Report on
Service Equity in Older Americans Act Nutrition Programs

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Summary

The intent of this project was to learn about best practices and suggest approaches and opportunities on reaching and serving the neediest and most diverse older adult populations under the Older Americans Act Nutrition Program (OAANP) in order to redress inequities in service.

To obtain best practices, a literature search was conducted and State Unit on Aging (SUA) Lead Nutritionists and/or directors of nine states were interviewed. The literature review centered on reviewing peer-reviewed publications, grey literature and federal and state government websites. Medline, Google Scholar and Google Search engine were used to search for appropriate references. The purpose of the interviews of the SUA Lead Nutritionists and/or directors was to learn about state policies, program initiatives and best practices and those of their Area Agencies on Aging (AAA) that may enhance equity in Title III program participation and increase cultural competence among staff. The criteria used to select states to interview were those with a large older adult population, a high proportion of ethnic population(s) or a high prevalence of food insecure households and, the geographic location of the states. The AGing, Independence, and Disability (AGID) Program Data Portal and Census Bureau information were used to select these states.

Through these methods, many successful approaches that were undertaken or recommended for application at the state, local and federal levels were identified. These were compiled and serve as a basis for developing suggestions on what states can do to reach and diversify the population served.

These suggested approaches and opportunities are organized based on the spheres of influence of the socioecological model (SEM) framework. This model considers the complex interplay between individual, relationship, organizational, community, and policy factors. It allows us to understand the range of factors that interact at one level to influence factors at another level. Therefore, a concerted effort to intervene at each of the levels is more likely to be effective in achieving sustainable change towards equity.

Introduction

This is a crucial time in U.S history where public, government and service provider institutions are examining their practices in order to correct some of the inequities that have led to health disparities among specific population groups. The intent of this project was to learn about best practices that are currently used by the Older Americans Act Nutrition Program (OAANP) to reach and serve the neediest and most diverse populations in the country. OAANP is the only federal program that reaches out to older adults who have difficulties leaving home without assistance, by providing them with healthy meals delivered to their homes. This program also provides meals to mobile older community-dwelling individuals in congregate settings in order to promote socialization while consuming a healthy meal. Along with nourishing meals, OAANP provides periodic nutrition screening, needs assessment, education, and counseling to participants. Older adults tend to prefer community living and aging-in-place, and this program helps people remain in their homes.

The racial and ethnic minority populations in the US, ages 65 years and over, represented 24 percent of the population in 2019 and is expected to increase to 34 percent by 2040 (ACL, 2020). African Americans, in particular, have the lowest life expectancy of all race/ethnicities and the greatest health inequity (Johnson et al., 2022. As stated by Espinosa and Accius (2020), by the time people of color reach older age, they have experienced a lifetime of discrimination with impact on their physical, emotional and economic well-being. Because of these experiences, this population faces more serious age-related vulnerabilities that are higher than their white counterparts, including economic insecurity, social isolation, physical and cognitive decline, malnutrition and chronic health conditions. There is growing urgency to reach out to these populations with needed services. The latest version of the OAA, enacted in 2020 (Older Americans Act of 1965 [Public Law 89–73]), targets those most at risk for nutritional deficiencies, social isolation, and institutionalization. Minority populations, be they racial, ethnic, cultural, or sexual minorities, are at high risk for all three.

Methods

In order to learn about best practices and offer suggestions on reaching and serving minority populations that traditionally have not been well served, such as African American,

Black, Latinx, Hispanic, Asian and LGBTQ populations, a literature search was conducted and SUA Lead Nutritionists/directors of nine states were interviewed.

The literature search centered on reviewing peer-reviewed publications, grey literature and federal and state government websites. Grey literature sources, (outside of the traditional publishing and distribution channels), included policy and practice publications, video presentations, reports and blogs. Medline, Google Scholar and Google Search engine were used to search for appropriate references and, the following search terms in various combinations were utilized: Older Americans Act Nutrition Program, OAANP, home-delivered meals, Meals on Wheels, congregate meals, health disparity, outreach, targeting, health equity, racial minority, best practices. A large number of references were generated but after reading the abstracts, articles and following the website links, the number of references and websites were reduced to those referenced in this document.

SUA Lead Nutritionists and/or directors were then interviewed to learn about state policies, program initiatives and best practices and those of their Area Agencies on Aging (AAA) that enhance equity in Title III program participation and increase cultural competence among staff. The criteria used to select the states to interview were: those with a large older adult population, a high proportion of ethnic population(s) or a high prevalence of food insecure households and, the geographic location of the states. The AGing, Independence, and Disability (AGID) Program Data Portal and Census Bureau information were used to select these states. The AGID data portal contains programmatic information on nutrition services provided to older adults and on the demographic and racial profile of people served in all 50 states and territories. Information from the Census Bureau was added for comparative information. Appendix 1 includes an excel document with the percent of minority populations for the 50 states and Washington DC, and the percent of minority populations that participated in Title III programs in 2019. Also included in the table is the percent of individuals ages 60 years and older who in 2019 were under the poverty line by state and the percent of poor individuals served by the Title III programs in 2019. A chart depicting the percent of minority populations by state is also included in Appendix 1.

The following states were invited and participated in the survey: Arizona, Colorado, Georgia, Mississippi, Nevada, New York, Texas, Washington and Wisconsin. A set list of questions was

used (Appendix 2). Information was collected from eight SUAs. Texas SUA was not interviewed due to scheduling conflicts, however, some information, albeit limited, was obtained mostly through online research.

Results

The information obtained from the two methods described above is presented here:

Literature Review

Information obtained from the literature review can be divided into 4 sections followed by suggestions and approaches synthesized from the review. They are as follows:

Outreach, targeting and retention

Older adults tend to prefer community living and aging-in-place (Barrett, 2008). It is, therefore, important to find ways to reach the neediest people in the different communities, especially minority and marginalized populations, to assist them in remaining independently living. Along with nourishing meals, the OAANP provides periodic nutrition screening, assessment, education, and counseling to participants. Nutrition screening and education are especially important considering that individuals may not be knowledgeable in nutrition and its effect on health status, especially as people age, because they may develop chronic conditions that require adjustments to their diets. Studies have shown that the home-delivered meals (HDM) of the OAA are well liked, provide quality food to needy individuals and help individuals remain living independently (Sahyoun and Vaudin, 2014). Despite the multifactorial effect on health status, HDMs were also shown to decrease institutionalization of older adults and consequently healthcare expenditures (Thomas and Mor, 2013). However, funding has not kept up with increased demand for this program and may likely remain flat in the future (Congressional Research Service, 2022; NANASP (a), 2020). This may lead to waiting lists and a limit on program participation.

With the increase in racial and ethnic diversity in the different neighborhoods, and, in order to reach people most at risk, outreach, targeting and retention are essential. According to a 2015-2016 national evaluation of the OAANP, 66% of Congregate Meal participants and 71.8% of

home delivered meal participants were non-Hispanic whites. Just 0.3% of home-delivered meal participants were Asian, 8.7% were Hispanic, and 17.7% were non-Hispanic black (Mabli et al., 2017). This is an underrepresentation of the minority population considering that they are at higher risk of food insecurity and experience a higher prevalence of chronic conditions and disabilities. In a study of a rural community in Texas, the authors showed that Mexican-Americans were at higher nutritional risk than non-Mexican Americans (Sharkey, 2004). Also, in another Texas rural community, more African Americans reported having a chronic illness or condition, ate alone, had malfunctioning cooking appliances and sometimes did not have enough money to buy food compared to White older adults (Getty et al. 2016). In 2008, a study was conducted in 11 states where AAA directors and local providers were interviewed to learn about practices used to identify individuals for the HDM program. The authors reported many barriers to service delivery overall but they stated that HDM participants with special health or religious/cultural needs may be inappropriately or sub optimally served (Lee et al., 2008). In a presentation by Edwin Walker, Deputy Assistant Secretary for Aging, emphasized the need to continue targeting minority populations because without it, the goals to include a larger percentage of minority populations within those programs will not be met (NANASP (a), 2020).

