, ombudsmen build relationships, which make their involvement critical, unique and an integral part of the MFP process. Since the partnership began, Ombudsmen MFP referrals have not only increased, but afforded married couples and individual residents the opportunity to be considered for community placement. When adequate resources, services and supports are provided, many residents living in long-term care facilities have the capability to reside outside of institutional settings.

## **ADULT PROTECTIVE SERVICES PROGRAM**

The Adult Protective Services Program (formerly the Elder Abuse and Neglect Program) became available statewide on April 1, 1991. It operated in accordance with the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), which was signed into law in 1988. The Act was amended to become the Adult Protective Services Act on July 1, 2013. The Adult Protective Services Act directs the Department to establish an intervention program to respond to reports of alleged abuse, neglect, and exploitation (ANE) of older adults and adults with disabilities who live at home at the time of the report, and to work with the individual in resolving the abusive situations. The Act also provides immunity from civil and criminal prosecution, both for persons who report ANE and for caseworkers who respond to those reports, as long as they act in "good faith" in the best interest of the older person involved.

The Elder Abuse and Neglect Act was amended in 1998 to require certain professionals to report suspected abuse, neglect and exploitation of persons 60 and over (and now adults with disabilities 18-59) if there is reason to believe that the individuals, because of a disability or other condition or impairment are unable to report for themselves. Other amendments to the Act included provision for persons cooperating with investigations; hearsay exceptions for victim testimony; law enforcement referral requirements; and the rights to petition a court to freeze a victim's assets pending investigation or interventions.

On January 1, 2004 additional amendments to the Elder Abuse and Neglect Act were implemented. Paramedics and emergency medical technicians were added to the list of professionals who are mandated reporters. Other amendments included the requirement that the Department on Aging establish an aggressive training program about elder abuse, and solicit financial institutions and utility companies for the purpose of making information available regarding financial exploitation and related financial fraud and abuse, as well as information regarding telemarketing and home repair frauds. These amendments also included the

introduction of penalties for physicians, dentists, and other mandated reporters who willfully fail to report elder abuse.

Effective January 1, 2007, the Elder Abuse and Neglect Act was amended to include self-neglect, contingent upon sufficient funding. In the absence of sufficient funding for implementation, provider agencies began receiving reports of self-neglect and referred the reports to the most appropriate agency(s) for follow-up.

In 2007, amendments to the Elder Abuse and Neglect Act added a requirement for 24 hour response to provider agencies' responsibilities, in cases of imminent risk to an alleged victim. In addition, amendments were added that allowed for the establishment of elder abuse fatality review teams.

The definition of self-neglect was enhanced in an amendment to the Elder Abuse and Neglect Act, effective January 1, 2010, which expanded the definition to include "compulsive hoarding," and included services that must be available to older adults who must be removed from their residences. In addition, the Elder Abuse and Neglect Act was amended, effective January 1, 2010, to allow for the identity of an elder abuse victim, who is at imminent risk of death as a result of abuse or neglect, to be shared with the office of a coroner or medical examiner.

An amendment to the Elder Abuse and Neglect Act, which became effective July 19, 2010, mandated training of new and current bank employees who have direct customer contact. The Department on Aging and the Department of Financial and Professional Regulation (DFPR) established, through joint rules, minimum training standards. DFPR oversees enforcement and provides the Department on Aging with bi-annual reports.

As a result of the new training requirement, more than 3,000 bank employees were trained prior to the deadline of February 1, 2012, utilizing the B\*SAFE training module. New employees must be trained within the first six months of employment, and training must be repeated every three years. An increase in reporting on the part of financial institutions has been documented.

Significant amendments to the Elder Abuse and Neglect Act occurred in 2013. The Act name was amended to become the Adult Protective Services Act. The Adult Protective Services Program expanded its responsibilities to include services to adults with disabilities age 18-59. Other amendments included reporting suspicious deaths to law enforcement and the coroner or medical examiner and establishing regional fatality review teams. In addition, the 2013 amendments included provisions for the Department on Aging to establish an abuser registry, which identifies any caregiver who has a verified finding of abuse, neglect or financial exploitation of an older adult or an adult with a disability under the Adult Protective Services Act.

The Adult Protective Services Program strives to build on the existing legal, medical, and social service systems to assure that it is more responsive to the needs of abuse victims and their families. In administering the program the Department designates regional administrative agencies (Area Agencies on Aging) to coordinate activities at the regional level. The Area Agencies on Aging, with Department approval, designate adult protective services provider agencies to respond to reports within their geographic service area.

Area Agencies on Aging (AAAs) provide administrative support to the State's Adult Protective Services Program in a number of key program areas. AAAs provide technical assistance to adult protective services provider agencies on program standards and procedures, conduct quarterly meetings with the provider agencies in their respective planning and service areas for

the primary purpose of addressing program implementation issues, and also monitor the performance of adult protective services provider agencies to assure appropriate service interventions on behalf of abuse victims. AAAs also participate in public education efforts on the issues of abuse, neglect and exploitation of older adults and adults with disabilities.

The service delivery components of the program include intake of reports, assessments, case work, follow-up, early intervention services, multi-disciplinary teams and public awareness and education. The adult protective services provider agency has up to 30 days to conduct a comprehensive investigation both to determine if the individual has been mistreated and to determine their needs for services and interventions. If the abuse is substantiated, the adult protective services caseworker involves the individual in the development of a case plan to mitigate the risk to the individual. Services might include in-home care; adult day services; respite; health services; counseling, etc. Other interventions might include an order of protection, obtaining a representative payee, or assisting the individual in obtaining other legal remedies. The Adult Protective Services caseworker continues to oversee the progress of case plan goals, alter the case plan as necessary and monitor the individual's level of on-going risk.

A major guiding principle of the Adult Protective Services Program is the victim's right to self-determination. If a victim, who is able to consent, refuses all services offered, the adult protective services provider agency is required to close the case; however, the agency must inform the victim of methods to contact the adult protective services provider agency in the future. When a victim lacks capacity, and in certain very serious life-threatening cases of abuse or neglect, the adult protective services provider agency is required to report the situation to law enforcement for investigation. In addition, when a victim who lacks capacity requires a substitute decision maker, the adult protective services provider agency is authorized to petition for guardianship, although the program may not act as guardian in order to avoid any real or perceived conflicts of interest.

All records concerning reports of abuse, neglect, and financial exploitation and all records generated by such reports are confidential and are not disclosed except under specific circumstances authorized by law or with the consent of the individual.

A wealth of public education materials on abuse continues to be distributed, including information targeted at four different professional groups (law enforcement, financial institutions, in-home workers and health care providers) explaining the indicators of abuse, neglect and exploitation, as well as material targeted at mandated reporters. The materials are designed to inform professionals and the general public about the signs of abuse, neglect and exploitation and encourage them to report cases to the Adult Protective Services Program.

The Department, Area Agencies on Aging, and local adult protective services provider agencies make numerous presentations at conferences, workshops, college classes and elsewhere to raise awareness about abuse, neglect and exploitation and the Adult Protective Services Program.

