Draft Attachment F: Goals, Strategies, and Outcomes

The State Plan on Aging goals describe the State Unit on Aging's (SUA's) strategic direction for statewide program administration. They elevate the values that the Older Americans Act (OAA) is founded on by targeting services to older adults in greatest social and economic need and advancing person-centered services to maximize consumer control and choice. Program goals represent key priorities for the state of Wisconsin as determined by demographic data, program utilization reports, and results of needs assessment activities that informed area agency on aging (AAA), county, and Tribal aging plan goals and summary reports.

In addition, several goals in this plan forecast efforts during the plan period to ensure that policies and practices are in alignment with the OAA and come into compliance with the OAA Final Rule (CFR 45 1321). The SUA is already in compliance with a majority of these regulations and will be able to align with many others by making minor adjustments to policies or practices, some of which are noted within program area goals. However, four areas will require longer term work projects with significant engagement and input from impacted partners. These include Title IIIB legal assistance; stewardship and oversight; contracts and commercial relationships; and the designation and de-designation of AAAs.

The regulatory compliance goal statements presented in this state plan constitute brief workplan summaries. More comprehensive information will be provided to the Administration for Community Living (ACL) about each project as part of a compliance report to be presented by September 30, 2025. This report will include detailed corrective action plans for each of these items as instructed by ACL.

Program Area: Supportive Services T-III B

☒Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Issue: The current practice of rolling up data related to T-IIIB services at the AAA level to ensure compliance with service percentages means that local variation is not visible. As a result, not all older adults have the same level of access to T-III B services. Where you live should not determine the availability of services. More consistency would be better for older adult across the state, ensuring fair availability of services to meet social and economic needs.

Goal: To assure consistent service delivery of T-III B Supportive Service for older adults within county aging units the Office on Aging will work in partnership with AAAs and aging units to assure the minimum expenditures for Access to Service 7%, In Home/Chore Services (6%) are provided by a greater number of aging units by Sept. 30, 2028.

Plan or strategy:

Strategy 1: Work with each AAA to measure and identify each aging unit not meeting minimum expenditures within T-III B categories by the end of July 1, 2026.

Strategy 2: Consult with aging units not meeting minimum expenditures within T-III B and identify barriers by the end of 2026.

Strategy 3: Develop draft policy/guidance to improve consistency in partnership with AAA/ Aging Units by the end of September 30, 2027.

Strategy 3: Publish final policy guidance and provide to all aging units by the end of 2027.

Strategy 4: Measure compliance with policy and consistency of expenditures for T-III B minimum services among all a AAAs and aging units by March 31, 2028.

Documenting efforts and tools:

Documenting **how much** has been done:

- Identify specific local aging units that are not meeting the required service percentages
- Extend TA and other supports to help aging units achieve required services
- Identify aging units that have increased their T-III B services

Documenting **how well** it has been done:

- Program and fiscal reporting from AAA that show aging units have increased expenditures and service delivery in the required T-III B categories

Assessing whether anyone is **better off**:

- Analysis shows an increase in the number of aging units that are meeting the required percentages in the two required services area under T-III B

Additional notes and considerations:

Program Area: Legal assistance

☒Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Goal statement:

1. Improve state capacity for coordinating the provision of legal assistance with priority provided to individuals with greatest economic or social need

Plan or strategy:

1.1. Oversee the legal assistance program's transition to come into compliance with OAA rules and regulations

1.1.1. Provide guidance to AAAs on necessary changes to contracting processes for OAA legal assistance in 2025

1.1.2. Identify and execute strategies to support systems changes that bring the program into compliance throughout the Aging Plan period

1.1.3. Assure that legal assistance providers contracted by AAAs assist older individuals in understanding their rights, exercising choices, benefiting from services and opportunities authorized by law, and maintaining the rights of older individuals at risk of guardianship, conservatorship, or other fiduciary proceedings throughout the Aging Plan period