Barriers and challenges

Targeting, outreach and retention present many challenges. Several studies reported on these challenges and despite the fact that some of these studies are dated, they describe barriers and challenges that are still relevant to this day. For example, in 2004, Choi and Smith conducted a study in a large metropolitan area in the Pacific Northwest to identify barriers to the participation of racial/ethnic minority older adults in the OAANP. The data were collected from a survey of OAANP staff and volunteers and from three focus groups of professionals working with minority older adults and minority community leaders. Several reasons were cited for low participation by older minority populations in the OAA meal program, including misinformation due to language barriers, lack of menus that can accommodate cultural preferences, discomfort with staff due to cultural and linguistic differences, fear and distrust of formal systems, and inadequate transportation to congregate meal sites. Choi (1999) also identified the unfamiliarity with and dislike of the foods served by the programs. The authors reported that a much higher proportion of African Americans than Whites discontinued participation in the OAANP due to

their dissatisfaction with the quality of the meals. Taste and cultural food preferences are critically important in attracting and retaining racial, ethnic, and cultural minority populations in the programs. For example, programs may lack culturally appropriate foods such as dairy-free meals for Asians who are largely lactose intolerant (Choi, 2002, 2004). Another study showed that African Americans were less likely to prefer most foods offered by the meal programs compared with Caucasians (Song et al. 2014)

State Level Diversity Initiatives

A few studies were conducted to examine diversity initiatives in outreach for Congregate Meals Programs (CMP) among states. In 2014, Porter and Cahill (2015) conducted a national study to determine the potential barriers to meeting the needs of minority populations and to explore the types of diversity initiatives employed at congregate meal sites to reach minority individuals. A survey was administered to the 50 SUAs and the District of Columbia and all but three states responded. The majority of states (64.6%) had CMP targeted to a specific racial, ethnic, or cultural minority and five states targeted sexual minorities (lesbian, gay, bisexual, and transgender (LGBT)). However, seventeen states offered no diversity initiatives, with six of these states having a high prevalence of minority populations. The authors identified three main themes as barriers, namely, lack of funding, lack of need, and issues specific to rural areas. Funding was a major reason with comments such as "the increase in the number of older adults can barely be satisfied, let alone targeting for the needs of ethnic populations" or that with so many different ethnicities in the state "it would not be financially feasible to provide meal sites that catered to any one population." Also, in some states, respondents stated that there were small minority populations and there were no requests for ethnic meals and no identified needs. This statement indicates that there is potentially no outreach to minority communities and there may be a discrepancy between understanding of need by providers and actual need. One stated barrier referred to is the lack of cultural competency in the leadership: ''We have found a clear relationship between the meal site coordinator's ability to relate and be culturally sensitive to the participants and the success of an ethnic site.'' These responses and other similar comments indicate a lack of cultural competence and it appears that not all programs recognize the importance of being culturally competent. Some programs stated that they did not feel that outreach to minority communities was necessary because they serve "all people." Nevertheless,

the results of this survey showed that the percentage of minority populations in a state was predictive of the number of diversity initiatives used in CMPs. States with LGBT CMPs reported the highest levels of racial/ethnic/cultural diversity initiatives and high levels of statewide LGBT protective policies. The results of this study also indicate that states develop different strategies to reach specific populations.

According to Adams and Tax (2017), some states have been leaders in targeting minority and LGBT older adults for services and support. For example, in 2012, Massachusetts' SUA, the Executive Office of Elder Affairs (EOEA), designated LGBT older adults as a population at greatest social need and requested that local agencies that work with older adults ''identify and assess the LGBT population as a part of their plan development.'' As a result of this directive, a number of Massachusetts AAAs hosted community needs assessment meetings, particularly for LGBT older adults and caregivers. Updated information is needed to determine outcomes of these assessment meetings.

Similarly, the New York State Office for the Aging targeted LGBT older adults for services, and implemented sexual orientation and gender identity data collection, but as of 2017, it had not designated the LGBT older adult population at greatest social need. As of Fall 2016, only nine states and the District of Columbia have attempted to assess and meet the needs of LGBT older adults, according to the National Resource Center on LGBT. This was determined by a review of the State Plans on aging. A total of 22 states had some mention of LGBT older adults in their state plans and attempted to address their needs in various capacities (Adams and Tax, 2017, National Resource Center on LGBT, 2017).

A state that is particularly active in its efforts to develop programs to reach out to minority populations is Wisconsin. The State of Wisconsin, Office on Aging, developed an equity plan that it is actively following, as described at a workshop presentation on May 13, 2021 (ACL, 2021). Also, at that workshop, an example of work done at the county level in the metropolitan Chicago area, Suburban Cook County, to reach a minority population during the pandemic was described (ACL, 2021). That county has a 30% minority population. During the fasting month of Ramadan, the organization contracted with an Arab-American food supplier to create custom boxes for that community. The Home-Delivered Food Boxes were tailored to Middle-Eastern preferences.

Additional initiatives were posted on the ACL National Resource Center on Nutrition and Aging website. This Resource Center was developed to build capacity of the aging network and identify current and emerging issues and opportunities. It reports on best practices, case studies, and other information of use to the network. For example, the Connecticut Senior Dine Program allows participants an option of going to a local restaurant for their meals. A registered dietitian works closely with restaurant owners on menu development to ensure that meals meet Title III C nutrition requirements. In addition, in rural Erie County, NY, the ACL-funded "Go & Dine" Senior Dining Program gives seniors an option to use vouchers at restaurants. It is, however, unclear whether any of the programs work with restaurants that offer ethnic food. These initiatives present opportunities for doing so. Another state's initiative was reported in South Bend Indiana where a food truck service was started to supplement the income of local service providers in order to serve more people. The truck creates a variety of menus and although one of their offerings is chipotle chicken tacos, it is not clear if the populations targeted are ethnic minorities. Although this truck was used to raise funds, the concept of a truck to target low-income minority populations is appealing and may need to be explored from an outreach potential and a cost perspective.

Community-based programs

There are limited peer-reviewed publications describing successful outreach and retention of OAANP programs at the community level. One such program, described by Mower (2008), shows how meal programs were developed targeting older adults in Korean, Vietnamese and Chinese communities in Montgomery County, Maryland. A group of Korean businesspersons who were concerned about the isolation of older family members contacted senior nutrition programs to request congregate meals. The nutrition program developed a partnership plan with the Korean organization to design a nutrition program tailored to the interests and needs of Korean seniors. Implementing the plan required staff to become knowledgeable about Korean culture and food consumption and to work with Korean seniors to develop a program appropriate to their needs while meeting local state and OAA requirements. The ethnic group provided a site at a church, staffed the program with Korean volunteers, and managed culturally tailored

activities that included nutrition education and physical fitness. A Korean restaurant provided meals at a reasonable cost. A year later, a Vietnamese organization requested a similar arrangement and this was followed later by a similar arrangement with a Chinese organization. These programs expanded and served an increasing number of older adults. The success of such programs requires a champion in the ethnic communities and a willingness by the providers to be educated in the needs of different communities. However, according to the author, funding must be secured to provide such programs. In addition, to address dietary preferences of ethnic groups while considering nutritional benefit, these food choices must be adjusted to conform to the dietary guidelines by decreasing, for example, the sodium content of the menus or reducing the saturated fats (Sandarangani et al., 2020).