## **LEGAL ASSISTANCE DEVELOPMENT**

As required by the Older Americans Act, the Illinois Department on Aging has assigned a staff member to serve as the Legal Services Developer for the Aging Network. The Legal Services Developer provides state leadership in securing and maintaining the legal rights of older persons, coordinates the provision of legal assistance services in Illinois, and provides technical

assistance, training and other supportive services to Area Agencies on Aging, legal assistance providers, long-term care ombudsmen, and adult protective services case workers. The Legal Services Developer is also responsible for promoting the development of pro bono legal assistance programs and state and local bar association committees on aging. During the next three years, the Legal Service Developer will be focusing on the following major activities that support elder rights programs in Illinois:

- Build communications with Title III legal service providers to discuss emerging issues and changes in laws and regulations.
- Identify training needs among Title III legal service providers and arrange for training as needed.
- Assist in organizing and participating in legal trainings for attorneys on elder rights issues.
- Facilitate coordination and communication among adult protective services provider agencies, the State Triad, law enforcement and legal service providers.
- Facilitate coordination and communication between Regional Long-Term Care Ombudsmen and legal service providers.
- Participate in legislative drafting, analysis and advocacy such as amending the Adult Protective Services Act, strengthening laws against financial exploitation, and strengthening long-term care residents' rights.
- Participate in the planning of the Adult Protection and Advocacy Conference, put on by the Department on Aging annually, to provide essential information to attorneys, adult protective services caseworkers and supervisors, and long-term care ombudsmen.
- Advise the adult protective services provider agencies on legal and policy matters, particularly relating to legal interventions, court relations and confidentiality.
- Work on drafting of rulemakings related to the Adult Protective Services Program and the State Long-Term Care Ombudsman Program.

**APPENDIX D**

**EMERGENCY PREPAREDNESS PLAN**

# EMERGENCY PREPAREDNESS PLAN

The Illinois Department on Aging (Department) works closely with the Illinois Emergency Management Agency (IEMA) and other participating State Agencies through interagency coordination under the Illinois Emergency Management Act and the Illinois Emergency Operations Plan (IEOP) in responding to all natural and man-made disasters. 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 State Incident Response Center (SIRC) so the Department can advocate for seniors before, during and immediately after an event.

Under the IEOP, the Department helps support the Operational Annexes of Population Related Disaster Services (formerly known as Mass Care) and Resource Management. In 2015 and 2016, several activities have and continue to be conducted by IEMA and the allied State Agencies (staff) to revise and update the Continuity of Operations Plan (COOP) and the IEOP.

In conjunction with the Governor's Office and the Illinois Emergency Management Agency (IEMA), the Department and other State Agencies established COOP Plans and they have been in existence since 2005. The Department is responsible for disaster preparedness and response activities to protect the agency's staff, their families and the older persons, caregivers and those who are disabled when disaster situations arise.

The Department's and other State Agencies' COOP Plans are established for circumstances in which any office location is threatened or incapacitated, and relocation of personnel and processes must occur. The Plans also provide policy and guidance to ensure the capability to implement actions that allow continuation of agency mission-critical processes—no later than 12 hours after COOP activation and to be maintained for up to 30 days. Governments at federal, state, and local levels have a fundamental responsibility to provide uninterrupted essential services to the public regardless of circumstances.

In April of 2015, IEMA requested the COOP Plans be updated for the purposes of re-accreditation. Illinois' re-accreditation efforts center around the Emergency Management Program, or whole community, that is reflective of all agencies, boards, commissions, and organizations represented in the State Incident Response Center (SIRC). IEMA was notified on October 21, 2015 that Illinois had retained its national accreditation status from the Emergency Management Accreditation Program (EMAP) following the rigorous, week-long program review that was conducted here in July of 2015 of all COOP Plans.

At the writing of this narrative, the Department and other State Agency liaisons are in the process of also revising the entire IEOP. The Department's efforts to coordinate activities throughout Illinois in Annex 8(H) entitled Population Related Disaster Services (PRDS) (formerly known as Mass Care) are briefly shown below:

1. Coordinate and support the implementation of state and federal disaster assistance programs to meet the needs of elderly populations.
2. Assist with providing Functional Needs Support Services (FNSS) to adult populations.
3. Coordinate and manage contact with elderly populations and their caregivers in the community.

4. Provide information on status and needs of elderly populations and their caregivers in the community.
5. Support identification and provision of specialized personnel at designated PRDS Facilities.

The Department has a functional Disaster Operations Plan in place. The Illinois Aging Network (which includes 13 AAAs and their local service providers) has developed their own proactive, action-oriented local disaster plans for use in their Planning and Service Areas (PSA). Through Illinois' emergency management system and having a liaison at the SIRC, the Department has developed and refined contingency plans to help Illinois' older residents. This is done by participating in the regular exercises conducted at the SIRC throughout the year that include AAAs and their respective service providers. It is extremely important that all exercises include everyone especially those at the local grassroots level. The Department also has taken advantage of the opportunity to participate in ongoing table top exercises during the monthly briefings at the SIRC.

In regard to the IEOP, the lead State organization for Annex 8(H) entitled Population Related Disaster Services (PRDS) (formerly known as Mass Care) is the State Liaison of the American Red Cross. In conjunction with a federal "Statement of Understanding," between the U.S. Department of Health & Human Services and the American Red Cross (ARC), the Department continues to work very closely with the ARC throughout Illinois, at the state and local levels, to prepare and respond to all disasters. The Illinois Aging Network works directly with and accompanies representatives of the ARC Chapters in the response and recovery phases of disasters. In conjunction with the AAAs' and their service providers' disaster plans, outreach workers, case managers, etc., do damage assessments, outreach, provide meals and assist with family/casework services with the ARC.

The Department continues to work with IEMA, ARC, Illinois Department of Public Health (IDPH) and other allied state agencies to provide ongoing training to meet the needs of our network annually. The ARC and the IDPH continue to offer training on the complex needs of the "Functional Needs Populations". In order to provide a coordinated disaster response/recovery, the Illinois Aging Network is tasked to develop and refine their ongoing relationships with their local ARC Chapters, Emergency Management Agencies, Volunteers Active in Disasters (VOADs), and other disaster relief organizations.

Disaster preparedness information and materials continue to be sent out by the Department to the Illinois Aging Network, as well as to Department staff and their families. Example materials include information on Earthquake Preparedness, Winter Storm Preparedness, Severe Weather Preparedness, Fire Prevention and "Functional Needs Populations" (Note: Please see the book entitled "Emergency Preparedness Tips for Those with Functional Needs" on the Ready Illinois' website at [www.ready.illinois.gov](http://www.ready.illinois.gov)).

In all of the preparedness materials the Department sends to the Illinois Aging Network, older persons are advised that the network will be there to support and protect them. However, with any significant or catastrophic disaster the older person must help too by having a basic survival kit on hand that includes shelf-stable food, water and medications for at least a 72 hour period. Older persons and the local communities in which they live must take a reasonable amount of responsibility for their general welfare.

Under the specific, detailed direction of the State ARC Liaison, when any disaster situation occurs, the Department's Disaster Coordinator coordinates and mobilizes resources and

activities of the Illinois Aging Network, as appropriate. In the event a health related pandemic occurs, the lead State agency is the Illinois Department of Public Health (IDPH). The Department's Disaster Coordinator works closely with them. The Department has participated in pandemic exercises sponsored by IDPH. The Department and the Illinois Aging Network will continue to work on improving coordination at the state and local levels to prepare for and respond to pandemics and other disasters. Additionally, the Department assists in Recovery Operations by helping and locating senior citizens and their caregivers to ensure they obtain all available aid.

Finally, when a disaster occurs, the Department's Disaster Coordinator immediately contacts the AAA(s) involved to see if they and their staff have been affected and to ask that they reach out to their service providers and ask the same. Once it has been determined that they are functional and services continue to be provided, the Disaster Coordinator will ask that they check on the older adults that they serve along with their caregivers.

During the initial response and the early recovery phases of a disaster, the Disaster Coordinator obtains information about the disaster's impact on older persons and their caregivers. The AAA(s) will submit a brief report via e-mail about the current situation to the Department's Disaster Coordinator. The Disaster Coordinator regularly communicates the Department's activities in writing to IEMA, the American Red Cross, allied State Agencies, the Administration on Aging/Administration for Community Living (ACL), and provides information requested/needed by the Federal Emergency Management Agency (FEMA). Additionally, periodic e-mails (updates) are sent to all of the involved parties to keep them apprised of the disaster situation.