1.2. Utilize and share the trainings, case consultations, and technical assistance provided by the OAA legal technical assistance contractor, the National Center on Law and Elder Rights (NCLER), with legal assistance providers at least once every two months

1.3. Promote financial management services to older individuals at risk of guardianship, conservatorship, or other fiduciary proceedings by sharing advanced directives and consumer rights resources on DHS's legal assistance webpages during the Aging Plan period

Documenting efforts and tools:

Documenting **how much** has been done:

Documenting **how well** it has been done:

Assessing whether anyone is **better off**:

Use OAAPS data to evaluate to what degree Wisconsin residents are receiving legal assistance in all OAA priority areas, with goals to increase the number of closed cases for the following priority areas:

- Abuse and neglect by 10%
- Age discrimination by 10%
- Defense of guardianship or protective service by 5%
- Nutrition by 5%
- Utilities by 10%

Additional notes and considerations:
Refer to the Wisconsin Older Americans Act Legal Assistance Corrective Action Plan for additional details.

Program Area: Elder Nutrition Program

☒Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☒Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Goal statement:

Working collaboratively with AAAs and local service providers, expand nutrition services to better serve the needs of eligible individuals with diabetes by expanding nutrition education options focused on diabetes prevention and management.

Plan or strategy:

- Wisconsin's Elder Nutrition Program manager will work with AAAs, local service providers, and other stakeholders to:
    - Conduct an environmental scan of educational resources available related to diabetes prevention and management for older adults.
    - Facilitate the creation of a collection of nutrition education options focused on diabetes prevention and management to be used at the AAA and local level.

Documenting efforts and tools:

Documenting **how much** has been done:

- Scan conducted and gaps in available education identified by September 30, 2026.
- Compile collection of existing nutrition education offered by AAAs, local service providers, and partner agencies that provide nutrition education to older adults by September 30, 2026.
- Work with AAA and local service provider's program nutritionists to develop additional materials by September 30, 2027.
- Evaluate use of nutrition education materials during the plan period by nutrition programs.

Documenting **how well** it has been done:

- More than 75% of Wisconsin's nutrition programs use diabetes-related nutrition education materials in their program during the 2026-2028 state plan period.

Assessing whether anyone is **better off**:

- Participant surveys of nutrition education and/or diabetes-related health promotion services self-report increased awareness of diabetes and how to lower risk, improved blood sugar control, and improved management of diabetes.

Additional notes and considerations:
According to the Wisconsin Diabetes Action Plan, the risk of developing type 2 diabetes increases with age. Wisconsinites age 65 and older have the highest rates of diabetes compared to other age groups. According to the Centers for Disease Control (CDC), approximately 19% of adults age 65-74 and 21% of adults age 75 and older have diagnosed diabetes.

According to the Wisconsin Diabetes Action plan, diabetes is the eighth leading cause of death in Wisconsin. It's the fifth leading cause of death for Hispanic and Asian people, sixth for Native American/American Indian people, and seventh for Black people. The worst disparities occur in Hispanic people in Wisconsin; 1 in 5 have diabetes.

Program Area: Elder Nutrition Program

☒Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☒Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Goal statement:

Working collaboratively with AAAs and local service providers, expand nutrition services to better serve the needs of eligible individuals with diabetes by increasing the number of nutrition programs offering congregate and home-delivered meals that are tailored to support the health of individuals with diabetes.

Plan or strategy:

- Wisconsin's Elder Nutrition Program manager will work with AAAs, local service providers, and other stakeholders to:
    - Share training and resources on medically tailored meals that nutrition programs can use to develop diabetic-friendly meals or food options for congregate dining and home-delivered meal programs.
    - Facilitate the creation of TA materials about adding carbohydrate counts to congregate dining and home delivered meal menus.
    - Facilitate the creation of nutrition education materials that can be shared with participants about:
        - how to use carbohydrate counts provided to manage their diabetes, and
        - ways meals offered by the nutrition program can be further portioned or consumed to better manage diabetes.