In the studies presented in this review, authors recommended several strategies to increase participation of minority populations. These recommendations include holding cultural events in addition to serving of ethnic foods, organizing ethnic food cooking demonstrations and working with religious or community-based organizations. Additionally, dissemination of information about the OAANP at senior housing was considered somewhat effective, and, extending hours of service for early and late comers, offering free food or grocery bags to take home and providing regular health screening and checkup service were all determined to be effective recruitment and retention strategies. Other recruitment and retention strategies included creating a warm, welcoming atmosphere, and a menu plan that allows participants diverse food and cafeteria-style choices. Other frequently mentioned strategies included increasing staffing devoted to focusing on outreach efforts, increasing bilingual and bicultural staff and volunteers, recruitment of drivers/volunteers from the same ethnic background. In addition, a recommendation was to train and hire staff with increased awareness of diversity issues and develop multilingual outreach materials so that information on availability of the meal programs can be disseminated to homebound older adults and their families in ethnic neighborhoods. Finally, the most frequent outreach strategy mentioned was reliable transportation. All these suggestions may require more staffing and resources.

Other recommended outreach strategies included: involvement of family members in the information dissemination process; establishment of good working relationships with community leaders and contact with key older persons and request of input from current participants. In

essence, understanding food preferences of older adults is one of the means to improve the quality of nutritional services, and to retain participants in the programs.

The results of a recent survey of SUA, presented at a workshop (NANASP(b), 2020), reported mixed results by states to increase minority participation in the OAANP. While some states are actively embracing cultural competence in training and planning outreach activities, others may be reluctant to undertake new approaches or may have limited resources. Nevertheless, in his presentation at the same workshop, Edwin Walker, Deputy Assistant Secretary for Aging, reported that the percentages of minority populations on the OAANP increased from 29% to 32% in FY14 to FY18. He attributed this increase to the number of initiatives undertaken by AAA, such as hiring of minority staff, developing materials in languages other than English, locating programs in communities identified by Census data as low income or high minority populations and marketing programs through minority media.

State Units on Aging Interviews

As expected, states vary widely in their commitment to social equity and in their interactions with their state AAAs and local service providers (LSPs) and, consequently, in their knowledge of program initiatives at the local level. In response to our questions about best practices and initiatives at the local level, some states surveyed their AAAs in order to obtain information that could assist them in responding to our questions. Others did not. This means that the information obtained may not be complete or a true reflection of best practices in those states that did not. It is also possible that state level officials may be unaware of initiatives taken at the local level. Therefore, some follow-up internet searches were undertaken on some states by: checking State Plans, and looking for more information on specific programs that were discussed at the interviews. From the interviews and follow-up reviews, it appears that some states may not have initiatives in place to increase cultural competence and service equity at the state and local levels while others have several.

The following are findings of activities that are in place to enhance social equity under Title III, for the nine states that were surveyed. The findings are presented under eight categories as follows:

State plans

The SUAs are an integral part of the aging network, and are responsible for developing and administering a multi-year State Plan on aging. The State Plan provides goals and objectives for the aging programs related to assisting older residents, their families, and caregivers.

Interviewees from seven out of the nine states that were surveyed have articulated a specific policy in their current state plans to encourage outreach and service to the underserved and diverse populations within their state or included a statement to that effect while the other two states did not. However, the federal government has provided guidance that requires any new State Plan taking effect on or after October 1, 2022 to include goals and objectives to increase service equity to underserved populations and address activities to support these goals. Serving individuals with the greatest economic and social need means ensuring equity in all aspects of plan administration. The *Guidance for Developing State Plans on Aging* which was released by Alison Barkoff, Acting Assistant Secretary for Aging states that

> "As you develop your State Plans, ACL encourages states and AAAs to take a broad approach to ensuring services are reaching older adults in greatest social need in line with recent Executive Orders by President Biden. These populations include: individuals who are Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders, and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; and persons who live in rural areas."

The Biden Administration has articulated four key priorities, which are COVID-19 recovery, advancing equity, expanding access to home and community-based services (HCBS), and building a caregiving infrastructure.

The guidance to incorporate a plan for diverse and culturally competent approaches has stimulated those states that currently do not have a plan that emphasizes equity or the ones that are in the process of revising theirs. In addition to the federal guidance, the tragic

death of George Floyd has spurred action in some states, according to the information obtained through the interviews. For example, several of the states interviewed stated that a new department of equity diversity, and inclusion (EDI) was created to lead initiatives, train employees and develop educational materials or hire one or more individuals to strengthen their EDI programs. Wisconsin, Washington and Georgia have, or will shortly, conduct listening sessions throughout the state, together with AAAs and/or with community organizations and populations of interest, to learn about needs and to understand why underserved populations do not access some services.

Texas submitted a new State Plan to the Administration for Community Living on July 1, 2022. One of the key areas of the State Plan is titled *Equity* and one of its objectives is to 'Ensure meals can be adjusted for cultural considerations and preferences.' Its strategies include an increase in awareness of nutritional needs based on cultural and ethnic considerations and preferences. A dietitian must provide AAA and LSP information on cultural and ethnic nutritional preferences once a year and share resource information for culturally and ethnically appropriate meals on the aging services website(s). In NY, the current State Plan includes goals and objectives to increase service to underserved populations and the AAA plans are required to reflect the state plan. Annually, in a performance review, the AAA must report on what they did, how they did it and how much they have accomplished.

The State Plan for Nevada that was released in 2021 has a goal that specifies, "Lead efforts to strengthen equity in service delivery throughout Nevada for targeted populations through collaborations and networking." The Nevada SUA is in the planning phase to initiate programs for that purpose. Wisconsin's State Plan expired and those of Mississippi and Arizona expire in 2022 and are due to be updated. Mississippi's current plan addresses cultural competence by stating that guidance must be provided to service providers so that they are aware of cultural sensitivities and take into account linguistic and cultural differences. The Arizona state plan does not have a goal on equity and cultural competence but does suggest an increase in the cultural/linguistic competency of aging services statewide. Finally, Colorado whose state plan is from 2019-2023 mentions the following in its plan: "providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to

be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences."

Training for state, AAA, Local Service providers (LSP)

Some states, such as Arizona, Georgia and Colorado, require their employees to take a course in EDI. Other states have optional programs; and provide activities irregularly while others have more extensive and regular ones. For example, in Colorado, in addition to the required training in EDI, there are optional activities, such as a book club that meets monthly to discuss books related to equity. For example, on Women's Day, the book club discussed a book that focused on equity in women. Colorado also provides webinars on similar topics. Arizona holds weekly meetings for all staff where they regularly discuss issues of EDI. This state has diverse staff and generally engages in regular EDI exercises.

It was clear from my interviews that states with a commitment to service equity and who had a champion tended to set a standard that trickled down to the various departments. For example, in Nevada, the governor urged a concerted effort to address equity and fairness issues in state programs. As of January 2022, every agency had to designate a diversity and inclusion liaison, trained by the Nevada Office of Minority Health and Equity, to maintain ongoing communication between the state agency and members of minority groups. The SUA is beginning to develop strategic plans to include cultural competence training and service equity initiatives for their staff. New York, for example, has a strong advocate within the SUA and this has led to policies that require similar commitments at the AAA and community levels. However, due to lack of adequate staffing, New York has informal trainings at irregular intervals.