# **APPENDIX E**

## **INTRASTATE FUNDING FORMULA**

# INTRASTATE FUNDING FORMULA

## A. INTRODUCTION

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." Illinois is in the last year of a three-year plan period. **Note:** The FY 2013-FY 2015 State Plan on Aging was extended into FY 2016. A new State Plan has been developed for FY 2017 through FY 2019. **Based upon our review of the formula, the Department has decided not to change the intrastate funding formula.**

**Note:** In the IFF Review Report, the Department on Aging outlined that the Department would consider amending the State Plan on Aging and the Illinois administrative rules with IFF revisions if the 13 Area Agencies on Aging can agree on needed changes in the IFF.

## B. 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.

### **C. 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.

### **D. 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	<b>41.0%</b>
Greatest Economic Need: (60+ Poverty)	<b>25.0%</b>
Greatest Social Need:	<b>25.0%</b>
(60+ Minority - 10.0%)	
(60+ Living Alone - 7.5%)	
(75+ Population - 7.5%)	
60+ Rural	<b>9.0%</b>

## **E. APPLICATION OF THE INTRASTATE FUNDING FORMULA**

The intrastate funding formula is:

$$A = (.41 \text{ POP-60} + .25 \text{ POV-60} + .10 \text{ MIN-60} + .075 \text{ LA-60} + .075 \text{ POP-75} + .09 \text{ RUR-60}) \times (T)$$

Where:

- A)  $A$  = Funding allocation from a specific source of funds to a particular PSA.
- B)  $\text{POP-60}$  = Percentage of the state's population within the particular PSA age 60 and older.
- C)  $\text{POV-60}$  = Percentage of the state's population within the particular PSA age 60 and older at or below the poverty threshold.
- D)  $\text{MIN-60}$  = Percentage of the state's population within the particular PSA age 60 and older and a member of a minority group.
- E)  $\text{LA-60}$  = Percentage of the state's population within the particular PSA age 60 and older and living alone.
- F)  $\text{POP-75}$  = Percentage of the state's population within the particular PSA age 75 and older.
- G)  $\text{RUR-60}$  = 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.

## **F. 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 reallocated to those Area Agencies on Aging, which request and demonstrate the need for additional funds in accordance with procedures developed by the Department. Any reallocation 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 reallocation 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 reallocation 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.

# **APPENDIX F**

## **% SHARE OF DEMOGRAPHIC CHARACTERISTICS & WEIGHTED FORMULA**

**BY**

**PLANNING & SERVICE AREA (PSA)**

**Illinois Department on Aging  
Demographic Characteristics of Older Persons  
by Planning & Service Area**

PSA	60+	GEN	Greatest Social Need			60+
	Population	Poverty	Minority	75+	Living Alone	Rural
01	150,520	10,271	13,322	48,194	34,780	60,210
02	612,698	32,316	105,436	171,490	119,935	0
03	117,289	8,000	7,598	39,612	31,094	64,824
04	94,771	6,174	6,520	31,311	22,545	9,256
05	172,973	11,863	12,939	57,023	43,595	53,657
06	31,338	2,595	775	11,264	7,475	29,871
07	107,399	7,403	5,161	35,484	27,355	42,759
08	142,006	10,202	19,111	46,212	34,530	11,398
09	35,423	2,636	1,250	11,825	9,130	35,423
10	30,611	2,350	558	11,067	8,200	30,611
11	68,252	6,318	4,189	21,874	18,070	39,459
12	442,499	71,405	303,554	133,697	122,125	0
13	547,123	36,280	157,986	167,285	125,320	0
<b>TOTAL</b>	<b>2,552,902</b>	<b>207,813</b>	<b>638,399</b>	<b>786,338</b>	<b>604,154</b>	<b>377,468</b>

**% Share of Demographic Characteristics by Planning & Service Area**

PSA	60+	GEN	Greatest Social Need			60+	IFF
	Population	Poverty	Minority	75+	Living Alone	Rural	Weight
01	5.90	4.94	2.09	6.13	5.76	15.95	6.19
02	24.00	15.55	16.51	21.81	19.85	0.00	18.50
03	4.59	3.85	1.19	5.04	5.15	17.17	5.27
04	3.71	2.97	1.02	3.98	3.73	2.45	3.16
05	6.78	5.71	2.03	7.25	7.21	14.21	6.77
06	1.23	1.25	0.12	1.43	1.24	7.91	1.74
07	4.21	3.56	0.81	4.51	4.53	11.33	4.39
08	5.56	4.91	2.99	5.88	5.72	3.02	4.95
09	1.39	1.27	0.20	1.50	1.51	9.39	1.99
10	1.20	1.13	0.09	1.41	1.36	8.12	1.73
11	2.67	3.04	0.66	2.79	2.99	10.45	3.29
12	17.33	34.36	47.54	17.00	20.21	0.00	23.24
13	21.43	17.46	24.75	21.27	20.74	0.00	18.78
<b>TOTAL</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>	<b>100.00</b>

## **APPENDIX G**

# **MINIMUM PERCENTAGE OF TITLE III-B FUNDS TOWARD PRIORITY SERVICES**

## **MINIMUM PERCENTAGE OF TITLE III-B FUNDS TOWARD PRIORITY SERVICES**

The 2006 Amendments to the Older Americans Act stipulate that each State Agency set a minimum percentage of funds to be used in the service categories of access, in-home, and legal to be used by each Area Agency on Aging.

Also, according to the 2006 Amendments, if an Area Agency on Aging expends at least the minimum percentage set by the State, the Area Agency on Aging will have fulfilled the requirement to spend an adequate proportion of funds on such services. The minimum percentage is intended to be a floor, not a ceiling. The amendments encourage Area Agencies on Aging to devote additional funds to each of these service areas in order to meet local needs.

The Older Americans Act continues to allow for the State to grant a waiver to an individual Area Agency on Aging to this provision "...if the Area Agency on Aging demonstrates to the State agency that services being furnished for such category in the planning and service area are sufficient to meet the need for such services in such planning and service area."

### **TITLE III-B ALLOTMENT**

For the purpose of determining minimum percentages and monitoring the expenditure of Title III-B funds on priority services, the Title III-B allotment used for each Area Agency on Aging will be determined as follows:

$$\text{Title III-B} = \text{Base Funding} + \text{Transfers} - \text{Ombudsman Allocation} - \text{AAA Carryover}$$

### **PRIORITY SERVICES**

In determining the minimum percentage of Title III-B funds to be directed toward priority services, the following categories and services will be used:

**Access:**

- Options Counseling
- Assisted Transportation
- Individual Needs Assessment
- Information and Assistance
- Outreach
- Transportation

**In-Home:**

- Adult Day Care
- Chore/Housekeeping
- Friendly Visiting
- Home Health

**In-Home:** Homemaker  
Residential Repair and Renovation  
Respite Care  
Telephone Reassurance

**Legal:** Legal Assistance

**MINIMUM PERCENTAGES FOR FY 2017 - 2019**

The Department will maintain the minimum percentages for the three-year plan period. The following minimum percentages will apply during FY 2017-2019.

<b>Access</b>	<b>33.1%</b>
<b>In-Home</b>	<b>0.04%</b>
<b>Legal</b>	<b>3.2%</b>

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 Department on Aging also administers a State funded in-home services program called the Community Care Program. Current services available through the Community Care Program include case management services, homemaker, adult day services, and emergency home response services. The estimated total expenditure for those three services in FY 2017 will be approximately \$563.3 million dollars. Additionally, in the Governor's proposed budget for FY 2017, the Department will administer a new \$225 million Community Reinvestment Program which will provide in-home and other services to the non-Medicaid population. These two programs reflect a significant commitment by this State to address the needs of our frail older population.