Documenting efforts and tools:

Documenting **how much** has been done:

- Track the number of nutrition programs offering diabetic-friendly meals or food options in FY 2025 and compare to FY 2028.
- Track the number of nutrition programs offering carbohydrate counts for meals provided.

Documenting **how well** it has been done:

- More nutrition programs offer carbohydrate counts for meals provided.

- More nutrition programs offering diabetic-friendly meals or food options by September 30, 2028.

Assessing whether anyone is **better off**:

- Participant surveys in 2026 indicate higher satisfaction with the foods available to them to support their health in comparison to survey data from 2023.
- Participant surveys of nutrition and/or health promotion services self-report improved blood sugar control and improved management of diabetes.

Additional notes and considerations:

According to the Wisconsin Diabetes Action Plan, the risk of developing type 2 diabetes increases with age. Wisconsinites age 65 and older have the highest rates of diabetes compared to other age groups. According to the Centers for Disease Control (CDC), approximately 19% of adults age 65-74 and 21% of adults age 75 and older have diagnosed diabetes.

According to the Wisconsin Diabetes Action plan, diabetes is the eighth leading cause of death in Wisconsin. It's the fifth leading cause of death for Hispanic and Asian people, sixth for Native American/American Indian people, and seventh for Black people. The worst disparities occur in Hispanic people in Wisconsin; 1 in 5 have diabetes.

Program Area: Elder Nutrition Program

☒Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☒Goal related to making a program or service more person-centered

☒Goal related to another quality improvement objective (specify: increase referrals between nutrition and health promotion programs)

Goal statement:

Working collaboratively with AAAs and local service providers, expand nutrition services to better serve the needs of eligible individuals with diabetes by improving coordination between nutrition and health promotion services.

Plan or strategy:

- Wisconsin's Elder Nutrition Program manager will work with AAAs, local service providers, and other stakeholders to:
    - Increase access to information about related nutrition and health promotion services that help with diabetes prevention and management.
    - Improve coordination between meal services, nutrition education, and health promotion services so that eligible individuals can access a breadth of resources to support prevention and management of diabetes.

Documenting efforts and tools:

Documenting **how much** has been done:

- Track the number of participants both (1) attending Healthy Living with Diabetes, Vivir Saludable con Diabetes, or other diabetes-related health promotion classes and (2) receiving nutrition services.
- Track referrals between nutrition services and health promotion programs in the statewide reporting system.

Documenting **how well** it has been done:

- Documentation in the statewide reporting system shows increases in the number of referrals between nutrition services and health promotion programs related to diabetes between October 1, 2025, and September 30, 2028.
- Documentation in the statewide reporting system shows increases in the number of OAA clients receiving both diabetes-related nutrition education and health promotion services between October 1, 2025, and September 30, 2028.

Assessing whether anyone is **better off**:

- Participant surveys of nutrition and/or health promotion services self-report increased awareness of diabetes and how to lower risk, improved blood sugar control, and improved management of diabetes.

Additional notes and considerations:

According to the Wisconsin Diabetes Action Plan, the risk of developing type 2 diabetes increases with age. Wisconsinites age 65 and older have the highest rates of diabetes compared to other age groups. According to the Centers for Disease Control (CDC), approximately 19% of adults age 65-74 and 21% of adults age 75 and older have diagnosed diabetes.

According to the Wisconsin Diabetes Action plan, diabetes is the eighth leading cause of death in Wisconsin. It's the fifth leading cause of death for Hispanic and Asian people, sixth for Native American/American Indian people, and seventh for Black people. The worst disparities occur in Hispanic people in Wisconsin; 1 in 5 have diabetes.

Program Area: Title IIID Health Promotion

☐Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☒Goal related to another quality improvement objective (specify)

Issue: Evidence within state program reports indicate there is underspending of Title IIID Highest Level- Evidenced Based Health Promotion Program (EBHPP) funds in some aging units. An enhanced amount of engagement and communication with aging units to identify service gaps and barriers to implementation of EBHPP across state would likely improve health outcomes of those with greatest social and economic need.