In Colorado, each AAA must have two goals to expand and improve their outreach. They are required to serve a higher proportion of individuals from ethnic populations than there are in the state and these are measured annually. The Wisconsin SUA director hosts a monthly statewide meeting and always includes an agenda item that deals with EDI.

Resources, awareness, availability

Knowledge of the availability of EDI resources varied widely, with some states reporting being unaware of training, tools and information while others knew of the existence of a few. Some states that had an accessible office of equity within their organization responded that they had some resources internally. Four of the states interviewed expressed a need for more resources and training and were hoping that ACL could provide speakers and webinars.

In Arizona, the Department of Economic Security that houses the State Department of Aging established an office dedicated to Equity, Diversity and Inclusion and one of their initiatives is to look at all elements throughout the structure of the organization, including the demographics of staff and leaders, job postings, customer feedback and other pertinent data.

Wisconsin provides access to training through their Office of Health Equity although the Milwaukee AAA, which is ethnically diverse, is initiating discussions on equity in their county and conducts weekly meetings with their staff for that purpose.

Building capacity, sustainability, growth

In Wisconsin, the staff must fulfill a certain number of hours of training each fall and so resources on gender identity, cultural humility, and cultural competence are available upon demand.

In Arizona, meal sites are selected because of their geographical, racial, ethnic and cultural diversity. Some Arizona AAAs also stated that they hire people who speak and look like those in the community that they serve.

The New York AAA must submit goals every 4 years that reflect the State Plan and must include specific services to their diverse populations. The Chief Diversity Officer at each state agency works with its various departments to consider diversity in hiring. New York conducts annual client surveys and focus groups to understand their clients and their needs.

Georgia is beginning to consider initiatives on increasing service equity and their first step is to train AAAs on understanding the data that they collect and their implications.

Cultural awareness and responsiveness

Washington stated that programs within their counties reflect the population diversity and needs of that county and they are hiring individuals with similar ethnicities and background. King county, which is the most diverse and includes Seattle, targets ethnic populations and provides ethnic food in half of its 15 sites.

New York had a Vietnamese population that was underserved and so the New York city AAA made a connection to open a congregate site in that community. New York reaches out to ethnic populations regarding special meals and posts pictures of food on their website and distributes brochures of their services.

Partnerships

Except for one state that was not aware of the existence of any partnerships, all other states had some formal or informal partnerships and some had plans to develop more of them. It was not always clear whether these partnerships included collaboration with the Title III programs. Arizona has a full-time individual who works as the community outreach liaison and one of their partnerships is with the Arizona Refugee Resettlement Program, where they work with the older refugees. Similarly, Georgia works with the Center for Pan-Asian Community to reach refugee populations and immigrant seniors. The center translates information into four Asian languages; Burmese, Korean, Chinese and Bhutanese. Nevada also has partnerships with refugee organizations. Colorado has a partnership with Easter Seals, which provides services for people with disabilities. They also have a Colorado Dental Health Care Program for Low-Income Seniors, which provides oral care for Latinx older adults through two AAA.

Nevada, Wisconsin and New York already do or are planning to partner with faith-based organizations of different ethnic groups such as Hispanic, black or African-American communities. In Nevada, one of the purposes of the diversity and inclusion liaisons is to collaborate with other state agencies to increase the accessibility and inclusivity of services to members of minority groups. Wisconsin has a partnership with the Great Lakes Inter-Tribal Council and works with 11 tribes who are encouraged to collaborate with the nearest counties to coordinate services. Wisconsin also has plans to collaborate with the Black Chamber of Commerce. New York stated having informal partnerships with the Alzheimer Association,

Hispanic Heritage Council and the Pride Center. They also partner with SNAP-Ed specifically because they discovered that older adults were underserved by that program. Washington has also established partnerships with seven tribal organizations to provide home delivered meals. Arizona has ongoing partnerships with a variety of community organizations serving Hispanic, African American and refugee groups. This enables them to expand outreach and provide services to diverse populations.

In Wisconsin, one of the AAAs developed a meal program in collaboration with the Urban Economic Association, and with restaurants owned by people of color to serve culturally appropriate meals and are marketing this program to the targeted communities. In addition, individuals from the Hmong community approached the SUA to open a site that caters to this population. The AAA opened a site but due to the pandemic, this population was no longer interested once they lost the physical location. Similarly, NY offers many ethnic menus, and their AAAs partner with restaurants to offer ethnic meals.

Data collection and use

All states do collect demographic data that they submit to ACL, as per federal requirement, and several states use their data to ensure that they meet their targets. However, some states use this information more extensively to guide their responses within the state. For example, Colorado overhauled its data collection tools and uses performance measures yearly to evaluate whether the AAAs hit their targets in service provision to the underserved populations. Nevada uses the data generated by their Analytics Office to create a report to inform legislators to drive state funding. Wisconsin is currently in the process of updating its policy manual to include statewide malnutrition screening and food security tools.

New York uses data to reach numerical objectives. If the AAAs do not reach those objectives, then the SUA takes corrective action and provides them with technical assistance. New York collects demographic data from participants at congregate meal sites and through HDM program on an ongoing basis. These data are a basis for the agency to select sites for the congregate meals, recommend closing of sites, if necessary, and alerts the state about low enrollment in some sites. The state also uses county-level census data to compare ethnicity of residents to those who participate in their programs.

Arizona AAAs are quite varied in their approach to service equity and some of them use data to identify gaps in service to ethnic minorities in an attempt to identify reasons for these gaps. The state is beginning to conduct a comprehensive needs assessment. Wisconsin compared ethnic populations served with the percent of residents in some counties and found discrepancies in services to Latinx and Asian populations. They are working to remedy this by including a goal in their new State Plan.

The AAA of San Antonio, Texas uses the Texas Equity Atlas to locate services in areas of need. The Texas Equity Atlas is an interactive tool that highlights the demographics, disparities and some infrastructure distribution within the city. This AAA hires staff from the communities to reflect the people who are being served. Many of the services are bilingual.

Languages

In Nevada, the governor has requested that every agency develop a language access plan, which is a document that spells out how to provide services to individuals who are Limited English Proficient. This is expected to provide fair and equal access to services and resources. The SUA is developing this language access plan.

Washington and Colorado have a sign language interpreter for the deaf and hard of hearing. Washington State has interpreter services in 16 languages at the local level for no extra charge. Additionally, Colorado has interpreters to translate materials in culturally appropriate Spanish.

Arizona has translated its menus in multiple languages although the menu is the same and does not necessarily include ethnic foods. Colorado has translated its nutrition educational materials and its messaging in Spanish, Mandarin and Russian. Most states have materials translated in other languages and Spanish is the language most frequently available.

Barriers to service equity initiatives

Several barriers were discussed that hindered states from increasing cultural competence and developing and implementing initiatives that would increase service equity. Some of these barriers include staff shortages, hiring freezes, frequent changes in management, lack of communication with local providers, lack of commitment at the State level, lack of awareness of resources available for training, lack of providers of ethnic meals, difficulty in reaching rural

populations without internet, and lack of staff of color. An observation was made that AAAs with no diversity in their staff were the ones who struggled the most.