## **APPENDIX H**

# **FY 2017 FEDERAL, STATE & NSIP PLANNING ALLOCATIONS**

**FY 2017 Federal Planning Allocations by Planning and Service Area**

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	43,448	763,602	993,749	518,323	42,842	344,463	2,706,427	16,179	34,949	51,128
02	144,294	2,282,172	2,970,009	1,549,107	131,828	1,029,495	8,106,905	27,490	116,067	143,557
03	35,397	650,111	846,051	441,286	36,160	293,267	2,302,272	6,558	28,473	35,031
04	30,261	389,820	507,310	264,604	26,334	175,849	1,394,178	5,133	24,341	29,474
05	60,383	835,151	1,086,863	566,889	46,930	376,739	2,972,955	25,571	48,571	74,142
06	12,771	214,647	279,341	145,700	11,398	96,828	760,685	4,175	10,272	14,447
07	34,980	541,553	704,775	367,599	31,915	244,296	1,925,118	14,964	28,138	43,102
08	46,016	610,635	794,678	414,491	40,405	275,459	2,181,684	6,342	37,014	43,356
09	13,326	245,488	319,477	166,634	11,398	110,740	867,063	4,344	10,719	15,063
10	10,134	213,414	277,736	144,862	10,613	96,273	753,032	4,168	8,151	12,319
11	19,503	405,856	528,180	275,491	23,977	183,083	1,436,090	5,222	15,688	20,910
12	97,098	2,866,901	3,730,973	1,946,013	223,093	1,293,268	10,157,346	30,690	78,104	108,794
13	146,446	2,316,713	3,014,960	1,572,553	149,201	1,045,076	8,244,949	36,679	117,798	154,477
<b>TOTAL</b>	<b>694,057</b>	<b>12,336,063</b>	<b>16,054,102</b>	<b>8,373,552</b>	<b>786,094</b>	<b>5,564,836</b>	<b>43,808,704</b>	<b>187,515</b>	<b>558,285</b>	<b>745,800</b>

Title III-B Includes:		Title III-C1 Includes:		Title III-C2 Includes:		Title III-D Includes:	
FY 16 Funds	14,316,068	FY 16 Funds	17,286,541	FY 16 Funds	8,373,552	FY 16 Funds	786,094
IDoA Admin.	1,083,915	IDoA Admin.	1,232,439	IDoA Admin.	0	IDoA Admin.	0
IDoA Ombud.	202,033						
III-B Distrib.	13,030,120	III-C1 Distrib.	16,054,102	III-C2 Distrib.	8,373,552	III-D Distrib.	786,094

Title III-E Includes:		Title VII EA Includes:		Title VII Omb Includes:	
FY 16 Funds	5,564,836	FY 16 Funds	197,384	FY 16 Funds	587,668
IDoA Admin.	0	IDoA Admin.	9,869	IDoA Admin.	29,383
		M-Teams			
III-E Distrib.	5,564,836	VII EA Dist.	187,515	VII Omb Dist.	558,285

**FY 2017 General Revenue Fund (GRF) Planning Allocations by Planning and Service Area**

<b>PSA</b>	<b>Title III Adm. Match</b>	<b>Title III Serv. Match</b>	<b>Home Del. Meals</b>	<b>Comm.-Based Services</b>	<b>Comm.-Based Services</b>	<b>Ombudsman Services</b>	<b>Total GRF</b>	<b>Total Federal</b>	<b>Total Funds Fed &amp; State</b>
<b>01</b>	90,662	57,708	1,092,535	329,622	134,707	177,875	<b>1,883,109</b>	<b>2,757,555</b>	<b>4,640,664</b>
<b>02</b>	271,400	172,031	3,265,250	985,139	134,707	506,625	<b>5,335,152</b>	<b>8,250,462</b>	<b>13,585,614</b>
<b>03</b>	77,165	49,153	930,155	280,631	134,708	138,500	<b>1,610,312</b>	<b>2,337,303</b>	<b>3,947,615</b>
<b>04</b>	46,651	29,092	557,740	168,272	134,708	120,375	<b>1,056,838</b>	<b>1,423,652</b>	<b>2,480,490</b>
<b>05</b>	99,611	62,661	1,194,905	360,508	134,708	233,375	<b>2,085,768</b>	<b>3,047,097</b>	<b>5,132,865</b>
<b>06</b>	25,527	16,179	307,110	92,656	134,708	52,000	<b>628,180</b>	<b>775,132</b>	<b>1,403,312</b>
<b>07</b>	64,402	40,823	774,835	233,771	134,708	149,875	<b>1,398,414</b>	<b>1,968,220</b>	<b>3,366,634</b>
<b>08</b>	73,058	45,590	873,675	263,591	134,708	187,375	<b>1,577,997</b>	<b>2,225,040</b>	<b>3,803,037</b>
<b>09</b>	29,047	18,652	351,235	105,969	134,708	58,625	<b>698,236</b>	<b>882,126</b>	<b>1,580,362</b>
<b>10</b>	25,233	16,234	305,345	92,124	134,708	44,000	<b>617,644</b>	<b>765,351</b>	<b>1,382,995</b>
<b>11</b>	48,118	30,741	580,685	175,195	134,708	88,125	<b>1,057,572</b>	<b>1,457,000</b>	<b>2,514,572</b>
<b>12</b>	340,056	216,989	4,101,860	1,237,547	134,707	293,750	<b>6,324,909</b>	<b>10,266,140</b>	<b>16,591,049</b>
<b>13</b>	276,094	174,049	3,314,670	1,000,049	134,707	449,500	<b>5,349,069</b>	<b>8,399,426</b>	<b>13,748,495</b>
<b>TOTAL</b>	<b>1,467,024</b>	<b>929,902</b>	<b>17,650,000</b>	<b>5,325,074</b>	<b>1,751,200</b>	<b>2,500,000</b>	<b>29,623,200</b>	<b>44,554,504</b>	<b>74,177,704</b>

**FY 2017 Nutrition Services Incentive Program Planning Allocations  
by Planning and Service Area**

<b>PSA</b>	<b>Congregate Meals FY 2015</b>	<b>HDMs FY 2015</b>	<b>Total Meals FY 2015</b>	<b>Percent of Meals</b>	<b>FY 16 NSIP Allocation</b>
<b>01</b>	149,099	407,593	556,692	6.67	408,206
<b>02</b>	162,852	584,901	747,753	8.97	548,966
<b>03</b>	78,694	228,912	307,606	3.69	225,829
<b>04</b>	64,042	192,836	256,878	3.08	188,497
<b>05</b>	206,199	354,330	560,529	6.72	411,266
<b>06</b>	53,010	65,721	118,731	1.42	86,904
<b>07</b>	115,730	252,956	368,686	4.42	270,505
<b>08</b>	146,991	293,396	440,387	5.28	323,137
<b>09</b>	59,066	97,337	156,403	1.88	115,056
<b>10</b>	96,683	105,356	202,039	2.42	148,105
<b>11</b>	193,201	209,809	403,010	4.83	295,597
<b>12</b>	800,387	2,392,951	3,193,338	38.29	2,343,358
<b>13</b>	277,740	750,449	1,028,189	12.33	754,599
<b>TOTAL</b>	<b>2,403,694</b>	<b>5,936,547</b>	<b>8,340,241</b>	<b>100.00</b>	<b>6,120,025</b>