By improving engagement and communication with AAAs and addressing challenges in spending Title IIID funds, older adults will benefit in the following ways:

1. Increased access to evidence-based health promotion programs.
2. Better health outcomes for older adults.

Goal: The Office on Aging will work with AAAs, aging units and the Wisconsin Healthy Aging Institute to identify key causes of underutilization of Title IIID funds and barriers of programs implementation and participation. By addressing these issues the state and partner agencies will work toward an increase of 25% in the expenditures of Title IIID funding and a 15% increase in participation within those counties expending 50% or less of their funding by September 30, 2028.

Plan or strategy:

Strategy 1: In cooperation with partner staff develop a statewide summary report identifying services gaps and barriers to implementation EBHPP by Sept. 30, 2026.

- Review current spending across all AAA and aging units and measure the cost to implement each type and the number of participants served in each class.
- Development a scale of difficulty for class implementation
- Identify each programs mode of delivery for each class: in-person or on-line
- Identify AAAs and aging units currently underspending Title IIID funds by 50%

Strategy 2: Develop and share EBHPP statewide report with all AAA's and aging units and request input to determine what additional supports are needed, beside additional funding, to increase, sustain or grow participation in EBHPP.

- Share statewide EBHPP summary report with all AAA aging units and partner agencies by December 30, 2026.
- Coven a statewide call with AAAs, aging units and partner agencies gather to gather feedback on EBHPP statewide report input by April 30, 2027.
- Post report EBHPP statewide report for comment on the ADRC/ Aging SharePoint site by May 30, 2027.

- Summarize share and summarize comments and identify opportunities for to address services gaps and barriers to implementation by July 15, 2027

Strategy 3: Develop additional state policy for AAAs and aging units related to Title IIID based upon input received from AAA and aging units by September 30, 2027.

Strategy 4: Develop and pilot statewide EBHPP customer satisfaction and suggestion survey to identify potential service delivery improvements of EBHPPP by March 31, 2028

- The focus of the survey will be on consumer defined personal outcomes and and suggestions for EBHPP class improvement.

Documenting efforts and tools:

Documenting **how much** has been done:

- Review current spending across all AAA and aging units and measure the cost to implement classes and the number participants served for each class.
- Identify each programs mode of delivery for each class: in-person or on-line

Documenting **how well** it has been done:

- Summarize EBHPP state-wide report comments and identify opportunities to address service gaps and barriers to implementation.

Assessing whether anyone is **better off**:

- Measure annual expenditure and participation in Highest Level -EBHPP with an expectation of a 25% increase in the expenditures of T-III D funds and a 15% increase in participation.

Additional notes and considerations:

Program Area: Title IIIE Family Caregiver Support Program

☒Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Issue statement: Title IIIE was not included in the previous version of federal OAA regulations. Wisconsin has incorporated the newly written Title IIIE regulations into state policy provided for AAAs and local/tribal aging units, including requirements for increased SUA monitoring of all program areas.

Goal statement: The SUA will improve oversight and adherence to OAA Final Rule provisions for Title IIIE by conducting at least one on-site AAA review and one virtual review each year.

Plan or strategy:

The state Title IIIE program manager will participate in AAA site reviews to monitor all Older Americans Act program areas.

1. An onsite mid-year review will be scheduled with each AAA by April 30 of each program year.
2. A virtual year-end review will be scheduled with each AAA by September 30 of each year.
3. A multi-program site review process to assess adherence to federal regulations and state policy will be designed by April 1, 2026.
4. The Title IIIE program manager will set annual program benchmarks for the five required NFCSP service areas to show adherence to OAA regulations for each site review.
5. Findings and follow-up actions will be documented within 30 days of reviews and submitted to the SUA Older Americans Act Supervisor.

Documenting efforts and tools:

Documenting **how much** has been done:

The SUA will create a tracking tool to record each agency's adherence to federal regulations.