Suggested Approaches and Opportunities

From the literature review and interviews of the SUA Lead Nutritionists/directors, several best practices were identified as were barriers to reaching and providing equitable services to the diverse populations within the states. These best practices, and an analysis of the barriers and how to overcome them form the basis for the suggested approaches on how to increase diversity in the OAANP. First, the barriers are divided into three categories as presented below, followed by suggested approaches and opportunities.

Barriers at the state level include, lack of funding, lack of understanding of cultural food needs, lack of cultural competence, hiring freezes, revolving management, and lack of communication with local providers.

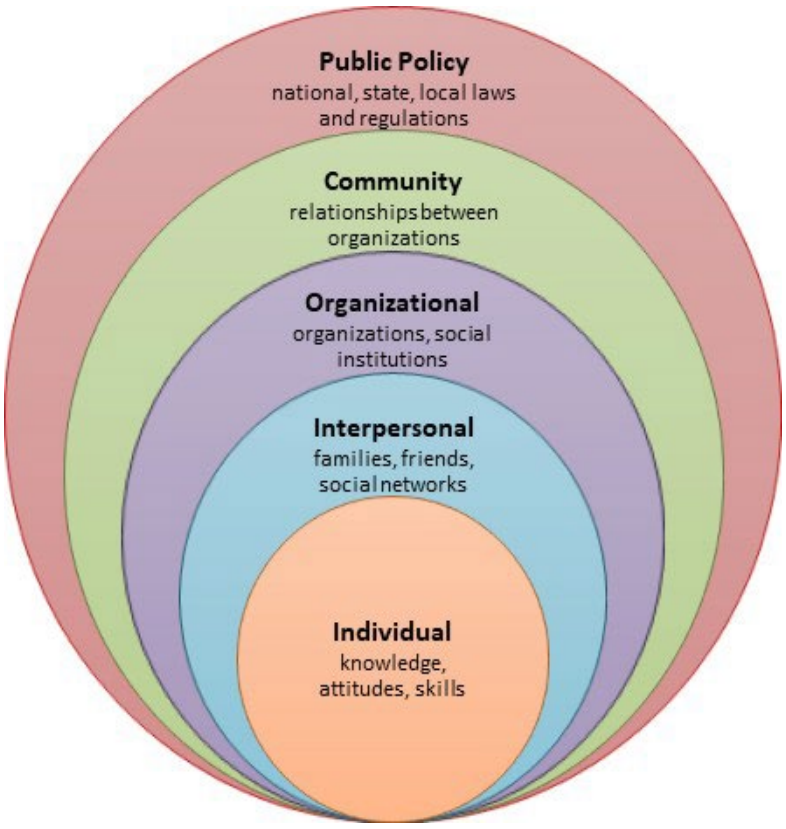
Barriers to service delivery include, staff shortages, lack of understanding of communities' needs, lack of cultural competence, lack of awareness of resources available for training, lack of providers of ethnic meals, difficulty in reaching rural populations without the internet, ineffective outreach due to language barriers and lack of staff reflecting the background of the people being served.

Barriers to participation by ethnic populations include, lack of menus that can accommodate cultural preferences, discomfort with staff due to cultural and linguistic differences, fear and distrust of formal systems, inadequate transportation to congregate meal sites, unfamiliarity with and dislike of the foods served by the programs. Taste and cultural food preferences are critically important in attracting and retaining racial, ethnic, and cultural minority populations.

As stated earlier, to increase outreach and services to the underserved and diverse populations within each state, ACL has taken a crucial step forward by requesting that OAA State Plans released after October 1, 2022 include goals and objectives to increase service equity to these populations and address activities to support these goals. With this guidance, serving individuals with the greatest economic and social need will mean ensuring that equity provisions in all aspects and levels of plan administration and implementation are incorporated.

There are a number of **best practices** that were identified through this project that could be used to begin to remedy some of the institutional and service biases towards ethnic minorities. These are presented below and organized using the Socioecological model (SEM) framework. This model considers the complex interplay between individual, relationship, organizational, community, and policy factors. It allows us to understand the range of factors that interact at one level to influence factors at another level. This approach provides a guide to individuals from any sphere of the model to arrive at a common understanding of the intended goals of redressing inequities in service because they are receiving and utilizing the same information and strategies to achieve a common goal.

Therefore, suggested approaches are organized below according to the spheres of influence of the SEM framework as illustrated in the diagram below.



Figure—Socioecological Model

Public Policy: National, state, local laws and regulations (Develop policies, initiatives and guidelines to protect against economic or social inequities between groups in society).

- **Require mandatory training** in cultural competence of all state employees. The staff could be required to take a certain number of hours of training a year in topics of gender identity, cross-cultural awareness, and cultural competence.
- **Develop a standardized training program** by ACL on cultural competence that can be adapted for use by states to train their staff. In interviews with the states, some requested additional training tools and expressed the desire for ACL to provide them.
- **Create or strengthen** the office of Equity Diversity and Inclusion (EDI) at the state level to provide ongoing training of employees and develop educational materials for use at AAA and at the local service providers' (LSP) level.
- **Evaluate agency structures** for the demographics of staff and leaders, job postings, customer feedback and other pertinent data to determine need for diverse staff and programs.
- **Identify a champion** at the SUA level whose responsibility is to set a standard that would trickle down to the various departments.
- Identify an EDI **community outreach liaison** to maintain ongoing communication between the state agency and members of minority groups.
- **Establish the proportion of minority individuals** that must be targeted by the OAANP to expand and improve outreach, and measure and evaluate this effort annually.
- **Develop a language access plan** that spells out how to provide services to individuals who are Limited English Proficient.

Community factors: (establishing or strengthening relationships between local organizations by collaborating and creating partnerships to effect change in the community).

- **Leverage resources** and **expand partnerships** with religious, community-based organizations and other community institutions. Partnerships can result in sharing limited resources and developing shared programs targeted to specific communities.

- **Partner with restaurants** or expand partnerships with restaurants owned by different ethnicities to offer congregate meals to ethnic groups.
- Expand the use of the ACL Nutrition and Aging Resource Center website as **repository of best practices**, **case studies, and other information of use to the network.** The Resource Center which already has useful materials, such as ethnic-specific menus shared by users, can continue to expand as a depository for menus and materials in various languages, including developing a database of menus of ethnic foods.

Organizational factors: Organizations, social institutions—(Changing policies and practices of organizations)

- **Train employees** on cultural competence and obtain available educational materials.
- **Designate a liaison** at the AAA level, as at the state level, to interact with community organizations and members of minority groups.
- **Expand and improve outreach to minority communities**. Develop an understanding of community needs by providers.
- Require that AAA plans **reflect the state plan in goals and objectives** for **outreach** and **service** to ethnic populations.
- Conduct **annual client surveys** and focus groups to understand clients and their needs.
- **Train employees in understanding data and how they can be applied** to improve outreach, identify gaps in service to ethnic minorities and identify reasons for these gaps. From these data, evaluate whether the AAAs hit their targets in service provision to the underserved populations. Demographic data may lead the agency to select sites for congregate meals, recommend closing of sites, if necessary, and alert the state about low enrollment in some sites.
- Explore the development of passive data collection as a **monitoring system** to collect the demographics of clients. This will facilitate the gathering of information without additional burden on the staff.
- **Hire minority staff** that reflect the ethnic make-up of ethnic communities served and who have an increased awareness of diversity issues. Preferably, hire staff from the communities served. Recruit volunteers from those same communities.
- **Develop multilingual outreach materials** targeting the areas of need.