**APPENDIX I**

**STATE PROGRAM ALLOCATIONS**

**FOR FY 2017**

## State Program Allocations by PSA for FY 2017

PSA	Title III Funds	Other Federal Funds	Non-Title III Funds	Total Funds
01	\$2,706,427	\$363,584	\$3,748,462	\$6,818,473
02	\$8,106,905	\$277,866	\$8,682,379	\$17,067,150
03	\$2,302,272	\$74,079	\$2,940,907	\$5,317,258
04	\$1,394,178	\$99,207	\$2,163,909	\$3,657,294
05	\$2,972,955	\$124,462	\$4,184,989	\$7,282,406
06	\$760,685	\$358,602	\$1,045,238	\$2,164,525
07	\$1,925,118	\$241,445	\$2,780,901	\$4,947,464
08	\$2,181,684	\$80,046	\$3,101,334	\$5,363,064
09	\$867,063	\$29,946	\$1,321,588	\$2,218,597
10	\$753,032	\$25,065	\$1,312,742	\$2,090,839
11	\$1,436,090	\$100,802	\$2,457,669	\$3,994,561
12	\$10,157,346	\$1,918,285	\$12,248,413	\$24,324,044
13	\$8,244,949	\$982,157	\$9,168,240	\$18,395,346
<b>Sub-Total</b>	<b>\$43,808,704</b>	<b>\$4,675,546</b>	<b>\$55,156,771</b>	<b>\$103,641,021</b>
<b>Other</b>			<b>\$740,382,800</b>	<b>\$740,382,800</b>
<b>TOTAL</b>	<b>\$43,808,704</b>	<b>\$4,675,546</b>	<b>\$795,539,571</b>	<b>\$844,023,821</b>

“Other OAA” Column = Title V Senior Community Service Employment Program, Title VII Elder Abuse, Title VII Ombudsman, and MIPPA Allocations.

“Non-Title III” Column = State General Revenue Funds including Planning and Service Grants, Home Delivered Meals, Community Based Services, LTC Systems Development Grants, Senior Employment Specialist, Adult Protective Services Contracts, NSIP Allocations, Tobacco Settlement/SHAP, Ombudsman and Long Term Care Provider funds.

“Other” Line = Community Care Program, Community Reinvestment Program, Foster Grandparent, Retired Senior Volunteer Program, and Grandparents Raising Grandchildren funding.

# **APPENDIX J**

***AREA AGENCY ON AGING PROPOSED***

***FY 2017 EXPENDITURES***

***FOR COORDINATION & PROGRAM  
DEVELOPMENT***

## **AREA AGENCY ON AGING PROPOSED FY 2017 EXPENDITURES FOR COORDINATION & PROGRAM DEVELOPMENT**

The Older Americans Act regulations require State and Area Agencies on Aging to submit the details of Area Agency's on Aging proposals to pay program development and coordination activities as a cost of supportive services to the general public for review and comment. The Department on Aging definitions for these two services and the amounts projected to be expended by each Area Agency on Aging for FY 2017 are outlined below. Note: Due to the due date that the State Plan must be submitted to the Administration for Community Living (ACL), the numbers listed below are based on the FY 2016 Area Plans.

### **Coordination Definition:**

Activities conducted toward the development of a comprehensive and integrated service delivery system through the establishment of working relations with other funding agencies and service providers.

### **Program Development Definition:**

Activities directly related to either the establishment of a new service(s); or the improvement, expansion, or integration of an existing service(s) within a specific fiscal year.

<b>Area Agency</b>	<b>Coordination</b>	<b>Program Development</b>
<b>01</b>	\$60,000	\$90,000
<b>02</b>	\$140,728	\$99,579
<b>03</b>	\$34,765	\$285,077
<b>04</b>	\$79,062	\$104,172
<b>05</b>	\$146,325	\$190,833
<b>06</b>	\$31,000	\$30,974
<b>07</b>	\$53,173	\$76,530
<b>08</b>	\$51,000	\$93,000
<b>09</b>	\$8,000	\$8,138
<b>10</b>	\$11,030	\$7,353
<b>11</b>	\$24,754	\$40,519
<b>12</b>	\$0	\$0
<b>13</b>	\$96,856	\$347,722

# **APPENDIX K**

***FISCAL YEAR 2017***

***SERVICE OBJECTIVES***

## FISCAL YEAR 2017 SERVICE OBJECTIVES

This exhibit represents the service delivery objectives for the State in Fiscal Year 2017 for services funded through Title III of the Older Americans Act.

Service	Persons	Units	PSA
<b><u>Access Services</u></b>			
Options Counseling	5,403	19,785	Statewide
Assisted Transportation	685	20,179	4,8
Ind. Needs Assessment III-B & III-C	0	0	
Info. & Assistance	353,243	784,040	Statewide
Outreach III-B	13,557	26,079	2,3,4,11,13
Outreach III-C	3,300	3,800	6,12
Transportation	31,188	420,998	1,2,3,4,6,7,8,9,10,11,12,13
Other	0	0	
<b><u>In-Home Services</u></b>			
Adult Day Care	0	0	
Chore/Housekeeping	1,291	51,912	4,12,13
Friendly Visiting	25	1,250	13
Home Delivered Meals	39,706	6,123,300	Statewide
Home Health	0	0	
Homemaker	0	0	
Respite	379	16,742	1,3,5,6,7,9,12,13
Residential Repair	543	579	2,8,11,13
Telephone Reassurance	255	20,335	10,13
Other	0	0	
<b><u>Community Services</u></b>			
Congregate Meals	82,082	2,509,983	Statewide
Counseling	1,010	7,500	2
Education	3,208	21,628	2,3,10
Health Screening	1,720	6,893	2,10
Housing Assistance	855	7,093	12,13
Legal Assistance	7,522	34,918	Statewide
Multi. Senior Center	44,665	493,600	2,3,6,9,12,13
Nutrition Education	400	600	6
Recreation	21,750	21,000	2,12
Health Promotion	22,357	37,040	Statewide
Other (Gap Filling)	495	520	1,2,4,6,
<b><u>Family Caregiver Services</u></b>			
Information	6,004	2,975	2,4,8
Assistance	48,591	88,326	1,2,3,4,6,7,8,9,10,11,12,13
Counseling, Support Grp., Training	10,979	35,187	Statewide
Respite	1,836	90,325	Statewide
Supplemental Services	1,021	2,908	1,2,3,4,7,8,10,11,12,13

Note: The information in the above table is based on the FY 2016 Area Plans since the FY 2017-FY 2019 State Plan will be submitted prior to the review and approval of the FY 2017 Area Plans. In addition to these Older Americans Act services, over 45,700 older persons will receive services through the state funded Community Care Program, 43,600 through the new Community Reinvestment Program, and over 17,000 reports of abuse and neglect will be responded to through the state funded Adult Protective Services Program.

# **APPENDIX L**

## **SERVICE PREFERENCES**

**SERVICE PREFERENCES FOR  
GREATEST ECONOMIC AND SOCIAL NEED  
WITH PARTICULAR ATTENTION TO  
LOW-INCOME MINORITY OLDER INDIVIDUALS INCLUDING  
THOSE WITH LIMITED ENGLISH PROFICIENCY &  
OLDER INDIVIDUALS RESIDING IN RURAL AREAS**

The Older Americans Act requires each State Unit on Aging to describe within their State Plan on Aging the proposed methods of carrying out preference for providing services to older individuals with greatest economic or social need, with particular attention to low-income minority older individuals including low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas. In addition, the plan also shall specify, with respect to the fiscal year preceding the fiscal year for which the plan is prepared, the methods used to satisfy the service needs of low-income minority older individuals, including older individuals with limited English proficiency, and older individuals residing in rural areas.

**"Greatest Economic Need"** means the need resulting from an income level at or below the poverty threshold established by the U.S. Department of Health and Human Services. Poverty thresholds for 2016 are currently set at \$11,880 for a one-person household and \$16,020 for a two-person household.

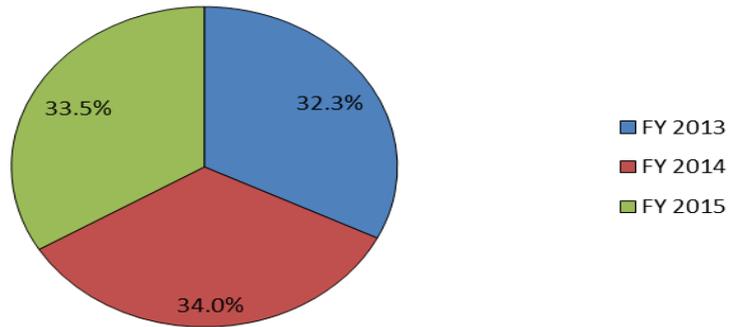
**"Greatest Social Need"** means the need caused by non-economic factors which include physical and mental disabilities, language barriers, cultural, social or geographic isolation including that caused by racial and ethnic status (for example - Black, Hispanic, Native American, Asian American) which restricts an individual's ability to perform normal daily tasks or which threaten his or her capacity to live independently.

**"Minority"** means those persons who identify themselves as belonging to a particular ethnic/racial grouping as classified by the Bureau of the Census. This includes persons who identify themselves as African American, Hispanic, American Indian, Alaskan, Asian, Hawaiian and Pacific Islander. Based on the 2014 Census Bureau's Population Estimates, Illinois has 638,399 individuals age 60 plus who identified themselves as a minority. The Aging Special Tabulation for the 2009-2013 American Community Survey conducted by the Census Bureau identified 217,598 older adults who have limited English speaking proficiency.

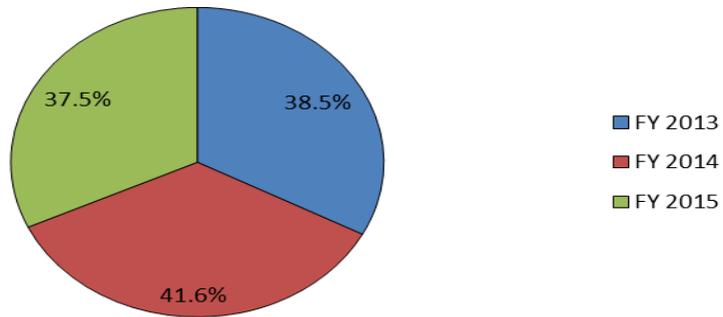
**"Older Persons Residing in Rural Areas"** means persons aged 60 or over residing in areas not defined as urban. Urban areas are defined as (1) a central place and its adjacent settled territories with a combined minimum population of 50,000 and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

The following charts outline the number of persons served in registered Older Americans Act services that were minorities, in greatest economic need and resided in rural areas in FY 2013, FY 2014 and FY 2015.

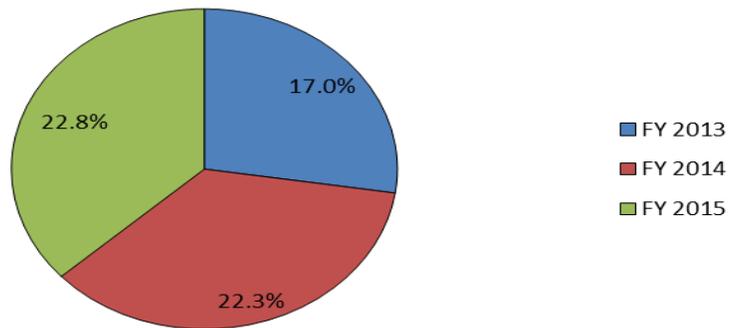
**Minorities Served as a % of Total Registered Persons Served**



**Persons Served Living in Poverty as a % of Total Registered Persons Served**



**Rural Persons Served as a % of Total Registered Persons Served**



**The proposed methods of carrying out preference for providing services to older individuals with greatest economic or social need, with particular attention to low-income minority older individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas, include:**

- A. Applications of weighting factors for low-income, minority, living alone, over age 75, and rural older persons in the distribution of federal and related state funds to the planning and service areas.
- B. Assuring Area Agencies on Aging target services to frail older persons by earmarking state funds for information and assistance, transportation, and home-delivered meals.
- C. Providing training to Area Agency on Aging and service provider staff on the delivery of services to older persons in greatest economic or social need, including minority, older individuals with limited English proficiency, and rural older persons.
- D. Requiring Area Agencies on Aging to set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need and set specific objectives for providing services to low-income minority individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the Area Plans.
- E. Requiring Area Agencies on Aging to include in each agreement made with a service provider under the Area Plans, a requirement that such provider will (a) specify how they intend to satisfy the service needs of low-income minority older individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider; (b) attempt to provide services to low-income minority older individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas in at least the same proportion as the population of low-income minority older individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas compared to the population of older individuals of the area served by the provider; and (c) meet specific objectives established by the Area Agency on Aging, for providing services to low-income minority older individuals, low-income older minority individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service areas.
- F. Assuring with respect to services for older individuals residing in rural areas, the Department on Aging will spend for each fiscal year of the State Plan, not less than the amount expended for such services for Fiscal Year 2000.

The Department will allocate a total of \$74,177,704 in FY 2017 to the 13 Area Agencies on Aging. Nine (9) percent of these funds (\$6,675,993) will be allocated to rural areas of the State based on the Department's funding formula.

- G. Requiring Area Agencies on Aging to conduct outreach efforts to identify older individuals eligible for assistance under the Older Americans Act, with special emphasis on rural elderly, older individuals in greatest economic and social need, with particular attention to low-income minority older individuals, older individuals with severe disabilities, older individuals with limited English-Speaking ability, and older individuals with Alzheimer's Disease or related disorders with neurological and organic brain dysfunction (and the caregivers of such individuals); and inform such individuals of services under the Area Plans.

**The methods used in FY 2016 to satisfy the service needs of low-income minority older individuals, low-income minority older individuals with limited English speaking proficiency and older individuals residing in rural areas included:**

- A. Application of weighting factors for low-income, minority, and rural older persons in the distribution of federal and related state funds to the planning and service areas.
- B. Assuring Area Agencies on Aging target services by earmarking state funds for information and assistance, transportation, and home-delivered meals.
- C. Providing training to Area Agency on Aging and service provider staff on the delivery of services to older persons in greatest economic or social need, including minority older individuals including those with limited English proficiency, and rural older persons.
- D. Requiring the Area Agencies on Aging to include in the Area Plans, with respect to the fiscal year preceding the fiscal year for which such Plans are prepared, to identify the number of low-income minority older individuals, low-income minority older individuals with limited English proficiency, and older individuals residing in rural areas in the planning and service area and to describe the methods used to satisfy the service needs of such minority older individuals including those with limited English proficiency, and older individuals residing in rural areas.
- E. Requiring Area Agencies on Aging to conduct needs assessments that take into consideration the number of older individuals with low incomes, and the number of older individuals who have greatest economic or social need (with particular attention to low-income minority older individuals including those with limited English proficiency, and older individuals residing in rural areas) and the efforts of voluntary organizations in the planning and service areas.
- F. Requiring Area Agencies on Aging to establish Advisory Councils consisting of older individuals (including minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under the Older Americans Act, representatives of older individuals, local elected officials, providers of veteran's health care (if appropriate), and the general public. The Advisory Councils advise the Area Agencies on Aging on all matters relating to the development of the Area Plans, the administration of the Area Plans and operations conducted under the Area Plans.
- G. Requiring the Area Agencies on Aging to ensure that each activity undertaken by the agencies, including planning, advocacy, and systems development, includes a focus on the needs of low-income minority older individuals including those with limited English proficiency, and older individuals residing in rural areas.

**APPENDIX M**

**CENSUS  
INFORMATION**

**BY**

**PLANNING & SERVICE AREA (PSA)**

## CENSUS INFORMATION BY PLANNING & SERVICE AREA

	County Name	60+ Pop	75+ Pop	85+ Pop	60+ Minority	60+ Poverty	60+ Live Alone	60+ Rural	60+ Limited English Speaking	65+ With a Disability	65+ Independent Living Difficulty
PSA 01	Boone	10,505	2,975	804	934	819	1,565	0	380	2,100	760
	Carroll	4,676	1,521	510	128	249	1,070	4,676	140	1,140	332
	DeKalb	16,702	5,153	1,662	1,031	804	3,990	0	480	3,405	1,553
	Jo Daviess	7,320	2,327	689	158	386	1,350	7,320	100	1,487	559
	Lee	8,415	2,771	845	449	519	1,910	8,415	135	1,659	599
	Ogle	12,249	4,014	1,235	522	747	3,060	12,249	155	2,755	1,005
	Stephenson	12,827	4,634	1,565	842	962	3,245	12,827	114	2,821	1,104
	Whiteside	14,723	5,067	1,677	1,071	852	3,465	14,723	180	3,573	1,385
	Winnebago	63,103	19,732	6,516	8,187	4,933	15,125	0	2405	14,630	6,149
	<b>PSA TOTAL</b>	<b>150,520</b>	<b>48,194</b>	<b>15,503</b>	<b>13,322</b>	<b>10,271</b>	<b>34,780</b>	<b>60,210</b>	<b>4,089</b>	<b>33,570</b>	<b>13,446</b>
PSA 02	DuPage	182,330	52,561	17,924	32,800	8,868	36,585	0	16,685	33,717	15,971
	Grundey	9,222	2,609	787	424	658	2,255	0	180	1,876	751
	Kane	89,825	24,871	7,599	17,803	5,004	17,055	0	8,695	16,476	7,277
	Kankakee	23,368	7,378	2,396	3,461	1,965	5,685	0	430	5,819	2,446
	Kendall	15,924	4,004	1,185	2,128	671	2,905	0	750	3,056	1,089
	Lake	125,883	35,900	11,954	22,417	7,043	25,265	0	11,525	23,589	10,630
	McHenry	54,966	14,138	4,168	3,940	2,517	9,985	0	2,605	10,120	4,408
	Will	111,180	30,029	8,762	22,463	5,590	20,200	0	7,530	21,870	9,290
	<b>PSA TOTAL</b>	<b>612,698</b>	<b>171,490</b>	<b>54,775</b>	<b>105,436</b>	<b>32,316</b>	<b>119,935</b>	<b>0</b>	<b>48,400</b>	<b>116,523</b>	<b>51,862</b>
PSA 03	Bureau	9,134	3,277	1,166	377	459	2,330	9,134	165	2,211	797
	Henderson	2,170	723	216	33	69	535	2,170	8	497	152
	Henry	12,652	4,128	1,290	403	817	2,900	0	155	2,716	997
	Knox	13,953	4,783	1,569	880	1,148	4,110	13,953	100	3,093	1,289
	LaSalle	26,881	9,322	3,177	1,202	1,803	6,760	26,881	285	6,103	2,226
	McDonough	6,554	2,232	844	209	390	1,925	6,554	59	1,631	631
	Mercer	4,428	1,429	474	54	243	915	0	28	1,088	381
	Putnam	1,648	466	147	38	45	314	1,648	14	344	93
	Rock Island	35,385	11,733	3,891	4,212	2,709	10,080	0	1,165	8,501	3,501
Warren	4,484	1,519	454	190	317	1,225	4,484	115	1,006	361	
	<b>PSA TOTAL</b>	<b>117,289</b>	<b>39,612</b>	<b>13,228</b>	<b>7,598</b>	<b>8,000</b>	<b>31,094</b>	<b>64,824</b>	<b>2,094</b>	<b>27,190</b>	<b>10,428</b>

## CENSUS INFORMATION BY PLANNING & SERVICE AREA

	County Name	60+ Pop	75+ Pop	85+ Pop	60+ Minority	60+ Poverty	60+ Live Alone	60+ Rural	60+ Limited English Speaking	65+ With a Disability	65+ Independent Living Difficulty
<b>PSA 04</b>	Fulton	9,256	3,194	1,046	186	868	2,310	9,256	65	2,274	934
	Marshall	3,555	1,237	387	64	278	910	0	4	729	238
	Peoria	39,492	12,490	4,212	5,472	3,060	10,205	0	650	8,470	3,598
	Stark	1,828	673	214	30	92	400	0	8	527	168
	Tazewell	31,667	10,649	3,323	600	1,492	7,100	0	124	7,066	2,871
	Woodford	8,973	3,068	1,109	168	384	1,620	0	35	1,545	567
	<b>PSA TOTAL</b>	<b>94,771</b>	<b>31,311</b>	<b>10,291</b>	<b>6,520</b>	<b>6,174</b>	<b>22,545</b>	<b>9,256</b>	<b>886</b>	<b>20,611</b>	<b>8,376</b>
<b>PSA 05</b>	Champaign	33,266	10,295	3,465	4,614	2,153	8,220	0	925	7,064	2,926
	Clark	4,082	1,408	469	54	259	1,050	4,082	19	1,194	519
	Coles	11,047	3,798	1,257	334	627	2,810	11,047	33	2,868	1,119
	Cumberland	2,666	875	296	41	230	595	2,666	4	748	292
	DeWitt	4,004	1,263	384	62	198	980	0	14	996	325
	Douglas	4,435	1,586	481	137	399	1,110	4,435	115	956	325
	Edgar	4,892	1,668	565	71	523	1,265	4,892	40	1,328	460
	Ford	3,523	1,399	505	72	224	1,040	0	4	872	281
	Iroquois	7,818	2,794	973	254	828	2,005	7,818	85	1,747	696
	Livingston	8,855	3,120	1,087	273	530	2,205	8,855	58	1,971	786
	McLean	28,617	8,840	3,004	1,942	1,679	6,665	0	345	5,946	2,238
	Macon	26,746	8,948	2,986	3,179	1,846	7,250	0	155	6,365	2,533
	Moultrie	3,765	1,388	533	41	174	710	3,765	105	980	333
	Piatt	4,088	1,360	398	55	218	825	0	4	898	358
	Shelby	6,097	2,071	666	91	461	1,395	6,097	19	1,602	624
Vermilion	19,072	6,210	1,905	1,719	1,514	5,470	0	145	4,915	1,866	
	<b>PSA TOTAL</b>	<b>172,973</b>	<b>57,023</b>	<b>18,974</b>	<b>12,939</b>	<b>11,863</b>	<b>43,595</b>	<b>53,657</b>	<b>2,070</b>	<b>40,450</b>	<b>15,681</b>
<b>PSA 06</b>	Adams	16,759	6,131	2,133	563	1,289	4,160	16,759	80	3,796	1,356
	Brown	1,220	421	128	28	129	310	1,220	25	272	81
	Calhoun	1,467	515	154	15	68	305	0	4	424	176
	Hancock	5,608	1,986	624	61	393	1,175	5,608	29	1,436	590
	Pike	4,291	1,538	516	72	481	1,095	4,291	24	1,135	353
	Schuyler	1,993	673	216	36	235	430	1,993	0	537	218
	<b>PSA TOTAL</b>	<b>31,338</b>	<b>11,264</b>	<b>3,771</b>	<b>775</b>	<b>2,595</b>	<b>7,475</b>	<b>29,871</b>	<b>162</b>	<b>7,600</b>	<b>2,774</b>

## CENSUS INFORMATION BY PLANNING & SERVICE AREA

	County Name	60+ Pop	75+ Pop	85+ Pop	60+ Minority	60+ Poverty	60+ Live Alone	60+ Rural	60+ Limited English Speaking	65+ With a Disability	65+ Independent Living Difficulty
<b>PSA 07</b>	Cass	2,928	1,036	318	118	163	700	2,928	33	742	297
	Christian	8,481	3,005	995	135	745	2,350	8,481	19	2,254	890
	Greene	3,364	1,141	339	50	331	925	3,364	19	937	355
	Jersey	5,412	1,823	553	96	253	1,110	0	25	1,197	456
	Logan	6,926	2,481	851	163	384	1,705	6,926	19	1,784	528
	Macoupin	11,909	3,994	1,279	198	676	2,865	0	60	2,967	974
	Mason	3,760	1,286	431	59	241	990	3,760	24	1,280	577
	Menard	3,145	981	317	52	221	875	0	0	623	321
	Montgomery	7,331	2,688	952	138	635	1,990	7,331	69	1,717	686
	Morgan	8,670	2,972	1,016	285	806	2,065	8,670	59	2,217	871
	Sangamon	44,174	13,606	4,506	3,849	2,822	11,480	0	490	9,926	3,923
Scott	1,299	471	134	18	126	300	1,299	4	341	109	
	<b>PSA TOTAL</b>	<b>107,399</b>	<b>35,484</b>	<b>11,691</b>	<b>5,161</b>	<b>7,403</b>	<b>27,355</b>	<b>42,759</b>	<b>821</b>	<b>25,985</b>	<b>9,987</b>
<b>PSA 08</b>	Bond	3,994	1,316	426	170	354	1,120	0	8	934	380
	Clinton	8,338	2,858	910	213	560	2,055	0	18	2,016	779
	Madison	58,210	18,901	6,040	4,240	3,632	13,680	0	475	13,346	5,412
	Monroe	7,517	2,617	861	131	325	1,360	0	75	1,525	552
	Randolph	7,795	2,631	894	289	714	1,980	7,795	40	2,039	882
	St. Clair	52,549	16,618	5,247	14,026	4,231	13,485	0	554	12,942	4,774
	Washington	3,603	1,271	447	42	386	850	3,603	54	880	354
	<b>PSA TOTAL</b>	<b>142,006</b>	<b>46,212</b>	<b>14,825</b>	<b>19,111</b>	<b>10,202</b>	<b>34,530</b>	<b>11,398</b>	<b>1,224</b>	<b>33,682</b>	<b>13,133</b>
<b>PSA 09</b>	Clay	3,476	1,177	379	49	228	800	3,476	0	1,057	437
	Effingham	7,889	2,698	858	107	478	2,120	7,889	23	1,857	641
	Fayette	5,029	1,754	538	81	364	1,125	5,029	0	1,363	447
	Jefferson	9,376	2,955	961	576	861	2,395	9,376	30	2,618	989
	Marion	9,653	3,241	1,107	437	705	2,690	9,653	45	3,027	1,103
	<b>PSA TOTAL</b>	<b>35,423</b>	<b>11,825</b>	<b>3,843</b>	<b>1,250</b>	<b>2,636</b>	<b>9,130</b>	<b>35,423</b>	<b>98</b>	<b>9,922</b>	<b>3,617</b>

## CENSUS INFORMATION BY PLANNING & SERVICE AREA

	County Name	60+ Pop	75+ Pop	85+ Pop	60+ Minority	60+ Poverty	60+ Live Alone	60+ Rural	65+ Limited English	65+ With a Disability	65+ Independent Living
<b>PSA 10</b>	Crawford	4,799	1,668	522	91	401	1,280	4,799	44	1,109	352
	Edwards	1,714	596	190	19	109	500	1,714	15	471	180
	Hamilton	2,240	788	270	45	273	625	2,240	15	646	213
	Jasper	2,386	837	274	39	98	470	2,386	4	612	239
	Lawrence	3,766	1,375	422	117	267	1,095	3,766	20	942	404
	Richland	4,263	1,660	569	75	348	1,225	4,263	29	1,252	518
	Wabash	2,998	1,068	362	49	259	785	2,998	15	993	389
	Wayne	4,383	1,527	435	68	299	1,165	4,383	4	1,181	513
	White	4,062	1,548	505	55	296	1,055	4,062	0	1,103	492
	<b>PSA TOTAL</b>	<b>30,611</b>	<b>11,067</b>	<b>3,549</b>	<b>558</b>	<b>2,350</b>	<b>8,200</b>	<b>30,611</b>	<b>146</b>	<b>8,309</b>	<b>3,300</b>
<b>PSA 11</b>	Alexander	1,896	607	173	523	261	480	0	4	722	324
	Franklin	10,278	3,328	944	194	985	3,000	10,278	110	3,230	1,302
	Gallatin	1,570	491	106	37	144	385	1,570	4	498	192
	Hardin	1,303	376	94	21	210	385	1,303	4	547	151
	Jackson	10,944	3,446	1,183	1,265	815	2,715	0	60	2,569	878
	Johnson	3,240	945	222	94	339	785	3,240	12	1,025	463
	Massac	3,968	1,433	503	280	485	1,090	3,968	4	1,280	577
	Perry	5,124	1,633	519	174	334	1,335	5,124	23	1,348	612
	Pope	1,295	395	98	37	103	335	1,295	10	361	154
	Pulaski	1,614	548	163	493	208	570	1,614	0	566	238
	Saline	6,400	2,151	642	316	629	1,570	6,400	29	1,936	765
	Union	4,667	1,523	435	150	531	1,155	4,667	24	1,197	542
	Williamson	15,953	4,998	1,385	605	1,274	4,265	0	134	4,031	1,623
	<b>PSA TOTAL</b>	<b>68,252</b>	<b>21,874</b>	<b>6,467</b>	<b>4,189</b>	<b>6,318</b>	<b>18,070</b>	<b>39,459</b>	<b>418</b>	<b>19,310</b>	<b>7,821</b>
<b>PSA 12</b>	<b>Chicago</b>	<b>442,499</b>	<b>133,697</b>	<b>39,534</b>	<b>303,554</b>	<b>71,405</b>	<b>122,125</b>	<b>0</b>	<b>85,980</b>	<b>113,705</b>	<b>58,105</b>
<b>PSA 13</b>	<b>Suburb. Cook</b>	<b>547,123</b>	<b>167,285</b>	<b>56,915</b>	<b>157,986</b>	<b>36,280</b>	<b>125,320</b>	<b>0</b>	<b>71,210</b>	<b>118,352</b>	<b>58,480</b>
<b>STATE</b>	<b>TOTAL</b>	<b>2,552,902</b>	<b>786,338</b>	<b>253,366</b>	<b>638,399</b>	<b>207,813</b>	<b>604,154</b>	<b>377,468</b>	<b>217,598</b>	<b>575,209</b>	<b>257,010</b>

60+, 75+ , 85+ and Minority are from the Census Bureau's 2014 Population Estimates except for PSA 12 and PSA 13.

PSA 12 and 13: Used 2014 American Community Survey (ACS)-1 Year Estimates (Table DP05-- Demographic and Housing Estimates)

Limited English Speaking and Living Alone is from the Aging Special Tabulation-ACS 2009-2013. Poverty, Disability & Independent Living are from the ACS 2010-2014.