Documenting **how well** it has been done:

The SUA will record how well the agency is meeting state and federal regulations, issue a correction plan if necessary, and provide technical assistance to address any deficiencies.

Assessing whether anyone is **better off**:

The SUA will collect feedback from local agencies about the benefits that resulted from our state reviews and our methods. Responses will be used to improve processes planned for future state reviews.

Additional notes and considerations: This goal is part of an overarching SUA plan goal for improved oversight and adherence to federal regulations across all program areas.

Program Area: Title IIIE Family Caregiver Support Program

☐Goal related to addressing regulations

☒Goal related to targeting services to those in greatest social and economic need

☒Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Issue statement: The OAA requires states to give priority to older adults with greatest economic and social needs. The number of older adults is growing, but funding to serve caregivers of older adults has not kept pace with needs. As a result, it is becoming more difficult to serve every family in need of NFCSP services. To fairly determine which customers have greatest economic and social needs, a uniform caregiver needs assessment will be required to measure who is most in need.

Goal statement: The SUA will support local agencies to use a state-approved caregiver needs assessment to identify participants with the greatest economic and social needs. Assessment findings will be used to deliver person-centered services based on individual needs assessment results.

Plan or strategy:

1. The SUA will distribute the Wisconsin Family Caregiver Support Needs Assessment to identify the unique unmet respite, emotional, physical, educational, and resource needs of each AFCSP and NFCSP participant. (Assessment available in English and Spanish)
2. County and tribal aging units will conduct the state needs assessment with every AFCSP and NFCSP participant. (Ongoing)
3. Needs assessment results will be used to develop a person-centered service plan. (ongoing)
4. Local agencies will use assessment results to prioritize which caregivers on waiting lists will be served first, raising those with greatest economic need or at high risk of requiring institutionalization to the top of the waitlist. (ongoing)

5. By June 30, 2026, the SUA will add clarifying language to state policy outlining how AAAs, tribes, and local agencies should assess needs and target limited resources to participants with greatest economic and social need across all OAA program areas.
6. The SUA will survey county and tribal programs about how successful they were identifying caregivers and other OAA program participants with greatest economic and social need using the SUA's newly issued guidance. (July 2027)

Documenting efforts and tools:

Documenting **how much** has been done:

The SUA will collect the results of local agencies' caregiver needs assessments, initial and post program evaluation results, and required OAA economic and demographic data in PeerPlace.

Documenting **how well** it has been done:

The SUA will survey county and tribal programs on how well they were able to identify and serve caregivers with greatest economic and social needs.

Assessing whether anyone is **better off**:

The SUA requires local programs to complete an initial and post program evaluation for every family caregiver support program participant, which measures changes in their emotional, physical, and self-confidence in providing care over the course of receiving our services. These evaluation results are entered into PeerPlace along with caregiver needs assessments and customer satisfaction survey results.
Together these four person-centered data sets provide us with information that allows us to identify if family caregivers are better off as a result of participation in caregiver support programs.

Additional notes and considerations: Two goals combined into one because they were interrelated.

Program Area: Title IIIE Family Caregiver Support Program

☐Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☒Goal related to another quality improvement objective (specify)

Issue statement: Family caregivers of people participating in managed LTC are not accessing respite equally. While respite is included in our state's LTC waiver program, each MCO currently uses its own process for determining what level of caregiver supports will be approved, which may or may not adequately meet a family's needs. Our goal is to create a standardized process and assessment tool that will be used by all MCOs in our state.

Goal statement: The SUA will implement a new family caregiver needs assessment tool for managed care waiver participants to ensure that family members and friends who provide care to individuals enrolled in Medicaid Long Term Care programs can receive appropriate and adequate respite.

Plan or strategy:

The SUA Title IIIE manager will coordinate with staff from the DHS Division of Medicaid Services, Respite Care Association of Wisconsin, and contracted Managed Care Organizations (MCOs) to design and implement an enhanced caregiver needs assessment tool that will promote respite services for family caregivers of people enrolled in WI Medicaid LTC waiver programs.