- **Locate programs** in communities identified by Census data as low income or high minority populations and market programs through **minority media.**

Interpersonal processes: Families, friends, social networks-- Increasing support from friends, family and peers at the local level

- **Provide or sponsor cultural events** while serving ethnic foods or organizing ethnic food cooking demonstrations in partnership with local institutions, community organizations and families.
- **Disseminate** information about the nutrition programs at senior housing.
- **Disseminate** outreach materials to homebound older adults and their families in ethnic neighborhoods.
- **Extend hours of service** for early and late comers, offer free food or grocery bags to take home and provide regular health screening and checkup services.
- **Create a warm, welcoming atmosphere**, and a menu plan that allows participants diverse food and cafeteria-style choices.
- **Increase bilingual and bicultural staff and volunteers**, including recruiting drivers/volunteers from the same ethnic background as clients served.
- Provide reliable and affordable **transportation**.
- **Involve family members** in the information dissemination process.
- **Establish good working relationships** with community leaders and with key older persons.
- **Request input** from current program participants. Understanding food preferences of the older adults is one of the means to improve the quality of nutritional services, and to retain participants in the programs.

Individual factors: Knowledge, attitudes, skills-- Enhancing skills, knowledge, attitudes and motivation of individuals working in OAANP

- **Require mandatory training** of employees in cultural competence to understand the needs of the communities that they serve.
- **Increase self-awareness** of nutritional needs based on cultural and ethnic considerations and preferences.

- **Obtain information from a dietitian** on cultural and ethnic nutritional preferences and share resource information for culturally and ethnically appropriate meals on the aging services website(s).
- Ensure **menus can be adjusted** for cultural considerations and preferences.
- Become **aware of cultural sensitivities** and take into account linguistic and cultural differences.

The SEM framework is useful as a guide to effect sustainable changes because of the interconnectedness of all its levels. An intervention at one level will have repercussions at all the other levels. Interventions may involve institutions and individuals working at various levels of governmental structures, (federal, state and local) as well as institutions and community groups/organizations at the local level. These approaches are in line with the HHS Office of Minority Health National CLAS Standards (culturally and linguistically appropriate services) which are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities (U.S. Health and Human Services).

Conclusion

Overall, this was a productive exercise. It was very enlightening to the interviewer but also to the individuals that were interviewed. Several interviewees stated that the questions were very stimulating, encouraged discussions within their state on current and future programs and, spurred some of them to contact or survey their AAAs and LSPs to learn about their best practices.

The results show that the states are very different in their readiness to initiate programs that would increase equity in services. Some states are highly aware of health disparities and service inequities and have ongoing programs to rectify these issues while other states are just beginning to consider approaches to it.

State Plans with a specific guidance on this topic from the federal government are a good conduit to begin to develop goals and objectives on increasing cultural competence among staff and outreach to underserved communities. This guidance from the federal government and the initiation of some programs or the expansion of others is essential because promoting social equity can contribute to dismantling systemic racism, reverse centuries of inequality, and ensure that all people can participate and reach their full potential.

References

- Adams M, Tax AD. Assessing and Meeting the Needs of LGBT Older Adults via the Older Americans Act. LGBT Health. 2017; 4:389-393.
- Administration for Community Living, The National Resource Center on Nutrition and Aging. Success Stories. https://acl.gov/senior-nutrition/success-stories Accessed December 6, 2021.
- Administration for Community Living (2021, May 13). Advancing Health Equity Through Meal Programs Serving Older Adults. Sara Koenig [Video]. YouTube. https://www.youtube.com/watch?v=jwb5klm4_14, Accessed December 6, 2021.
- Administration for Community Living (2021, May 13). Advancing Health Equity Through Meal Programs Serving Older Adults. Philip Lanier, AgeOptions [Video]. YouTube. https://www.youtube.com/watch?v=jwb5klm4_14 Accessed December 6, 2021.
- Administration for Community Living (2020, May). 2020 Profile of Older Americans. U.S. Department of Health and Human Services.
- Barrett LL. (2008). Healthy @ Home. AARP Foundation. http://assets.aarp.org/rgcenter/il/healthy_home.pdf Accessed December 13, 2021.
- Choi NG. Determinants of frail elders' lengths of stay in Meals on Wheels. Gerontologist. 1999; 39, 397-404.
- Choi NG. Asian American Elderly Participants in Congregate Dining Programs, An Exploratory Study. J Nutr Elder. 2002; 21:1-13. DOI: 10.1300/J052v21n03_01
- Choi NG, Smith J. Reaching out to racial/ethnic minority older persons for elderly nutrition programs. J Nutr Elder. 2004; 24:89–104.
- Congressional Research Service. Older Americans Act: Overview and Funding. R43414, June 23, 2022. Colello, KJ, Napili, A. Available from : https://crsreports.congress.gov/product/pdf/R/R43414, Accessed 7/17/2022.
- Espinoza R, Accius J. (2020). The Case for Racial Equity in Aging Has Never Been Stronger [Blog Post]. https://www.diverseelders.org/2020/05/12/the-case-for-racial-equity-in-aging-has-never-been-stronger/ Accessed December 6, 2021.

- Getty MD, Mueller M, Amella EJ, Fraser AM. Differences in Medical and Life-style Risk Factors for Malnutrition in Limited-Resource Older Adults in a Rural U.S. State: A Descriptive Study. J Nutr Health Aging. 2016; 20:121-127. DOI**:** 10.1007/s12603-015- 0561-5.

- Johnson, CO, Boon-Dooley AS, DeCleene NK, et al. Life Expectancy for White, Black, and Hispanic Race/Ethnicity in U.S. States: Trends and Disparities, 1990 to 2019, Ann Intern Med. 2022: 175(8): 1057-1064.

- Lee JS, Frongillo EA, Keating MA, Deutsch LH, Daitchman J, Frongillo DE. Targeting of Home-Delivered Meals Programs to Older Adults in the United States, J Nutr Elder. 2008; 27:405-415, DOI: 10.1080/01639360802265947.

- Mabli J, Gearan E, Cohen R, et al. (2017). Evaluation of the effect of the Older Americans Act Title III-C Nutrition Services Program on participants' food security, socialization, and diet quality. https://acl.gov/sites/default/files/programs/2017-07/AoA_outcomesevaluation_final.pdf**.** Accessed December 6, 2021.

- Mower MT. Designing and implementing ethnic congregate nutrition programs for older Americans. J Nutr Eld. 2008, 27:417-430. DOI: 10.1080/01639360802265954.

- NANASP(a) and Benjamin Rose Institute on Aging. (2020, October 19). Racial Equity: Perspectives on Delivery of OAA Programs. Edwin Walker [Video]. YouTube. https://www.youtube.com/watch?v=Fh2ea0WdxrE. Accessed December 6, 2021.

- NANASP(b) and Benjamin Rose Institute on Aging. (2020, October 19). Racial Equity: Perspectives on Delivery of OAA Programs. Bob Blancato [Video]. YouTube. https://www.youtube.com/watch?v=cSStbZafkkA&t=502s Accessed December 6, 2021.

- National Resource Center on LGBT Aging and Services and Advocacy for GLBT Elders (SAGE): Strengthen your state and local aging plan: A practical guide for expanding the inclusion of LGBT older adults. 2017.

www.lgbtagingcenter.org/resources/pdfs/Sage_StrengtheningGuidebook2017.pdf Accessed December 6, 2021.

- Older Americans Act of 1965. Public Law 89–73, [As Amended Through P.L. 116–131, Enacted March 25, 2020]. https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20Of%201965%20as%20amended%20by%20Public% 20Law%20116-131%20on%203-25-2020.pdf**.** Accessed December 10, 2021.
- Porter KE, Cahill S. A State-Level Review of Diversity Initiatives in Congregate Meal Programs Established Under the Older Americans Act. Res Aging. 2015; 37:719–740.
- Sadarangani TR. Beasley JM, Yi SS, Chodosh J. Enriching Nutrition Programs to Better Serve the Needs of a Diversifying Aging Population. Fam Community Health. 2020; 43:100-105.
- Sahyoun NR, Vaudin A. Home-delivered meals and nutritional status among older adults. Nutr Clin Pract. 2014; 29: 459-465.
- Sharkey JR. Variation in nutritional risk among Mexican American and non-Mexican American homebound elders who receive home-delivered meals. J Nutr Elder 2004; 23: 1-19.
- Song HJ, Simon JR, Patel DU. Food preferences of older adults in senior nutrition programs. J Nutr Gerontol Geriatr. 2014; 33:55-67.
- Thomas KA, Mor V. Providing more home-delivered meals is one way to keep older adults with low care needs out of nursing homes. Health Aff (Millwood). 2013; 32:1796-1802.
- U.S. Department of Health and Human Services. Office of Minority Health. National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available from: https://thinkculturalhealth.hhs.gov/assets/pdfs/. Accessed 8/24/2022.

Appendices

Appendix 1--Table. US and Title III program characteristics sorted by minority status

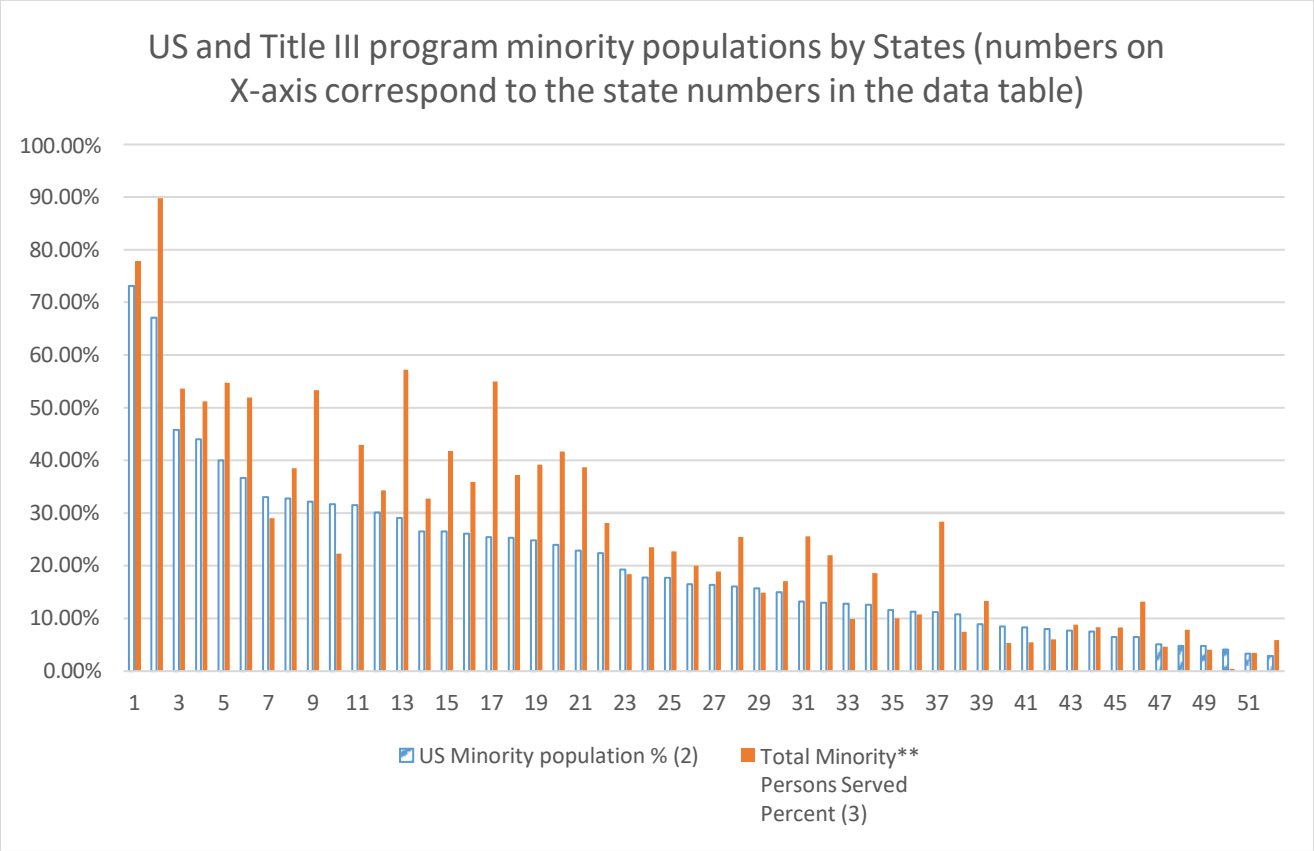
State	US Population 60+ (1)	US Minority population (2)	Total Minority** Persons Served (3)	Total Non-Minority Persons Served (White (Alone) - Non-Hispanic) (4)	US Poverty by state (5)	Poverty status on program (6)	Rural on program (7)	Minority and poverty on program (8)	US Minority below poverty level (9)
				Percent					
Hawaii	25.30%	73.10%	77.74%	20.95%	8.58%	18.50%	60.00%	14.40%	8.30%
District of Columbia	26.40%	67.10%	89.76%	6.20%	16.11%	52.10%	0.00%	49.20%	20.58%
California	20.50%	45.80%	53.61%	39.32%	10.44%	45.60%	12.50%	28.80%	13.05%
New Mexico	24.50%	44.00%	51.18%	38.60%	14.81%	28.20%	32.90%	18.70%	21.22%
Texas	18.20%	40.00%	54.74%	42.89%	10.44%	43.80%	35.00%	29.80%	16.24%
Maryland	22.30%	36.70%	51.93%	44.36%	7.92%	24.20%	27.30%	11.70%	11.66%
Georgia	20.10%	33.00%	28.99%	41.17%	10.63%	39.50%	33.20%	11.70%	15.83%
New York	23.40%	32.80%	38.51%	44.30%	11.70%	31.80%	14.00%	15.50%	19.19%
Mississippi	22.70%	32.20%	53.32%	44.38%	14.15%	57.10%	83.60%	37.00%	24.41%
Nevada	22.10%	31.70%	22.29%	67.74%	10.42%	31.30%	41.80%	9.70%	13.86%
Louisiana	22.30%	31.50%	42.90%	50.17%	14.08%	39.50%	40.60%	21.40%	24.07%
New Jersey	23.20%	30.10%	34.28%	63.06%	8.70%	27.70%	0.00%	14.60%	15.12%
Florida	27.50%	29.10%	57.20%	42.59%	10.90%	47.00%	1.30%	37.30%	18.35%
US Total	22.80%	26.50%	32.70%	58.40%	9.77%	32.60%	33.60%	14.70%	16.20%
Virginia	22.10%	26.50%	41.78%	54.57%	7.42%	36.50%	27.90%	18.70%	11.44%
Alaska	18.70%	26.10%	35.86%	59.20%	8.34%	40.50%	78.50%	21.60%	15.88%
South Carolina	24.80%	25.40%	54.93%	41.93%	10.56%	48.90%	55.40%	31.10%	20.13%
Illinois	22.50%	25.30%	37.20%	60.05%	8.92%	36.60%	20.10%	14.30%	15.90%
Alabama	23.90%	24.80%	39.18%	43.39%	11.36%	27.30%	43.80%	12.50%	18.59%
North Carolina	23.00%	24.00%	41.68%	55.43%	9.94%	43.30%	44.00%	22.00%	16.59%
Arizona	23.90%	22.90%	38.65%	47.09%	9.80%	29.70%	37.10%	18.50%	15.78%

Delaware	26.40%	22.40%	28.09%	69.40%	7.99%	7.10%	44.20%	3.40%	14.54%
Oklahoma	22.10%	19.30%	18.38%	81.16%	10.26%	43.40%	56.20%	11.00%	15.75%
Colorado	20.70%	17.80%	23.47%	64.85%	7.99%	23.70%	23.60%	9.50%	13.46%
Connecticut	24.60%	17.70%	22.71%	77.20%	8.22%	15.70%	13.70%	7.70%	17.76%
Washington	22.10%	16.50%	19.93%	61.74%	8.10%	32.90%	28.70%	12.50%	14.25%
Arkansas	23.60%	16.40%	18.89%	80.18%	11.70%	29.90%	58.20%	9.20%	21.56%
Tennessee	23.10%	16.10%	25.46%	73.67%	10.23%	46.90%	47.80%	16.30%	16.25%
Michigan	24.60%	15.70%	14.86%	74.20%	9.06%	25.60%	46.50%	7.10%	17.25%
Massachusetts	23.50%	15.00%	17.04%	62.58%	8.88%	10.70%	5.40%	3.20%	20.63%
Ohio	24.30%	13.20%	25.54%	70.68%	8.84%	43.80%	37.70%	14.90%	18.84%
Pennsylvania	25.70%	13.00%	21.97%	73.72%	9.08%	26.10%	28.70%	8.20%	21.54%
Rhode Island	24.60%	12.80%	9.86%	73.06%	9.82%	15.90%	2.60%	3.80%	23.63%
Missouri	23.90%	12.60%	18.54%	77.67%	9.50%	38.40%	67.00%	9.90%	18.29%
Kansas	22.60%	11.60%	9.98%	85.54%	7.59%	23.50%	61.40%	4.10%	12.72%
Utah	16.00%	11.30%	10.70%	80.34%	6.49%	16.80%	33.90%	3.60%	12.51%
Indiana	22.50%	11.20%	28.35%	62.45%	7.98%	34.10%	18.10%	9.70%	13.28%
Oregon	24.60%	10.80%	7.43%	49.67%	8.22%	15.10%	24.20%	3.90%	12.28%
Kentucky	23.30%	8.90%	13.25%	86.71%	12.56%	46.10%	67.00%	7.30%	20.43%
Nebraska	22.30%	8.50%	5.34%	91.32%	9.22%	17.30%	78.20%	1.80%	18.50%
Wyoming	24.10%	8.30%	5.41%	88.65%	8.26%	19.50%	72.30%	2.00%	7.91%
Idaho	22.40%	8.00%	5.98%	87.59%	8.00%	22.60%	50.80%	2.00%	13.62%
Wisconsin	24.40%	7.70%	8.78%	90.71%	7.15%	23.30%	68.00%	4.20%	18.09%
Minnesota	22.80%	7.50%	8.30%	86.14%	7.84%	19.00%	72.40%	4.30%	17.37%
Montana	26.50%	6.50%	8.21%	53.84%	8.87%	24.70%	15.30%	3.30%	17.80%
South Dakota	23.80%	6.50%	13.16%	84.46%	7.82%	37.30%	77.60%	8.00%	13.72%
North Dakota	21.90%	5.10%	4.61%	95.34%	7.61%	21.50%	65.10%	2.60%	17.48%
West Virginia	27.70%	4.80%	7.83%	91.31%	10.05%	39.50%	75.90%	3.50%	10.96%
Iowa	24.00%	4.80%	4.01%	91.57%	7.93%	20.50%	41.40%	1.60%	17.05%
New Hampshire	26.30%	4.10%	0.37%	37.03%	6.94%	15.80%	71.10%	0.10%	12.70%
Vermont	27.70%	3.30%	3.45%	90.51%	6.85%	23.00%	89.60%	1.70%	8.05%
Maine	29.10%	2.90%	5.87%	82.58%	8.24%	46.30%	82.30%	3.90%	14.03%

(1) Persons 60+ in the US, as a percent of all ages
(2) Persons 60+ who are minority served by the program, as a percent of all the served population
(3) Persons 60+ who are minority served by the program, as a percent of all the served population
(4) Persons 60+ who are White (non-Hispanic) served by the program, as a percent of all the served population
(5) Persons 60+ under the poverty level, as a percent of the US population
(6) Persons 60+ under the poverty level, as a percent of all the served population
(7) Persons 60+ who live in a rural area, as a percent of all the served population
(8) Persons 60+ who are minority and under the poverty level, as a percent of all the served population
(9) Persons 60+ who are minority and below poverty level, as a percent of minority 60+ population in the US

Datasets used:
AGID State Profile. https://agid.acl.gov/StateProfiles/Profile/Pre/?id=109&topic=l&startyear=2019&endyear=2019
https://agid.acl.gov/StateProfiles/Profile/Pre/?id=101&topic=0&years=2019
Table 3. Persons Registered (Clusters 1 and 2) and Served Under OAA Title Ill by Racial/Ethnic Characteristics. https:ljagid.acl.gov/StateProfiles/Profile/Pre/?id=101&topic=0&years=2019

Appendix 1


US and Title III program minority populations by States (numbers on X-axis correspond to the state numbers in the data table)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51
US Minority population % (2)
Total Minority** Persons Served Percent (3)

Appendix 2

Service Equity Project--Site questions

ACL and the University of Maryland

February 2022

1. Has your organization made a public commitment to service equity? Have you included an approach to it in your work plan?
   If so, how?

2. Do you provide to your staff and/or receive any training in cultural competence at the state level?

3. Are you aware of any such training at the AAA or LSP level? If so can you provide specific examples of such activities?

4. Are you aware of current resources available to you such as training, tools, information?

5. How are you building capacity to ensure Service Equity sustainability and growth within your staff? and staff at the AAA and LSP level? Please provide concrete examples.

6. How do you encourage cultural awareness and responsiveness of your staff?
   and also staff at the AAA/LSP levels?

7. Does your organization have formal partnerships with other organizations serving communities with known disparities?

8. What efforts are in place now at the state level to engage with AAA and LSP on service equity?

9. How are you currently collecting relevant data to determine Service Equity practices, needs and assessment? How do you use and apply this data?

10. What data do you currently use to drive decisions on Service Equity? Can you share any policies and procedures that were instituted as a result?

11. Have you identified any gaps and disparities vis-a-vis Equity within your policies that you plan to change? If yes, what changes do you plan to make?

12. Have you identified best practices in your state or within the local programs?
    If so, can you provide some examples of those best practices?

13. Do any of the meal sites in your state publicize their services in culturally sensitive ways to target specific racial, ethnic, or cultural communities? If so, can you provide examples?

14. Does your state offer services in languages other than English? Are your information and educational materials available in languages other than English? If so, which languages? What specific materials?