1. A series of meetings with all affected partners will be scheduled throughout 2025, or longer as needed.
2. MCO staff will be trained on the benefits of offering caregiver respite and the proper use of administering the new needs assessment tool.
3. Beginning in July 2026, and annually thereafter, DHS will analyze levels of respite requested by, and provided to, family caregivers by MCOs compared to respite levels provided prior to implementation of the new needs assessment tool and staff training.

4. The respite needs assessment tool use results will be reported to ACL as part of the two-year States Implementing the National Strategy to Support Family Caregiver grant awarded to the State of Wisconsin.

Documenting efforts and tools:

Documenting **how much** has been done:

The caregiver program manager will keep meeting records documenting the development, planning, and implementation phases of the project. Records will include meeting minutes and external meetings with MCOs, a list of who participated, successes and barriers encountered, a record of the frequency of tool use by MCOs.

Documenting **how well** it has been done:

Wisconsin's contracted MCOs will be report the frequency of caregiver needs assessments and the amount of technical assistance required to implement the tool. Due to Medicaid billing codes, some questions remain about what data will be able to be collected.

Assessing whether anyone is **better off**:

The DHS/DMS will survey MCOs semi-annually on the effectiveness of using the enhanced caregiver assessment tool for managed LTC, and caregivers served through Wisconsin MCOs will receive a customer satisfaction survey from the DHS/DMS to measure changes in the caregiver support experience.

Additional notes and considerations: This is also an objective in our States Implementing the National Strategy to Support Family Caregivers grant workplan.

Program Area: Regulation Compliance: Stewardship and Oversight

☒Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Goal statement:

(1) In order to more effectively monitor program expenditures and operations across OAA and related program areas, the SUA will create a toolkit of program oversight tools, train SUA program managers in their use, and support full implementation across all funded program areas by September 30, 2026. This will bring the SUA into compliance with

(2) In year two of the plan, AAAs will be presented with selected elements of this toolkit and supported to extend their use for oversight of provider agencies with implementation encouraged by September 30, 2027.

(3) Standards for utilization of these tools and approaches will be incorporated into the Aging Network Operations Manual by September 30, 2027.

Plan or strategy:

Assemble existing materials and create new elements for Stewardship and Oversight Toolkit including meeting agenda templates, note/minutes templates, scheduling standards for partner consultations, documentation guidelines and storage system, program report templates for collecting information from partners, and expectations for program performance evaluation and summary reports. SUA will customize as appropriate, train, pilot, revise with feedback from team members and partners, and implement for SUA use as the strategy for the first year. Similar procedures will apply to AAAs in the second year. Across this period the SUA will track utilization and provide technical assistance and support for comprehensive implementation.

Documenting efforts and tools:

Documenting **how much** has been done:

For each of the three components of this goal, a project management spreadsheet will be developed with action steps and completion metrics.

Documenting **how well** it has been done:

Each stage of this project will include feedback from impacted individuals and partners to assess the utility of tools, trainings, and TA encounters. Results will be documented and used to inform revisions and upgrades.

Assessing whether anyone is **better off**:

This project does not conform to standard Results Based Accountability evaluation criteria, in that there is no expectation that end user or consumers will experience improved outcomes. The main outcomes sought are more consistent practice and compliance with regulatory expectations for stewardship and oversight.

Additional notes and considerations:

Program Area: Regulatory Compliance: 1321.9(c)(2)(xiv) Contracts and Commercial Relationships

☒Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Issue statement: Wisconsin's SUA does not currently have established policies to assist AAAs in the identification of CCRs in need of prior approval under section 212 of the Act and the requisite assurance documentation required of AAAs for revenue generating CCRs be accounted for separately and will not interfere with the accomplishment of T-III funded programs.

Goal statement:
The SUA will establish polices for AAAs to receive prior approval for CCRs permitted under section 212 of the Act. And develop assurances that revenue generating CCRs be accounted for separately and will not interfere with the accomplishment of T-III funded programs by Sept 30, 2026.

Plan or strategy:

- Engage with both AAA fiscal and program staffs to understand the scope of CCRs, identify contracts that might be pre-approved to minimize agency burden and to identify contracts permitted but in need of additional oversight.
- Develop initial draft policies and procedures to come into compliance with OAA regulations.
- Share draft policies and procedures with partners, collaborators, and key stakeholders including AAAs, aging units, and State Aging Advisory Council and incorporate input.
- Develop final policy including a timeline for implementation and request AAA's share with their boards or commissions on aging.
- Publish policy in the SUA Aging Operations Manual.

Documenting efforts and tools:

Documenting **how much** has been done:
We have established policies and processes for AAAs to receive prior approval for CCRs

permitted under section 212 of the Act. And developed assurance mechanisms that revenue

generating CCRs be accounted for separately and will not interfere with the accomplishment

of T-III funded programs.

Documenting **how well** it has been done:
We have engaged affected partners and collaborators to ensure we're getting their advice

and input in planning, and their feedback on resulting actions.

We have sought public input into plans and results including the State Aging Advisory Council.

We've proceeded with accountability and integrity, communicating consistently with affected partners and ensuring their concerns are recognized and addressed as the project goes forward.

Assessing whether anyone is **better off**:

The time frame for assessing whether these policy changes lead to improved outcomes for

individuals is too long to be measured within the three-year state plan period. The SUA

would anticipate improvements over a period of ten years or more. This three-year state plan period would be an appropriate time to establish a baseline measure activity.

Additional notes and considerations:

Program Area: Regulatory Compliance: § 1321.19 Designation of and designation changes to area agencies & § 1321.21 Withdrawal of area agency designation

☒Goal related to addressing regulations

☐Goal related to targeting services to those in greatest social and economic need

☐Goal related to making a program or service more person-centered

☐Goal related to another quality improvement objective (specify)

Issue statement: Wisconsin's SUA does not currently have established policies and procedures to designate and de-designate a AAA. This exposes us to risk as there is no existing documentation of past designations and de-designations. Our goal, in accordance with the regulations, is to document and justify our actions. The established policies and procedures would not be utilized regularly.

Goal statement: Establish policies and procedures to ensure that the process of designating AAAs, as well as the voluntary or involuntary de-designation of a AAA, will be transparent, will hold the state agency accountable for its decisions, and will afford due process to affected parties.

Plan or strategy:

- Understand the designation process pursuant to section 305 of the Act and the types of agencies permitted by the Act to serve as AAAs.
- Engage affected partners and collaborators to ensure the SUA is getting their advice and input in planning.
- Develop initial draft policies and procedures to come into compliance with OAA regulations.
- Share draft policies and procedures with partners, collaborators, and key stakeholders (like the AAAs, aging units, and State Aging Advisory Council) and incorporate input.
- Engage affected partners and collaborators to ensure we're getting their feedback on resulting actions.
- Finalize policies and procedures and share with AAAs. Request that AAAs share the approved policies and procedures with their boards or commissions on aging.

- Publish established policies and procedures in the state operations manual.

Documenting efforts and tools:

Document **how much** has been done:

We have established policies and procedures to ensure that the process of designating AAAs, as well as the voluntary or involuntary de-designation of a AAA, meet regulation requirements.

Documenting **how well** it has been done:

We have engaged affected partners and collaborators to ensure we're getting their advice and input in planning, and their feedback on resulting actions.

We have sought public input into plans and results including the State Aging Advisory Council.

We've proceeded with accountability and integrity, communicating consistently with affected partners and ensuring their concerns are recognized and addressed as the project goes forward.

Assessing whether anyone is **better off**:

The time frame for assessing whether these policy changes lead to improved outcomes for individuals is too long to be measured within the three-year state plan period. The SUA would anticipate improvements over a period of ten years or more. This three-year state plan period would be an appropriate time to establish a baseline measure for this.

Additional notes and considerations: