

STATE PLAN COVER PAGE (PDF)

Draft Draft Draft

**A Message from the Director**

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Corinda Crossdale

Director

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**Verification of Intent**

I hereby authorize the New York State Office for the Aging, as the designated State Unit on Aging for the State of New York, to develop a state plan, submit it to the Administrator for the United States Administration for Community Living for approval, and administer such plan upon approval.

\_\_\_\_\_

Date:

Andrew M. Cuomo, Governor  
State of New York

**Verification of Intent**

The State of New York, Office for the Aging, hereby submits the New York State Plan on Aging for the period October 1, 2015 to September 30, 2019 and certifies that the administration of the State Plan shall be in compliance with the required assurances and provisions of the Older Americans Act of 1965 as amended. The State Agency named above has been given the authority to develop and administer the State Plan on Aging in accordance with the requirements of the Older Americans Act, and is primarily responsible for the coordination of all State activities related to the Act, and serves as the effective and visible advocate for the elderly in the State of New York.

This Plan on Aging has been developed in accordance with all federal statutory and regulatory amendments.

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Corinda Crossdale, Director, New York State Office for the Aging

June \_\_\_\_\_

## **New York State Office for the Aging**

*It is the mission of the New York State Office for the Aging to help older New Yorkers to be as independent as possible for as long as possible through advocacy, development and delivery of person-centered, consumer-oriented, and cost-effective policies, programs and services which support and empower older New Yorkers and their families, in partnership with the network of public and private organizations which serve them.*

The New York State Office for the Aging (NYSOFA), established in 1965 by Article 19-J of the Executive Law (now, New York State Elder Law, Article II, Title 1), is New York's designated state unit on aging as required by the federal Older Americans Act (OAA). NYSOFA is the lead agency for promoting, coordinating, and administering federal, state and local programs and services for older New Yorkers ages 60 and over and their caregivers. NYSOFA is the state's administrator for the federally designated Aging and Disability Resource Center (called NY Connects) as well as the state Long Term Care Ombudsman Program (LTCOP).

NYSOFA plays a central role in advocating on behalf of New York's 3.7 million older adults ages 60 and older as well as over 4 million informal caregivers (family, friends and neighbors) providing daily or intermittent care for older adults and persons of all ages with disabilities. The role of NYSOFA is based on its mission and OAA and state statute. NYSOFA partners with 59 area agencies on aging (AAA's), 56 of which are county based, one AAA located on each of the St Regis and Seneca Reservations and one AAA run by the City of New York. Of the 56 county based AAAs, 52 are sponsored by county governments and four are sponsored by not-for-profit organizations. Combined, NYSOFA and the AAAs contract with over 1,200 organizations to deliver cost-effective, pre-Medicaid, non-clinical long-term services and supports in the homes and communities of at risk older adults. Our common goals include:

- Coordinating and guiding policy development to improve the quality of life of older New Yorkers;
- Strengthening and expanding the state's No Wrong Door system that will result in greater access to consistent information and assistance across systems to people with disabilities and older adults;
- Expanding opportunities to de-silo systems through the use of technology to securely share information, as well as to identify services to be provided as needed and appropriate to help individuals get the right services at the appropriate time;
- Providing leadership and facilitating community action that enables communities to develop sustainable planning processes that recognize demographic changes and how those communities can better plan for the growth in the older population and other change drivers;
- Assuring the delivery of coordinated, high-quality services in communities across the State to help older adults remain as independent as possible for as long as possible.
- Expanding opportunities for integration of non-clinical support services within physical and behavioral health care systems;
- Working with State and local stakeholders to create local environments that will reduce the out-migration of older adults that will enhance New York's position as a viable retiree destination that positively impacts the economy;

- Utilizing the experience, expertise and skills of older New Yorkers to help address workforce shortages in areas such as health care, long-term services and supports and new and emerging fields such as information technology and green jobs;
- Utilizing the experience, expertise and skills of older New Yorkers through community volunteerism and civic engagement;
- Making government work better by developing quantifiable metrics to measure performance and improve quality; and
- Working smarter by enhancing relationships with local governmental agencies ( Social Services Districts, Public Health, Mental Health, etc.) and other partners (Managed Care Organizations, Regional Health Information Organizations, Community Based Organizations, Health Homes, etc.) to better integrate services, streamline eligibility for programs and provide assistance to help reduce barriers to services for the state's residents, while breaking down silos.

It is widely known that there are challenges related to the growth of the baby boomers and older population. However, there are tremendous opportunities to utilize the social, intellectual and economic capital of older adults themselves to address social problems. Further, the infrastructure of the area agencies on aging and the network of community-based providers are well suited to identify problems early and coordinate a services to assist individuals and families. These resources, when recognized and organized, can help leverage and expand resources to better serve individuals in their homes and communities and are a critical element to a seamless service system that better connects clinical care with human services.

NYSOFA's priorities include:

- Strengthening core OAA and state funded services to meet existing and future needs among older adults and their families;
- Expanding and strengthening the states No Wrong Door to serve all populations, regardless of age and payer source;
- Increasing the business acumen of the network to strengthen partnerships with health care providers and to develop models that reach new populations;
- working with other state agencies and local partners to prevent readmission to hospitals;
- Teaching older adults how to manage complex chronic conditions and working to expand to other populations;
- Providing one-on-one assistance to understand the complexities of and navigating Medicare and other health insurance;
- Assisting individuals in understanding, applying for and receiving benefits they may be eligible for;
- Supporting caregivers of all ages to continue to serve their loved ones;
- Marketing the value of network services in health care and LTSS reorganization; and
- Instituting measurements and metrics to determine the efficacy of programs and for program/service improvements.

### **Current Status of the Network**

The Older Americans Act and NYS Elder Law allow for flexibility in how AAAs meet locally determined needs. The OAA was founded on the principle of building local partnerships and leveraging additional resources from these partnerships. While the OAA pays primarily for care

and services for those over the age of 60, over time the networks portfolio has expanded to assist other populations. For example, the Health Insurance, Information and Counseling Assistance Program (HIICAP) may be accessed by Medicare beneficiaries of any age and NY Connects (New York's Aging and Disability Resource Center and No Wrong Door) is available to provide information and assistance to individuals of any age and their families who are seeking long term services and supports, and the Long Term Care Ombudsman Program (LTCOP) may be accessed by any resident in facilities covered under its jurisdiction.

## Funding

State and Federal funding in the amount of \$215 million leverages an additional \$235 million in resources from municipal government, private fundraising, participant contributions and cost-sharing.

NYSOFA's four pronged approach to utilize public resources as efficiently as possible and leverage private resources and partnerships has resulted in a comprehensive strategy designed to:

1. Help older adults, families and baby boomers develop a personal independence plan which provides strategies individuals can themselves implement to maintain their independence.
2. Expand access to information and assistance on long term services and supports for persons of all ages with disabilities and their families while simultaneously strengthening partnerships with other state and local partners to meet the holistic and cross-systems needs of New Yorkers.
3. Coordinate, integrate and break down state and county level service silos through state level policy and program work and direction setting, strengthening existing and developing new local partnerships (managed care organizations, MLTC, DSRIP, Health Homes, care transitions, RHIOs, behavioral health, etc.) as a result of a multitude federal and state actions and opportunities.
4. Initiate new or support existing community efforts to help communities organize and plan for sustainable community neighborhoods that are future-based and inclusive, grounded in smart growth and livability principles designed with an understanding of the changing demographics of the state and that good community design is good economic policy and beneficial across the age span.

The New York State Office for the Aging's home and community-based programs:

- provide at risk frail older persons access to a cost-effective, well-planned, coordinated package of in-home and other supportive services designed to support and supplement informal care;
- provide support services to caregivers of frail individuals in need of assistance with their daily activities;
- provide opportunities to volunteer which result in the ability to serve more individuals and improve the volunteers health; and
- provide triage, critical linkages and assistance to other programs within and across different systems.

The New York State Office for the Aging's overall goal is to improve access to, and availability of, appropriate and cost-effective non-medical support services for functionally impaired older individuals and through this service, improve outcomes and reduce costs to other systems such as health, long term care, human services, etc. NYSOFA's primary goal is to maximize the ability

of an individual to age in their community and avoid higher levels of care and the need for publicly financed care. The focus of this effort is through the provision of services and supports to people in their homes; and delivered in a coordinated manner.

The key elements of NYSOFA's efforts include:

1. Providing non-medical home and community-based services;
2. Providing a No Wrong Door system that offers consistent information and assistance, including screening that assists individuals in accessing care through multiple systems;
3. Supporting New York's caregivers;
4. Helping to increase access to economic security programs and other benefits for Older New Yorkers;
5. Promoting and expanding access to health and wellness/disease management and prevention programs;
6. Advancing civic engagement and volunteerism;
7. In conjunction with state agency and local partners, developing and implementing innovative programs and services and setting future policy direction; and
8. Supporting community efforts designed to improve livability.

### **Performance Management**

NYSOFA's continued commitment to effective and responsive management remains one of the agency's priorities. As a result, over the course of the next four years, the agency will administer consistent performance management practices that will include but not be limited to, standardized metrics, improved outcomes, and targeted projections. NYSOFA will review POMP, NCI-AD, and other NY governor's initiatives and integrate where necessary as part of its performance management framework.

The 2015-2019 State Plan includes goals, objectives, strategies, and expected outcomes but with a mixed methodology approach. Some expected outcomes include outputs which can be conceptualized as products, where other expected outcomes illustrate the expected benefit.

NYSOFA will continue to work towards developing a performance management system that will align with our priorities as we transition to the next level in overall performance management.

## AGING IN NEW YORK STATE

### Growth in the Older Population

New York's demographic structure reflects some of the same major demographic forces that have shaped the nation's population; for example, like the rest of the country, and the world, New York's Baby Boom cohort will swell the ranks of the State's older population in the coming decades.

The impact of the aging of the Baby Boom population is seen clearly in the chart, which depicts the projected increase in the older population for the State's 62 counties (which include all of the boroughs of New York City) by the year 2020. In 2015, 7 counties had populations where older people (aged 60 and over) constituted less than 20 percent of the total population; by 2025, the number of counties with less than 20 percent of the population aged 60 and over will dwindle to the four boroughs in New York City and Jefferson County, home of Fort Drum. Overall, the state population is projected to be over 24 percent older people, which is comparable to the national projection in 2025.

The State's population characteristics also are unique in many ways. New York's population size, distribution, and composition have been driven by very dynamic demographic events both internal and external to the State. Forces such as foreign immigration, high levels of domestic in- and out-migration, and the state's expanding ethnic populations have shaped New York's population and will continue to do so in the future.

New York's total population is currently estimated to be over 19 million individuals, and, with 3.7 million individuals aged 60 and older (Woods & Poole 2015 estimate), the State ranks fourth in the nation in the number of older adults behind California, Florida, and Texas, based on the latest data available (the 2013 American Community Survey, one-year estimates). Rich in ethnic, racial, religious/spiritual, cultural and life-style diversity, New York is known for its status as a finance, transportation, and manufacturing center, as well as for its history as a gateway for immigration to the United States. According to the 2013 American Community Survey, over 22 percent of the population is foreign-born, with 30 percent of the population speaking a language other than English at home.

<b>New York State</b> <b>62 Counties</b> <b>Change in Population Aged 60 and Over</b> <b>2010 to 2020</b>		
<b>Proportion of County Population Aged 60 and Over</b>	<b>Number of Counties with Specified percent of Older Persons</b>	
	<b>2015</b>	<b>2025</b>
Less than 20%	7	5
20% to 24%	41	6
25% to 29%	12	33
30% and over	2	18
Source: Woods & Poole Economics, Inc., 2014 State Profile		

## Racial/Ethnic Diversity and Foreign Immigration

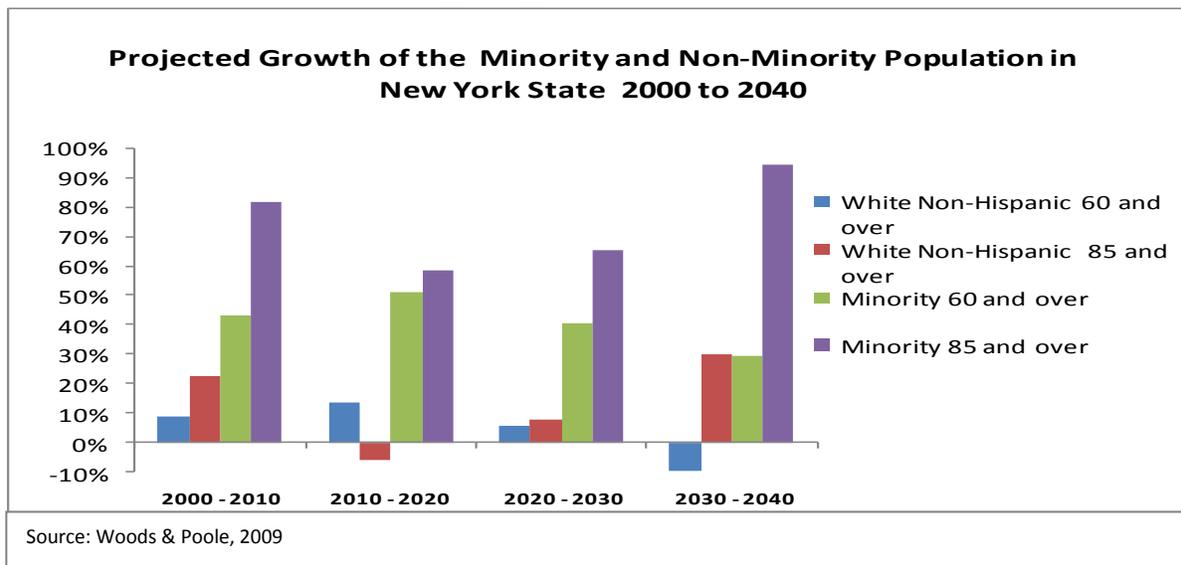
Between the 2000 and the 2010 Census, the minority population aged 60 and over grew by 43 percent, compared to 8 percent for the non-minority population. This high growth rate will continue over the next three decades:

- Between 2010 and 2020, the minority population will increase by 51 percent, as the last of the Baby Boom population enter the 60 and over age group.
- Between 2020 and 2030, the growth rate will be 40 percent for the minority population groups, and 5 percent for non-minority population groups.
- Between 2030 and 2040, the non-minority population will *decline* by 9 percent while the minority population groups will increase by 29 percent.

***Between 2000 - 2010, the minority population aged 60 and over grew by 43 percent, compared to 8 percent for the non-minority population. This high growth rate will continue over the next three decades.***

Growth in the aged 85 and over minority population group is expected to be even stronger. Over the last decade, this age group grew by 81 percent, compared to 22 percent for the non-minority population.

- Between 2010 and 2020, the minority population growth rate for this age group will be 58 percent.
- Between 2020 and 2030, the growth rate will be 65 percent.
- Between 2030 and 2040, it is expected to grow by 94 percent, compared to 30 percent for the non-minority population in this age group.



## Migration Patterns

New York's migration patterns have been consistent for many decades, with a net out-migration pattern over time. For older adults, the *rate* of interstate migration – the percentage of older persons who live in a different state than they did five years prior, has remained remarkably steady over the last 40 years. Approximately four percent of older adults (aged 55-74) make an interstate move during a five year period after turning 55, compared to ten percent of non-older individuals. The likelihood of undertaking an interstate move has changed little and is still substantially smaller for older adults than for younger individuals.

Net migration by age follows a distinct life-course pattern in New York State. The State has a high rate of net out-migration among young adults (aged 20-34), who often leave the State for the economic opportunities afforded them elsewhere. The impact of this trend for New York is the loss of educated entry-level workers, which, together with the expected high retirement rates among the oldest baby boomers, has significant implications for New York's future workforce, including gaps in those industries devoted to delivering services to our older population.

Another of the State's trends is the out-migration of early retirees and "young-elderly" (aged 55-74, typically healthy and financially stable couples), who move for a variety of reasons, primarily to southern and western states. For New York, this trend represents a decrease in retirement income, pensions and savings, home equity and other assets that support the state's tax base and local economies: this is an especially troubling pattern as it represents a loss of earnings that were generated in New York and that are then transferred to other states. Further, this generates a loss of social and intellectual capital as the pool of skilled and experienced community volunteers/workers, and community-based caregivers is decreased. Overall the state continues to experience an in-migration trend among the oldest population (aged 80 and over, typically frail, widowed, and poor), who are moving back to New York to live near family/support systems. The frailty characteristics of these returning older residents have an impact on both the costs and structure of the State's health and long-term care systems.

## Income and Poverty

According to most accounts, the past decades have brought tremendous gains in reducing poverty among older adults. Although the official poverty rate for children continues to be near 20 percent, the official poverty rate among older adults is slightly over nine percent nationally and 11 percent in New York. Pockets of poverty remain do remain, for example, among older women living alone, the overall picture is one of good progress. However, many New Yorkers live just above poverty: *per capita*, according to the 2008-2013 American Community Survey (Special Tabulation on Aging), markedly fewer older adults are in the 300% and over poverty range, while markedly more are in the 125% to 250% poverty range.

In many ways, New York is a study in contrasts. In terms of income, the 2013 American Community Survey reports the State's median household income as \$ 57,369; yet, 16 percent of the population was living in poverty. While economic security is a reality today for more older people than perhaps ever before thanks to Social Security and other benefits, the older adult

population remains vulnerable to a range of economic security problems as they age. Poverty and low incomes, prescription drug and other out-of-pocket health care and long term care costs, local property and other taxes and household and housing expenses remain vital concerns of older New Yorkers, particularly, with advancing age and among minority and impaired older individuals. Paradoxically, the greatest burden in terms of out-of-pocket costs within any age group is borne by persons with the lowest incomes, as they are least likely to carry sufficient insurance coverage (see, e.g., The Commonwealth Fund, “Too High a Price: Out-of-Pocket Health Care Costs in the United States”).

Health care costs disproportionately impact older persons and increase with the onset of chronic health conditions as they age. While more older adults are insulated against rising costs by insurance covering gaps in Medicare than were previously, policy changes to Medicare over the past decade have led to higher cost-sharing for older adults and a future that is uncertain in terms of how much of the risk the government will carry.

Household and housing costs also impact disproportionately on older adults. According to the 2008-2012 American Community Survey (Special Tabulation on Aging), while comprising 19 percent of the household population, people 65 and older comprise 23.7 percent of all householders, owning or renting a disproportionate share of the State’s occupied housing units – over 1.7 million of the State’s 7.1 million homes.

People aged 65 and over living alone comprise 46.7 percent of all householders in that age group, and own or rent over 799,000, or 11% of occupied housing units in the State. Approximately 21 percent of these householders are living in poverty on incomes under \$11,170 (poverty level published in the 2012 Department of Health and Human Services Poverty Guideline).

New York State’s property tax initiatives have helped to ease the burden on older home owners, still, older householder’s face increasing costs for property and other local taxes, home fuel, maintenance and operations including electrical and other day-to-day expenses.

According to the National Council on Aging, 59% of renters and 33% of homeowners spend up to 1/3 of their income on housing expenses, essentially unsustainable housing costs.

#### Gender

The experience of women as they age typically are greatly influenced by the roles they assume and the resources available to them. Older women spent less time in the workforce than their male counterparts. This translates into lower pay wages, lower personal earnings and lower retirement income compared with men. Also, the greater longevity among women compared to men tends to translate into women spending more time living alone as they age. Women are more likely to be the primary caregiver to a spouse and more likely to be in need of long-term care services. Therefore, often they rely on Medicaid to finance the support of their care, especially if a spouse were to have consumed the family savings paying for their long-term care services: such situations leave women especially financially vulnerable. Approximately 10 percent of women aged 15 to 64 live alone: this more than triples among women aged 65 and

older (35%), and 55% of women ages 85 and older –not in group quarters-- live alone. More women than men assume caregiving responsibilities for older family members.

According to a 2009 National Alliance for Caregiving study, 70% of primary caregivers are women; the average caregiver is a 48 years old married woman who is working outside the home with a median annual income of \$57,200. The average caregiver surveyed in the New York State Caregiver Support Program system is a 64 year old female. Forty six percent reported a total household income between \$20,000 and \$50,000 and nineteen percent reported a total household income of less than \$20,000. Furthermore, women who assume elder care responsibilities early in life are at a higher risk of poverty later because of foregoing promotions, reducing their working hours or quitting their jobs altogether to care for a loved one. Couple that with years lost in the workforce due to childbearing and women are at a disadvantage financially later in life.

### Family Characteristics

The characteristics of families across New York continue to change. Family structure is becoming increasingly diverse and non-traditional, including increases in persons living alone or living with non-family members, decreases in married couples, smaller family sizes among the white majority population and higher growth rates among ethnic minority families, increases in both single-female and single-male households, and increases in many other types of non-traditional households.

<b>FAMILY STRUCTURE in the United States</b>	
<b>Married couple families</b>	
<b>Married couple families with children</b>	
<b>Single parent households</b>	
<b>Single person households</b>	
<b>Non-traditional households</b>	

### Health and Impairment of Older Adults

Chronic conditions are singled out as *the* major cause of illness, disability, and death in the United States. It is estimated that the cost of chronic conditions will reach \$864 billion by 2040, with chronic conditions among older adults being more costly, disabling, and difficult to treat – and also the most preventable.

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By 2020, NYSOFA projects (based on Woods & Poole Economics, Population Projections, 2014) that the number of people aged 60 and over with functional impairments will grow by a rate of 11.2 percent, and by over 20% by 2025, comparable to the rate of the overall population

growth, with 81% living in the community, and 19% (based on New York’s current long-term care structure) living in nursing homes or other group care facilities.

In addition, the Centers for Disease Control and Prevention’s (CDC) Office of Minority Health and Health Disparities states that “compelling evidence indicates that race and ethnicity correlate with persistent, and often increasing, health disparities among the U. S. populations.” In addition to

New York State Population: Disability	
Age Group	% of Group with All Types of Disabilities
5-20	4%
21-64	9%
65 and over	35%

race and ethnicity, the CDC found that health disparities also occur among various segments of the population by gender, education or income, disability, geographic location, or sexual orientation. Older adults who have health problems and chronic diseases and have lower incomes face very difficult choices in terms of affording their care and financing other important household-related expenses.

The projected increase in the number of older adults in New York State will have a significant impact on

health and long-term care services and the state’s ability to deliver and pay for those services. Recent survey findings (“Facts About 50 Plus in NY -- Health of Older Adults in New York” Gibson et al. 2003) of individuals aged 50 years and over indicate that only approximately one in four) older adults (27 percent of people aged 50 and over) have sufficient resources to pay for long-term care expenses totaling \$150,000 over the course of a three-year period, leaving almost *three* out of four who could *not* do so – in total leaving 4.75 million people at risk of impoverishment. The financial burden of health care services is complicated further by the fact that many of New York’s older residents live in rural areas where health and long-term care services, and other community-based services are less accessible, may not exist, are more costly to provide, and where availability of specialized services is less likely.

Health promotion strategies directed toward all age groups represent another important means to stem rising health care costs since the behaviors that place people at-risk of disease often begin earlier in life. Of particular concern is the rise in the rate of obesity observed among children and young adults and its future, as well as current impact. Communities designed to promote exercise and healthy lifestyles have a benefit on the general population, while age-appropriate programs that promote physical activity and balance are beneficial to the overall health of older adults. Additionally, helping all individuals develop accurate expectations for aging is essential, in view of the fact that those who perceive aging as an inevitable decline in well-being are least likely to participate in physical activity. Individuals with a more informed view tend to engage in activities that promote their physical well-being throughout their lives. Lastly, health strategies must couple effective treatments and best practices with opportunities for prevention and reduction in health disparities.

### Growth in Long-Term Care Needs

According to the 2010 Census, 4.4 percent (or 115,485 persons) of State’s aged 65 and over population live in group-care facilities. Historically, about 80 to 85 percent of that number would live in nursing homes: in the 2010 Census that number was 96,495, or 86%.

In addition, historically, for people aged 65 and older living at home in the community:

- 10 percent of the population have self-care limitations - that is, had difficulty taking care of his or her own personal needs, such as bathing, dressing, or getting around inside the house due to a health condition that had lasted for six or more months; and
- 20 percent of the population have mobility limitations - that is, had difficulty going outside the house alone, for example, to shop or visit a doctor's office due to a health condition that had lasted for six or more months.

Among people aged 75 and older living at home, these prevalence rates have historically increased to 15 percent and 30 percent, respectively.

The severity of functional impairments related to disabling health conditions varies considerably. Two frequently used classifications of functional impairments are instrumental activities of daily living (IADLs) - where help is needed for outside mobility, meal preparation, grocery shopping, money management, housework and laundry or taking medications, and, activities of daily living (ADLs) - where help is needed for bathing, transferring, dressing, toileting or eating.

While 4.4 percent (or 115,485 persons) of the aged 65 and over population live in nursing homes or other group care facilities, NYSOFA estimates (based on historical data) that approximately 30 percent of the 2,616,716 people 65 and older in New York State (Census 2010) were functionally impaired by chronic health conditions. This includes 8 percent with ADL limitations living at home in the community and 16 percent with IADL limitations living at home in the community.

Home and community-based services will become increasingly more important to support those with chronic conditions and functional limitations particularly given the effort to assure that individuals live in the most-integrated setting supported by legal precedent (*Olmstead v. L.C.*) and policy changes (i.e. Balanced Incentive Payment, DSRIP, etc.). For most, residential facilities are not appropriate and their needs can be met in the community. Data has shown that frail individuals can indeed live independent and productive lives with community supports such as personal care, case management, and other support services.

### Nutritional Needs

The nutritional needs of older adults become more critical with advancing age, especially when recuperating from acute and chronic health problems. Preparing and eating meals and maintaining recommended diets are particularly problematic for functionally impaired older adults, older people following discharge from an acute care setting, and those most disadvantaged and at-risk, the older-old (85+), older women and older minorities. Older people most in need of sound daily diets are, in fact, those who are least able to maintain their nutritional well-being.

Poor diet and physical inactivity contribute to the leading causes of disability among Americans, and unhealthy eating and physical inactivity cause one-third of premature deaths, according to the Centers for Disease Control and Prevention's Division of Nutrition, Physical Activity, and Obesity (2010). Among the known facts about the nutritional needs of older adults are the following:

- Chronic Disease - The nutritional status of older adults has a significant role in disease causation, risk reduction and the treatment of chronic degenerative diseases. The presence of one or more of the chronic diseases that especially affect older individuals

with advancing age often requires that they follow a prescribed, therapeutic diet.

- Medications - Side effects and drug-nutrient interactions associated with some medications may cause mal-absorption of nutrients, weight loss, anemia, dehydration, low or high blood sugar, fatigue and depression, all of which may lead to poor nutrition and other serious health complications.
- Oral Health - Poor oral health may limit the type, quantity and consistency of food eaten, increasing nutritional risk.
- Weight Loss - Being underweight often indicates an inadequate dietary intake and is associated with frailty and possible underlying illness.
- Social Activities - Social interaction positively affects an individual's food intake, but its absence, social isolation, may lead to loneliness which can negatively affect dietary adequacy and thereby increase an individual's risk for malnutrition.

Malnutrition has been found to affect one out of four older Americans living in the community and is a factor in half of all hospital admissions and readmissions of older people. Individuals must consume and assimilate food to promote and replace worn or injured tissues. Without proper nutrition, water, exercise or oxygen, cells die, muscle mass decreases, respiratory and other muscles weaken, the immune system becomes depressed, and illness, disease, or disability ensues.

### Community Involvement

The aging of the Baby Boomers provides us with challenges as well as tremendous resources and opportunities; for example, eligibility for retirement of the Baby Boom generation from the work force will challenge the State to think differently about older age. Strategies to retain, retrain, and hire older workers, engage businesses, and provide policy changes to address the tax and health-care implications that retirement brings are critical elements to consider, along with the human capital of the Baby Boomers that New York can harness. Older adults play a vital role in the state's economy and in economic development. By engaging baby boomers and older adults to be more involved in their communities, either through second careers or volunteerism, the likelihood of out-migration diminishes, keeping the valuable financial, social and intellectual capital in New York State. Social Security alone brings \$49 billion annually into New York State. Baby boomers and older adults account for 63% of all the personal income (over \$379 billion) generated in the state. An AARP survey found that 90% of New Yorkers want to retire in New York State. The recognition of their value will pay long-term dividends to the state and its local communities. Some elements to consider include: providing opportunities for older adults to fill needed positions in the workforce; consider strategies to engage older adults in post-retirement work and second careers; and enhance opportunities for meaningful paid and non-paid volunteer engagement.

### Summary

While there are current and future challenges related to the growth of the older population, there are tremendous opportunities. Recent science related to the social determinants of health and the growing recognition of the valuable role the aging network can play, in partnership with the health care system, provides an opportunity to focus and prioritize community based services that can prevent higher levels of care, and more importantly, are critical to ensuring that clinical outcomes are successful. The aging network is the only network that was designed with broad

based partnerships in mind. It is designed to advocate for the individual and to help navigate, multiple, complex systems.

The dynamics of population change are vitally important to planning and preparing to create an efficient, successful system of services and supports for older New Yorkers. Population changes and change drivers provide opportunities to re-imagine systems and using sound data, focus limited resources on those areas that have proven to be effective. Demographic change and the evolution in our population characteristics over time have important implications for the State Plan on Aging as we prepare to effectively work with and serve older adults, particularly in the areas of long-term care, housing and health, nutrition and well-being, legal issues and employment, and the ability to utilize informal caregivers to help with activities and instrumental activities of daily living. Such changes need to be considered fully as New York prepares to serve older New Yorkers into the future.

In New York State, under the Older Americans Act of 1965 (codified as 42 U.S.C. § 3001-3057(n)) and New York State Elder Law (Chapter 35-A of the Consolidated Laws), the New York State Office for the Aging is the designated State Unit on Aging. NYSOFA is responsible for the development and administration of a State Plan that addresses federally prescribed goals and priorities as required by the Older Americans Act.

It is the Mission of the New York State Office for the Aging to help older New Yorkers to be as independent as possible for as long as possible through advocacy, development and delivery of person-centered, consumer-oriented, and cost-effective policies, programs and services which support and empower older New Yorker's and their families, in partnership with the network of public and private organizations which serve them.

The New York State Plan on Aging for Federal Fiscal Years (FFY) 2015-2019 has been prepared by NYSOFA. The State Plan highlights the demographics and trends of New York State's older population, describes the aging services network, and the goals, objectives and strategies that will guide specific actions over the next four years.

The New York State Plan is organized to be consistent with the Administration on Aging's four focus areas:

- Older Americans Act Core Programs,
- AoA/ACL Discretionary Grants,
- Person Centered Planning, and
- Elder Justice

Material incorporated in this State Plan has been derived from studies conducted by NYSOFA, information received from Area Agencies on Aging, information garnered from statewide community forums and conference meetings sponsored by the State Office, its Advisory Committees and State Agency partners.

The Objectives and Strategies described in the State Plan necessarily reflect broad initiatives. The State Plan is not intended to represent a detailed task oriented proposal.

State Units on Aging, area agencies on aging and their partners and providers of services to older adults are now being asked to do more than ever. As the policy and program shift has clearly been moving toward a home and community centric approach to service delivery, the coordination and cooperation of service systems is paramount in order to meet the individual's needs holistically and their families. As individuals move within and between systems, these systems must communicate with one another, share information, and work to maximize the strengths of each without duplication and waste and without individuals falling through the cracks.

Understanding the dynamics generated by demographic change and the importance of the human service system in health care delivery are vitally important to planning and preparing to create an efficient, successful system of services and supports for older New Yorkers. Understanding what people want, where they want it and the cost implications of various models are equally as important. To date, long term services and supports provided to older adults are traditionally medically driven, are very expensive and are often provided at a stage of advanced disability. A robust community-based network of services, such as those administered by NYSOFA, are designed to intervene earlier and prolong the ability of an individual to maintain their independence. As we continue to design and redesign the health and long term care systems, the critical role of nutrition, transportation, socialization, in-home care, volunteerism, management of chronic conditions, etc. needs to be at the forefront. While there are many challenges in the coming years related to the growth of the older population, there are also tremendous opportunities to utilize the strengths and skills of older adults to help address pressing social problems and to be leaders in helping communities implement changes to make communities more livable for people of all ages, benefitting people of all ages. NYSOFA's home and community-based programs provide frail older persons access to a well-planned, coordinated package of in-home and other supportive services designed to support and supplement informal care. These services are even more important in helping older adults maintain good health, as many of the services provided by the aging network are critical to assuring sound discharge planning from hospital to home, or from rehabilitation setting to home.

The overall goal of the state Plan in partnership with a broad network of service providers is to improve access to, and availability of, appropriate and cost-effective non-medical support services for functionally impaired older individuals to maximize their ability to age in their community and avoid higher levels of care and publicly financed care. The overall goal is important for older adults who may need some minor assistance episodically, or ongoing, to maintain their independence. It is even more important for individuals who are recovering from an acute care episode and are in need of supports to improve their health functioning. The State Plan provides a summary of the programs and services administered by NYSOFA and the area agencies on aging and is not intended to be a collection of independent, unrelated or separate programs. Readers of the Plan should understand that as older adults connect with the area agencies on aging and their partners, a process begins to assess the strengths and needs of the individual and their family and based on the information gathered and the desires articulated by the individual or their representative, a care plan can be developed that might include one or more of the services listed in the Plan. The Plan should be viewed in the context of a coordinated system of supports to maximize independence.

This 4 Year Plan on Aging seeks to expand and strengthen Older American Act core programs by utilizing federal, state and local funding and the flexibility they provide to the greatest extent possible. The network of aging providers continue to meet existing needs through a combination

of government resources, private fundraising, participant contributions and through building and strengthening new and/or existing partnerships. Further, this Plan seeks to strengthen partnerships at both the state and local level that will continue to build bridges between systems and to work to position the aging network as a viable resource for the private pay market as well as a compliment and partner with hospitals, primary care physicians, and health networks that are reorganizing to provide more integrated, community-based care.

NYSOFA and the network of area agencies on aging will continue to build, in partnership with the state Department of Health (DOH), the No Wrong Door (NWD) under the Balanced Incentive Program (BIP). This effort will lead to a fully functional NWD in every county of the state with processes to assure access to specialists for persons with intellectual and or developmental disabilities or behavioral health issues. The federal Lifespan Respite and Systems Integration grants will further integrate systems to create a dementia capability within the aging network and will include the following elements: dementia screening; cross-training and dementia capability; an inventory of resources and services for inclusion in the NWD web-based resource directory; options counseling and care consultation collaboration; cross referrals; education and outreach; access to public benefits; and data collection. The NWD will provide a systematic way for individuals to understand their LTSS options and to connect to the appropriate networks and providers in a seamless way.

NYSOFA and the network will continue its rebranding effort to describe more accurately what it means to be aging in NYS. For too long, older adults have been portrayed negatively. Older adults are portrayed as frail, forgetful, unhealthy, and cognitively impaired and in need of assistance. Older adults are often not portrayed for their contributions, which far outweigh their needs. NYSOFA will continue to publish information that shows older adults in a positive light which includes their economic value to their communities and state, their volunteer contributions that help their neighborhoods, and their intellectual contributions. Older New Yorker's are a very important part of the community. Eliminating generalizations and stereotypes are important in the context of program, service and community planning.

### **Concluding Statement**

This State Plan on Aging outlines the goals, objectives and strategies that are sensitive to the needs and wants as expressed by older New Yorkers. The State Plan outlines strategies to increase the availability of information and assistance, support opportunities for volunteerism and civic engagement, promote health, protect consumer rights and assist people with obtaining needed benefits, while setting measurable and achievable outcomes Throughout this Plan, the focus is on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging Network to address local needs. By strengthening the infrastructure for home and community-based services, the State Plan continues to build the foundation for a future in which every older New Yorker has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities.

## Introduction

The New York State Office for the Aging (NYSOFA) administers federal funding provided under the Older Americans Act. NYSOFA also administers state general fund dollars that in essence, wrap around and build upon OAA funding and significantly expand and strengthen the OAA core programs. Further, state funds help to address needs of older New Yorkers that are not able to be met with limited federal funds alone, and are consistent with the mission of the goals of the OAA and state Elder Law.

It is important to recognize that Sections A-D follow the prescribed framework laid out by the Administration for Community Living for State Plan submission. The programs and services listed within these Sections are not to be viewed as independent and separate. In practice, they are an integrated and coordinated set of programs, services and supports available to older New Yorkers and their families statewide. The chart below demonstrates the importance of state funding to strengthen and expand OAA core programs while assuring they are integrated and coordinated, as demonstrated in the area agencies on aging annual implementation plans.

Services Provided	Funding Streams Used to Support Services
<b>PC Levels I and II</b>	IIIB, IIIE, EISEP, CSE
<b>Consumer Directed In-Home Services</b>	EISEP, CSE
<b>Home Health Aide</b>	IIIB, IIIE, CSE
<b>Case management</b>	IIIB, IIIE, EISEP, CSE, WIN
<b>Home Delivered Meals</b>	IIIC-2, IIIE, EISEP, CSE, WIN
<b>Congregate meals</b>	IIIC-1, IIIE, EISEP, CSE, WIN
<b>Nutrition Counseling</b>	IIIC-1, IIIC-2, IIID, IIIE, EISEP, CSE, CSI, WIN
<b>Nutrition Education</b>	IIIC-1, IIIC-2, IIID, IIIE, CSE, CSI, WIN
<b>NSIP/Community Food</b>	IIIC-1, IIIC-2, IIIE, EISEP, CSE, WIN
<b>Escort</b>	IIIB, IIIC-1, IIIE, CSE, CSI, WIN
<b>Transportation</b>	IIIB, IIIC-1, IIIE, EISEP, CSE, CSI, WIN
<b>Legal Services</b>	IIIB, IIIE, CSE
<b>I &amp; A</b>	IIIB, IIIC-1, IIIC-2, IIID, IIIE, CSE, CSI, WIN
<b>Outreach</b>	IIIB, IIIC-1, IIIC-2, IIIE, CSE, CSI, WIN
<b>In-Home Contact and Support</b>	IIIB, IIIC-1, IIIC-2, IIIE, EISEP, EISEP, CSE, WIN
<b>Senior Center Programming</b>	IIIB, IIIC-1, IIID, CSE, CSI, WIN
<b>Health Promotion/Disease Prevention</b>	IIIB, IIID, IIIE, CSE, CSI
<b>PERS</b>	IIIB, IIIE, EISEP, CSE
<b>Caregiver Services</b>	IIIB, IIIE, CSE,
<b>Adult Day Services</b>	IIIB, IIIE, EISEP, CSE
<b>LTC Ombudsman</b>	IIIB, Title VII

Titles IIIB, C-1, C-2, D and E make up the core programs under the Older Americans Act. In New York State, Title III funding directly supports the services listed in the above chart. OAA Core programs include Access Services; In-Home Contact and Support Services; those that support Aging in Place; Nutrition Services; Disease Prevention and Health Promotion Services; Caregiver Services; Activities for Health, Independence and Longevity, and those that support protecting the Rights of Vulnerable Older Adults and Elder Justice.

## Section A. Older Americans Act Core Programs

- **Access Services – Information and Assistance**

The growth of the older adult population and the characteristics of this population has increased the demand for information. Today, older New Yorkers and their caregivers face a complicated array of choices and decisions about a variety of issues, such as health care, housing, financial management, transportation options, nutrition, and long-term services and supports. Federal, state, and local programs are administered by a multitude of different public and private agencies that have differing requirements to be eligible or to access. Older adults and their caregivers often need help to know what services are available, how to access them and whether they qualify. The Older Americans Act Information and Assistance (I&A) system, in partnership with funding from New York State, helps older adults access a variety of services and to make important linkages to non-network services. This system is designed to be community-based, and to be a source of accurate and objective information and assistance, that will support all older adults and their caregivers in: assessing their needs, identifying appropriate services, and linking the older persons and caregivers to agencies providing those services. The information and assistance system is the vital link between older persons who need services and those who can provide them and is particularly important during crisis.

In order to empower older New Yorkers, their families, and other consumers to make informed decisions about their care needs, and to be able to easily access information on the myriad of aging programs and services that best address their needs, NYSOFA has established various methods to provide prompt and thorough I & A. As a result of the cataloging of information provided by the Aging Network regarding relevant programs and services that meet specific needs, older New Yorkers and their caregivers are able to become connected and able to more efficiently access vital supports in their community.

The provision of I & A is one of the most critical services provided by the Area Agency on Aging and their network of local providers. This service can be provided quickly depending on the nature of the request or it can be much more complex. Access to timely and accurate information is vital as it is the portal through which services of the AAA are provided. Throughout New York State's network of 59 AAAs and their partners, I & A is funded through a combination of federal, State and local funding sources.

In addition, NYSOFA maintains a 'Senior Helpline' phone center that provides hundreds of callers each month access to information each day from 9-5pm. Still further specialized I & A for long term services and supports is funded through NY Connects (New York's ADRC and NWD) and is an important component in the states Systems Integration work to develop a dementia capable network.

I & A includes three primary components; the provision of information where a questions is asked and answered, assistance where information is exchanged between the caller and the staff person so that an understanding of the callers needs can be determined and lastly making a referral made to an appropriate service(s) provider. Each AAA must have an established system for following up on calls to ensure that individuals who received a referral for services were provided with the help/service they needed.

New York commits over \$25 million annually above what it receives from ACL to support I & A and even more to support the states NWD/ADRC. These funds significantly strengthen and expand OAA core services.

- **Access Services – NY Connects**

The NY Connects program provides a locally coordinated system of specialized information and assistance (I&A) on long term services and support (LTSS) options available to the age sixty and older population, individuals of all ages with physical disabilities, the informal caregiving population and providers of services from other systems (e.g. discharge planners). The core functions of the NY Connects program include the provision of I&A on LTSS; upholding an active local Long Term Care Council (LTCC); and an ongoing Public Education campaign to promote the program.

Since the 2006 launch of NY Connects, the program has grown beyond the initial set of core functions. Grants awarded to New York State from the AoA/ACL have been responsible for the addition of Options Counseling, Care Transitions and Systems Integration programming within the NY Connects programs. NY Connects programs implemented Options Counseling as an essential component of I&A provision. Options Counseling is a specialized form of person-centered assistance that supports consumers in making informed decisions about their plan of care based upon their unique circumstances, needs, preferences, and costs. The goal of Care Transitions is to facilitate smooth and effective transitions from hospital and other pathways of care to home and to avoid preventable readmissions. NY Connects staff play an important role within these programs as they empower individuals to navigate their health and LTSS options. Lastly, through the 2010 Systems Integration grant, NY Connects programs are expanding upon local partnerships and establishing improved linkages across the LTSS system as New York State continues to move towards a more person centered, dementia capable long term care network. (See SI write-up for more detail on the integration of these core services within this grant.)

As a result of the federal Balancing Incentive Program (BIP), NY Connects is being expanded geographically and enhanced functionally. Governor Cuomo has committed resources to sustain the BIP enhancements after the BIP program funding expires. The implementation of BIP requires three structural changes in the LTSS system: a No Wrong Door/Single Entry Point (NWD/SEP), a Core Standardized Assessment, and Conflict-Free Case Management. In New York State, NY Connects will meet the structural reform of a NWD/SEP. Enhanced functionality includes the addition of the following core functions: working with the State-designated specialized NWD, implementation of a preliminary functional and financial screen, application and enrollment assistance for public benefit programs including Medicaid as appropriate, coordination with other agencies to guide the individual through financial and functional eligibility processes, as well as through the continuation and expansion of Options Counseling and Care Transitions.

The Balancing Incentive Program (BIP) will enable NY Connects to provide increased access to supportive services under Title III and VII of the Older Americans Act (OAA) through geographic expansion and enhanced functionality. As a result, BIP will require formalized partnerships and collaborations among key state agencies in the expansion of NY Connects I&A activities. Additionally, the development of sustainability plans through BIP will present opportunities for NY Connects programs to draw down FFP to further support activities such as I&A, Options Counseling and Care Transitions.

- **Access Services – Case Management**

Case Management is a core service provided by the aging network that is person-centered, flexible, cost-conscious and quality driven. Consumer values and preferences strongly influence the timing, duration and intensity of the level of service provided. Case management is at the center of wellness and autonomy for older adults and their caregivers. Case management provides advocacy, access, assessment, planning, communication, education, resource management, and service coordination.

Case Management is supported primarily by state and local funds and through OAA funds. New York State contributes over \$37 million to support case management activities because of their recognized value to the older adult and family member in helping navigate complex systems, monitoring the individual, applying for benefits and programs, and linking to programs and services.

Based on the needs and values of an older adult and their caregivers, case management facilitates collaboration with all service providers participating in the individual's care. The case manager, who is accountable to the individual, facilitates access to appropriate providers, resources and care settings, while ensuring that the care provided is safe, effective, client-centered, timely, efficient, and equitable. This approach works to achieve optimum value for the client and promotes quality and cost-effective interventions and outcomes.

NYSOFA has moved its case management program to be rooted and based on consumer values and preferences which strongly influence the timing, duration and intensity of the level of service provided.

Protocols will be developed that will inform case managers of their roles and responsibilities relative to referrals and I & A as they interface with the NY Connects specialist(s) when delivering services to individuals who contact the aging network through the "No Wrong Door" system. Further, behavioral health training will be offered to case managers to help them identify problems among older adults and to know where and how to refer for behavioral health services.

The aging network will also be offered dementia capable training developed through the Systems Integration grant to assure that case managers have the knowledge and skills to appropriately assist individuals with dementia.

- **Access Services – Transportation**

Due to the structure and design of communities across the country after World War II, people of all ages rely heavily on their ability to drive in order fully participate in community life and the economy. Older adults are no different. Many older adults have to give up their right to drive each year because of health conditions, visual impairments, etc. This can be devastating as the American culture has a strong foundation in the role the automobile plays in our lives. Older people who stop driving become dependent on rides from family and friends if available, particularly in areas where public transit options are limited. This state of dependence can last a decade or more and can often result in isolation and a deterioration of their physical and psychological health. The problem is compounded by where older people are living and how communities have been designed and zoned: three out of four older adults live in rural or suburban community, which lack the density to support traditional mass transit. Even in areas

where mass transit services are available, diminishing mobility and increasing frailty can preclude older adults from accessing transportation.

Transportation is a high demand and key service in the array of services that are offered by the Area Agencies on Aging and their local partners in New York State. Many older adults utilize the transportation services offered by the aging network to enable them to gain access to needed services and maintain their dignity, independence, and ties to their communities. Transportation has become more important as the population is living longer, living with multiple and complex conditions, and doing so in their homes. As policy makers work to implement state plans to comply with the *Olmstead v L.C.* Supreme Court Decision, a broad and creative approach to the delivery of transportation for older adults is necessary.

NYSOFA is committed to a policy of coordinated, shared transportation and testing innovative and replicable models of sustainable, community-based transportation. To expand and strengthen the OAA core programs, New York State provides over \$11 million to support community-based transportation for older adults that help them access doctor's appointments, pharmacies, shopping, senior centers, adult day programs and socialization.

In New York, AAAs are innovative in how they finance and develop partnerships to meet local transportation need and demand. Some provide discounted bus tokens while others arrange volunteer rides to medical appointments. A number of AAAs provide their own van services which enable congregate diners to attend meals and activities at local senior centers. The AAA network negotiates with private vendors, city bus services and local taxi companies for discounted fares and for services that meet the needs of older residents and AAA's are integral in many local mobility management programs and operations.

Transportation to medical appointments is a primary destination of the rides provided through the AAA network. Keeping such appointments is key to preventing readmissions to hospitals after discharge and to maintain good health. Helping to ensure access to medical care when a person transitions from a stay in a hospital rehabilitation facility is vital to their successful recovery. Similarly, access to chronic disease management programs through Title III –D is accomplished with transportation services to community centers where these activities are taking place.

- **Access Services – Health Insurance, Information, Counseling and Assistance**

Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (OBRA) (Public Law 101-508, codified at 42 USC 1395 b-4) authorized the Centers for Medicare & Medicaid Services (CMS) to make grants to States and Territories to fund State Health Insurance Assistance Programs (SHIPs). The Consolidated Appropriations Act of 2014 (Public Law 113-76) transferred the SHIP program from CMS to the Administration for Community Living (ACL) effective January 17, 2014.

In New York State, the SHIP is known as the Health Insurance Information, Counseling and Assistance Program (HIICAP). The NYS Office for Aging (NYSOFA) coordinates HIICAP through a network of 59 county Offices for Aging where approximately 500 trained insurance counselors are available to assist beneficiaries.

HIICAP educates the public about Medicare, Medicare Advantage plans and other health insurance issues and saved consumers over \$77 million last year by helping them access “Extra Help” programs. HIICAP provides free, accurate and objective information, counseling and assistance on Medicare, Medicare Advantage plans and other health insurance coverage plans. HIICAP also provides information on low income programs such as the Elderly Pharmaceutical Insurance Coverage (EPIC) Program, Medicare Savings Programs, "Extra Help" prescription assistance and pharmacy discount programs.

The HIICAP Program is available to Medicare beneficiaries, of all ages, including those who will soon be “New” to Medicare. New Yorkers can schedule free and confidential appointments with highly trained HIICAP Staff and volunteer counselors to understand:

- Medicare and health insurance benefits, options, paperwork, and resources.
- Medicare covered costs, deductibles and programs.
- Health care costs that clients will be responsible for.
- Information on insurance products that may help to pay for costs not covered by Medicare alone such as a Medigap or Medicare Advantage Plan.
- Help in selecting Medicare Advantage and Medigap supplemental plans
- How to review and select a Medicare Part D prescription plan.
- Help in resolving specific health insurance problems.
- Programs that can help pay for Medicare and prescription costs.

- **In-Home Contact and Support Services – Expanded In-Home Services for the Elderly Program**

The Expanded In-home Services for the Elderly Program (EISEP) enables many frail older adults to remain in their homes. The program provides a well-planned, coordinated package of in-home and other supportive services, including case management, designed to supplement informal care. EISEP is administered by NYSOFA using uniform statewide program regulations and is implemented locally by the 59 Area Agencies on Aging (AAAs).

The following services are provided under EISEP:

- **Case Management** – To help older persons and their families assess their needs and develop, implement, and maintain an appropriate plan of services and how they are to be delivered. It brings order to the confusing array of services and benefits that an older adult might need.
- **In-Home Services** – Consisting of personal care level I and personal care level II. Personal care level I provides assistance with instrumental activities of daily living (e.g., housekeeping, cooking, and shopping). Personal care level II provides assistance with both instrumental activities of daily living and activities of daily living (e.g., dressing, bathing, and transferring in/out of bed/chair).
- **Non-Institutional Respite** – To temporarily relieve the client's primary informal caregiver from the stresses and strains associated with caregiving. Types of respite include companion services and social adult day care.
- **Ancillary Services** – A flexible service category that includes a variety of services and goods/items designed to maintain/promote independence, support a safe and adequate living environment and address everyday tasks.

In 2011, the EISEP regulations were amended to provide a consumer directed option. Consumer direction under EISEP is a person centered planning approach that empowers the

older adult by enabling him/her (or his/her representative) to hire, train and oversee their In-home workers. It is currently being implemented in 22 counties and is important in helping to mitigate the aide shortage that many counties experience.

EISEP is not an entitlement program. It operates under a fixed, capped budget consisting of state, county and private funds. In order to maximize resources and expand service capacity, the program includes a cost sharing component. A cost sharing requirement begins for individuals whose income is at or above 150% of the Federal Poverty Level. The program participant's cost share increases proportionally with income.

Several issues are being addressed to expand and strengthen the program including increasing the number of AAAs providing consumer directed EISEP. This is being undertaken as part of an effort to expand consumer control over services and to address many of the identified gaps in the LTSS system (e.g. workforce shortage, caregiver burden, consumer satisfaction). The issues being covered include: maintaining equitable provider rates across LTSS system to help assure there will be home care aides available to provide services to EISEP participants; revising EISEP Rate Cap Policy to afford AAAs more flexibility in establishing rates that are equitable with the rates providers are being paid through other payer sources; and enhancing cost effectiveness, increasing consumer choice and promoting independence by expanding uses of Ancillary services through EISEP funding for clients who would benefit from allowable services, items/goods and other supports that maintain or promote the individual's independence.

- **In-Home Contact and Support Services – Community Services for the Elderly (CSE)**

In New York State, the Community Services for the Elderly (CSE) program is a flexible funding stream designed to meet the individual program and service needs of the area agency on aging and their planning and service area. Coupled with OAA Title III-B, CSE funds a myriad of community services, some directly and some as a supplement to other network funding sources, including the Older Americans Act titles and other State-funded programs.

CSE provides a wide range of services including but not limited to: case management, personal care, home delivered meals, information and assistance, referral, social adult day care, transportation, respite, telephone reassurance and friendly visiting, health promotion and wellness activities, senior centers and other congregate programs, personal emergency response systems, minor residential repairs, escort and other services.

To strengthen and expand OAA type services, New York commits over \$25 million annually to CSE to provide community-based services.

- **Supporting Aging in Place – Livable New York**

Programs and services administered by NYSOFA and provided directly or indirectly via AAAs are all designed to support aging in place. There has been a movement however to also promote changes in how communities are planned for, designed or redesigned that consider features that are important for people of all ages to help make them more livable.

*Livable New York* (Chapter 58 of NYS Laws of 2007) is a statewide public/private initiative to help communities' better plan for the needs of their older adults, people of all ages with

disabilities, families, and caregivers. Communities can be provided with information, training, technical assistance, and examples of successful models and practices related to the initiative's focus areas: housing; universal design; planning; zoning; land use; energy alternatives; green building; mobility; and transportation.

Significant demographic, public policy, economic, environmental, and social "change-drivers" are transforming New York's communities and the circumstances and conditions under which the tasks and activities affecting residents' quality of life are planned and implemented. In the face of such forces, municipalities are searching for assistance to employ proven, often innovative models and strategies to improve the quality of life and well-being (livability) of their neighborhoods—to create communities that *all* residents say are good places to live, work, grow up, and grow old.

The initiative has led to the development of a series of products, including training and technical assistance materials that follow principles that help create a sustainable framework for community planning and development:

- Future oriented planning, to assure that definitions of issues and design of solutions accurately reflect a community's evolving profile and circumstances.
- An inclusive, collaborative approach to planning and implementation to maximize expertise, resources, and diverse perspectives residing within a community and to deepen all community members' investment in the outcome of their efforts.
- A cross-community approach for defining issues and identifying solutions, which includes all ages, all cultures, and all abilities.
- Broad resident participation to gain the benefits derived from greater community empowerment and to strengthen a "sense of community."
- Community-driven planning and development—to truly reflect the expressed needs, preferences, and expectations of its members.

NYSOFA will continue to work with public and private stakeholders to support community level planning on livability and work to advance the Livable New York training process in communities who are interested in inclusive planning.

- **Supporting Aging in Place – Naturally Occurring Retirement Communities**

New York currently funds two models of naturally occurring retirement communities. The first is the Naturally Occurring Retirement Community - Service Support Program (NORC-SSP) model and the Neighborhood Naturally Occurring Retirement Program (NNORC) The overarching goal of a NORC/NNORC program is to maximize the health of its community. This is accomplished by these programs facilitating and integrating the health and social services already available in the community, as well as organizing those necessary to help meet the goal of enabling older adults to remain at home.

NORC/NNORCs provide case management and assistance, healthcare management and monitoring, I&A, in-home services, transportation, health promotion, shopping assistance and other services that maximize independence.

NORC/NNORC programs are proactive in their approach, seeking to expand and strengthen the connections older adults have in, and to their communities before an event triggers a crises.

NORC/NNORC programs operate through multidisciplinary partnerships that represent a mix of public and private entities and provide on-site services and activities. Each component of the partnership is familiar, at the core are social service and health care providers; housing managers or representatives of neighborhood associations; and, most important, the community's residents, especially its older residents. These core partners connect to the many other stakeholders in a community – typically, local businesses; civic, religious, and cultural institutions; public and private funders; and local police and other public safety agencies. By harnessing these resources, NORC/NNORC programs help to transform the community into a good place in which to grow old. In addition to supporting older residents to age successfully, the NORC/NNORC program model also promotes community change. It offers opportunities that 1) empower older adults to take on new roles in shaping communities that work for them, 2) weave a tighter social fabric and foster connections among residents and 3) maximize the health and well-being of all older adults in the NORC/NNORC.

This program model is built from the ground up, in response to needs identified by a community after completion of an assessment. Inevitable challenges to healthy aging often include environmental factors, health and social service gaps, transportation problems, lack of infrastructure, or a frayed social fabric. The NORC/NNORC programs identify strengths that can then be used to address these challenges that integrates:

- Community engagement (educational programming, community action initiatives, and opportunities for seniors to take on new roles).
- Social work services (to individuals, caregivers, and groups of older adults).
- Health care-related services (addressing both individual health management needs and the health of the community).

- **Activities for Health, Independence and Longevity – Foster Grandparent Program**

The state provides additional resources to the Foster Grandparent Program (FGP) to supplement the federal Foster Grandparent Programs supported by the Corporation for National and Community Service. FGP provides an opportunity for older persons aged 55 and over to serve as mentors, tutors, and caregivers for children and youth with special needs. The program is designed to provide meaningful volunteer roles for older adults. Foster Grandparents provide anywhere from 15 to 40 hours of weekly service to community organizations such as Head Start, hospitals, public schools, day care centers, and juvenile detention centers where they provide support to special needs children aged birth to 21 years. Volunteers who meet income guidelines receive a modest hourly tax-free stipend.

Foster Grandparents offer emotional support to children who have been abused and neglected, mentor troubled teenagers and young mothers, and care for premature infants and children with physical challenges. In the process, they strengthen communities by providing caring services that community budgets are unable to financially support and by nurturing a bond across generations.

- **Activities for Health, Independence and Longevity – RSVP**

The state provides additional resources to the Retired and Senior Volunteer Program (RSVP) supplements the federal RSVP programs in New York State that are supported by the

Corporation for National and Community Service, the largest older adult volunteer program in the nation. The RSVP program recruits, trains, and places senior volunteers over the age of 55 in a host of community-based human service agencies. RSVP priority areas include: senior citizen health promotion and wellness; assistance to frail and vulnerable older persons in the areas of home visiting, escort, transportation, and home-delivered meals as well as cross-generational efforts in tutoring and mentoring children. RSVP volunteers are strongly connected to the area agencies on aging and volunteers are relied upon for many important direct services as well as organizational support.



- **Activities for Health, Independence and Longevity – Senior Community Services Employment Program**

Senior Community Services Employment Program (SCSEP) is a community service and work-based training program for older workers. SCSEP was authorized by Congress in Title V of the Older Americans Act of 1965 to provide subsidized, part-time, community service training for unemployed, low-income persons 55 or older who have poor employment prospects. SCSEP participants are placed in a wide variety of community service activities at non-profit and public facilities, including day-care centers, senior centers, schools and hospitals. These community service training assignments promote self-sufficiency; provide assistance to organizations that benefit from increased civic engagement; and support communities. These assignments are intended to serve as a bridge to unsubsidized employment. In turn, regional economies and employers benefit from an expanded pool of experienced, dependable labor in the local workforce.

- **Activities for Health, Independence and Longevity – Civic Engagement/Volunteerism**

Over the past two decades there has been a growing body of research that demonstrates volunteering benefits the physical and mental health of a person, while also helping address pressing social issues. This research has established a strong relationship between volunteering and health and wellness of a person: those who volunteer have lower mortality rates, greater functional ability, and lower rates of depression later in life than those who do not volunteer. These findings according to the Corporation for National and Community Services are particularly relevant today as the numbers of volunteers age 65 and older is expected to increase significantly over the next decade. By promoting increased civic engagement, government can lessen the costs of an aging population, while enhancing the benefits to participating older persons and their communities. As the number of older New Yorkers has grown, NYSOFA seeks to enhance strategies that will increase the civic engagement of older persons in volunteer service as well as encourage them to remain in the workforce. This has become important to helping maintain the economy and social fabric of the state.

- **Nutrition Services – Nutrition Program for the Elderly**

New York State's commitment to healthy, nutritious meals and providing nutrition counseling, nutrition education and evidence based interventions in settings where older adults congregate for nutrition is unparalleled. New York invests over \$114 million to the nutrition programs above what it receives through the OAA funding for Titles IIIC-1 and 2.

The nutritional needs of older adults become more important with advancing age, especially when recuperating from acute and chronic health problems.

Since its inception, the Nutrition Program for the Elderly (NPE) has operated statewide through 59 AAAs, including two Indian Tribal Organizations (ITOs). Services are provided directly or through contract. Funding for nutrition services comes from a combination of federal, state, and local government sources, program income (contributions), and other sources at the local level coordinated into a single statewide nutrition program. Since 1984, New York State's Wellness in Nutrition (WIN) program provides funding primarily for home-delivered meals to frail older persons who are unable to prepare meals for themselves. This funding also support access to nutrition counseling, education and congregate meals. Nutrition Services is the largest program administered by the New York State Office for the Aging, and it is well-integrated into home and community settings through coordination with community partners. It is a proven, cost-effective means of helping older adults maintain their health and independence, engage in community life, and stay in their own homes and communities as long as possible.

Nutrition Services strive to prevent or reduce the effects of chronic disease associated with diet and weight; strengthen the link between nutrition and physical activity in health promotion for a healthy lifestyle; improve accessibility of nutrition information, education, counseling and related services, and healthful foods. This is accomplished through:

- Community dining options at congregate sites to improve food and nutrient intakes and offer choice (culturally appropriate, entrees, salad bars, and restaurant vouchers) and meet special dietary needs (low sodium, low fat).
- Home-delivered meals that meet dietary and therapeutic needs and are nutritionally dense.
- Nutrition education and health-promotion and disease-prevention services in a variety of settings.
- Nutrition screening to determine nutritional risk and individualized nutrition counseling for chronic-disease management and to improve nutritional status.
- Advocacy to improve access to food by those in greatest economic and social need.

AAAs use congregate meal sites, home delivered meals programs, multipurpose senior centers or other appropriate locations to deliver health-promotion and disease-prevention services, thereby allowing them to be integrated with the nutrition program. Priority is given to areas that are medically underserved and where there are a large number of older individuals in greatest economic and social need. Broad services include health risk assessments; routine health screening (hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, bone density, and nutrition screening); nutritional counseling and educational services; evidence-based health-promotion programs, including those related to the prevention and mitigation of the effects of chronic disease, alcohol and substance abuse reduction, smoking cessation, weight loss and control, stress management, falls prevention, physical activity and improved nutrition; physical fitness programs; home injury control services; mental health screening services; and information and education about Medicare preventive-care benefits including influenza and pneumonia vaccinations. All AAAs provide medications management screening and education.

Senior Farmers Market Nutrition Program (SFMNP) has operated in New York since 1989, when it began as a State initiative. Under the auspices of the U.S. Department of Agriculture, the New York State Department of Agriculture and Markets works with NYSOFA, DOH and

Cornell University (Cornell Cooperative Extension) to administer the program. The largest segment of the program operates statewide through New York's 59 AAAs, including two ITOs. The smaller segment operates in four downstate jurisdictions by the DOH Commodity Supplemental Food Program (CSFP). This program provides income-eligible (185 percent federal poverty level) older adults with a one-time \$20 allotment, as coupons, to use at farmers markets. Federal money is the primary funding source for the program. In 2014, NYSOFA allocated 80,360 booklets with a total value of \$1,607,200 to the AAA network.

The purposes of the Senior Farmers' Market Nutrition Program are to:

- (1) Provide resources in the form of fresh, nutritious, unprepared, locally grown fruits, vegetables, honey and herbs from farmers' markets, roadside stands and community supported agriculture programs to low-income seniors,
- (2) Increase the domestic consumption of agricultural commodities by expanding or aiding in the expansion of domestic farmers' markets, roadside stands, and community supported agriculture programs, and
- (3) Develop or aid in the development of new and additional farmers' markets, roadside stands, and community supported agriculture programs (a major component of the New York economy).

NYSOFA has also engaged with NYS Office of Temporary and Disability Assistance to offer training on having the nutrition program become SNAP capable. Further, NYSOFA, in partnership with NYS Agriculture and Markets has been working with area agencies on aging to connect their nutrition programs with locally grown NY products to improve access to fresh fruits and vegetables and other commodities.

- **Disease Prevention and Health Promotion Services**

NYSOFA has been working with the AAAs for almost a decade to promote healthy behaviors, the use of health promotion and wellness programs and services and screenings as well as the implementation of Evidence-Based Interventions (EBIs). Most recently this has included requiring the AAAs to only fund highest-level EBI's through Title III-D.

Older Americans Act (OAA) Title III-D was, and continues to be, intended to fund the provision of programs designed to help older adults prevent and/or manage chronic diseases and promote healthier lifestyles. Over recent years, AoA/ACL has been shifting emphasis to interventions with proven outcomes to maximize the impact of limited resources and deliver programs with proven beneficial outcomes to those served. These programs are referred to as, "evidence-based". Evidence-based programs are shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce the use of costly medical services. Furthermore, evidence-based programs empower older adults to take control of their health by maintaining a healthy lifestyle through increased self-efficacy and self-management. Priority is given to serving older New Yorkers living in medically underserved areas or who are of greatest economic need.

As of 4/1/15, in keeping with AoA/ACL's emphasis on highest-level programs, NYSOFA requires that health promotion programs fundable by Title III-D, a program must both meet the AoA/ACL Definition of Evidence-Based **and** must have gone through the vetting process to be included on one of the two lists below; alternatively a program is approvable if it is documented to be an

evidence-based program by any operating division of the U.S. Department of Health and Human Services (HHS).

1) ACL's Center for Disability and Aging Policy (CDAP), Office of Performance and Evaluation, Aging and Disability Evidence-Based Programs and Practices (ADEPP) webpage: <http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx>

2) National Council on Aging listing of highest-level criteria programs as approved by AoA/ACL (also known as "cost chart"): <http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/Title-III-D-Highest-Tier-Evidence-FINAL.pdf>

Since the introduction and increased promotion of Medicare preventive and screening benefits, NYSOFA has worked to increase consumer awareness and use of these benefits among New Yorkers. The Affordable Care Act has provided even more opportunities to improve the overall health of older New Yorkers by expanding coverage for many prevention benefits and for screening and treatment for persons with behavioral health issues.

NYSOFA and the network have worked hard to promote the one-time Welcome-to-Medicare examination, flu and pneumococcal vaccinations, smoking and tobacco use cessation, diabetes screening and diabetes self-management, medical nutrition therapy, HIV testing, and various cancer screening including mammography, pap and colorectal. New York State's Nutrition Program for the Elderly and the Health Insurance Information Counseling and Assistance Program (HIICAP) use their networks to update and inform older consumers about these available benefits.

- **Supporting Caregivers – National Family Caregiver Support Program**

In New York State approximately 4 million caregivers provide more than 2.6 billion hours of care to loved ones at any given time each year. The economic value of this care is estimated to be \$32 billion dollars, the caregivers were being paid at the market rate.

NYSOFA administered programs and services that are designed to help older adults live as independently as possible. The services also however, directly support caregivers of older persons in addition to the specific program funds designated to support caregivers specifically. NYSOFA/AAA spending on supporting caregivers is estimated to exceed \$96 million through the provision of services through Title III funded programs, state/local funded respite and social adult day services, caregiver resource centers, personal care, case management, home delivered and congregate meals, transportation, shopping assistance and meal preparation, etc.

The National Family Caregiver Support Program (NFCSP) was established in 2000 to provide grants to States and Territories, based on their share of the population aged 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. NYSOFA administers this program statewide through the county based area agencies on aging (AAAs).

Services provided include:

- Information about available services.
- Assistance in gaining access to services.

- Individual counseling, support groups, and/or training to assist caregivers in the areas of health, nutrition and financial literacy and to make decisions and solve problems relating to their caregiver roles.
- Respite to temporarily relieve caregivers from their responsibilities by providing a short-term break through home care, overnight care in an adult home or nursing home, adult day care and other community-based care.
- Supplemental services to complement the care provided by the caregiver, such as a personal emergency response system, assistive technology, home modifications, Home Delivered Meals, transportation.

These services work in conjunction with other state and community-based services to provide a coordinated set of supports. Studies have shown that these services can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care.

- **Supporting Caregivers – Social Adult Day Services**

Social Adult Day Services (SADS) are an important component of the community-based service delivery system that helps to delay or prevent nursing home placement and the need for other more costly, yet preventable services, while providing vital assistance to the older person with cognitive and/or physical impairments and supporting their informal caregivers. Research demonstrates that caregivers who experience stress and burden are more likely to “burn out” and, thus, place their loved ones in an institution, directly impacting Medicaid spending. SADS can help to ease the burden of caregivers by providing them with time to continue to work or take care of other needs and address other priorities. At the same time, it addresses the basic needs of the individual needing care in a safe, nurturing, and stimulating environment.

SADS is a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in a protective setting. The program also may provide other services and supports, such as transportation, information and assistance, and caregiver assistance. In addition to addressing the individual’s needs for assistance in activities of daily living, these programs provide a secure environment in which therapeutic activities are provided that are aimed at helping participants to achieve optimal physical and mental/cognitive functioning. They improve the quality of life for older adults by reducing social isolation, and increasing social and community engagement. For individuals with Alzheimer’s disease or related dementias, SADS is a cost-effective package of services that provides person-centered interventions which promote slowing the progression of the illness- preventing further deterioration and the need for more expensive services. In addition to improving quality of life for functionally impaired adults, SADS services also improve quality of life for informal caregivers by giving them a break from their ongoing caregiving responsibilities and providing them with a feeling of confidence that their loved one is being cared for in a safe environment.

SADS programs and services are being strengthened and expanded under the states “care management for all model” under Medicaid. SADS services were included as a mandated service under the states managed long term care program which has led to a significant growth in the number of SADS programs statewide

- **Supporting Caregivers – Respite Services**

Respite services provide informal caregivers with a temporary break from their caregiving responsibilities and associated stresses. Informal caregivers often face financial, physical, and emotional burdens which have an impact on their families, social lives, and careers. As the boomers age and systems are better integrated to get information out to the public about available services, there is an increased likelihood that the area agencies and their partners will see a continued increase in demand for respite and other caregiver support services.

Respite services include home care (e.g., personal care levels I & II, home health care, and companionship/supervision), community-based services (e.g., social adult day services, adult day health care), and facility-based overnight care (e.g., in a nursing home, adult home). Respite services assist caregivers in maintaining their loved ones at home for as long as possible and delays or forestalls nursing home placement, which can result in a much higher cost both to the family and the Federal/State/Local Medicaid Program.

Area Agencies on Aging provide respite services throughout the state through a variety of federal and state-funded programs. Two primary programs are the New York Elder Caregiver Support Program funded under Title III-E of the Older Americans Act, and the State-funded Expanded In-home Services for the Elderly Program. Funding is also used to provide extended hours of respite services in the evening (after 5 PM), on weekends, and on an emergency basis. These respite programs provide a variety of services on a temporary and short-term basis, including home care, overnight stays in nursing homes, and social adult day services. In addition, many of these programs also provide other supports to caregivers, such as case management, counseling, support groups/training and information and assistance.

New York is working to expand access to respite and caregiver supports through BIP and through state funds. BIP funds will be used in 2015-2016 to build upon the National Family Caregiver Support Program (NFCSP) OAA Title III-E model to provide services to caregivers of Medicaid recipients who meet certain eligibility criteria. Further, the NYS budget in 2015-2016 contained \$25 million to assist caregivers of persons with Alzheimer's disease and related dementias.

- **Supporting Caregivers – Caregiver Resource Centers**

New York State also provides funds to 17 local Caregiver Resource Centers (CRC). The CRCs provide caregivers with information, assistance, and counseling/support group/training. Since the advent of the Title III-E funded caregiver program in 2000, these programs have coordinated their CRC programs with their Title III-E programs so that, from the caregiver perspective, there is a program consisting of a coordinated array of services that are comprehensive, complementary, and supplemental in nature. CRCs trained 5,903 individuals, provided on-going oversight to 45 support groups in which 723 individuals participated, counseled 5,001 individuals, and provided 12,401 units of information and referral services. Further, NYSOFA provides CRC funding to the Association on Aging in NY. The Association represents the 59 county-based area agencies on aging. The Association uses the CRC funds to coordinate statewide training, working in collaboration with NYSOFA, the Lifespan Respite grantees, the Systems Integration partners and others.

- **Emergency Preparedness**

NYSOFA collaborates with multiple public and private partners at the federal, state and local level to ensure that emergency planning needs of older New Yorkers are addressed and met. Partners include the Administration of Community Living at the federal level, New York State Division of Homeland Security and Emergency Services (DHSES) and the New York Department of Health at the state level, and the Area Agencies on Aging at the local level and include human service and other agencies such as the Red Cross and Salvation Army. The coordinated involvement of NYSOFA with these various entities is necessary in order to ensure that planning for, preventing and responding to emergencies and declared disasters is done in the most efficient way possible. NYSOFA cooperates with the Office of Homeland Security to help assure that all levels of governments, voluntary organizations, and the private sector identify areas of vulnerability which can be address and mitigated.

At the State level, NYSOFA coordinates with DHSES by participating on several task forces initiatives, and NYSOFA is a member of the State Emergency Operations Center during times of activation. SEMO operates a 24 hours alert and warning system that is designed to provide local, state and federal agencies with support while responding to incidents. NYSOFA assists SEMO in the dissemination of public health and safety information during a disaster in coordination with the Department of Health. At the local level, in times of emergency, NYSOFA coordinates and supports the relief efforts providing by AAAs, which play a critical role in identifying, and planning for the provision of services to older adults during a crisis.

To assure that NYSOFA staff are able to respond in an emergency, NYSOFA has offered NIMS training to staff. National Incident Management System (NIMS) outlines a comprehensive national approach to emergency management. It enables federal, state, and local government entities along with private sector organizations to respond to emergency incidents together in order reduce the loss of life and property and environmental harm.

**Section B. Administration for Community Living Discretionary Grants**

- **Chronic Disease Self-Management Education Program**

Approximately 6.2 million adult New Yorkers (41.1%) suffer from a chronic disease such as arthritis, asthma, stroke, heart disease, diabetes, or cancer and New Yorkers with chronic diseases are more likely to report poor health status and activity limitations than those without a chronic disease. Individuals with one or more chronic diseases have increased risks of adverse outcomes, including mortality, hospitalizations, and poor functional status. More than 80 percent of New York State residents age 60 and older have one or more chronic diseases. And, almost all of these older adults are living in the community. Even the highest quality of clinical care to individuals with chronic conditions will not guarantee improved health outcomes. Individuals must be informed, motivated, and involved as partners in their own care. Evidence-based interventions (EBIs) such as the suite of Stanford-derived Chronic Disease Self-Management Education programs (CDSMEs) have been proven effective to help people develop self-management skills and adopt behaviors to prevent and/or manage their conditions—leading to enhanced well-being and improved health outcomes.

NYSOFA, in partnership with the New York State Department of Health (NYS DOH) and the Quality and Technical Assistance Center (QTAC) at the University at Albany, has made great strides to expand access, availability and use of CDSMEs in New York. With funding support from the U.S. Administration for Community Living/Administration on Aging, the Centers for Disease Control and Prevention and the Prevention and Public Health Fund, collective activities of the three partners aim to build a sustainable, statewide local delivery infrastructure for these and other evidence-based health promotion/ disease prevention programs within New York State's health and long-term services and supports systems to improve health outcomes, quality of life, and realize cost savings to the system. In 2012, NYSOFA received the third, most recent grant to continue this work. The grant, "Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education Program" aims to further expand, embed, and sustain CDSMEs within the Area Agency on Aging network, public health community, and long term services and supports system. From September 1, 2012 to February 13, 2015, there have been 6,443 participants of CDSME workshops, 81.56% (5255) of whom have completed the full program. Currently, there are 93 community partners offering the program and 594 active local implementation sites.

- **Lifespan Respite**

The Lifespan Respite program, funded by a three-year grant awarded by the Administration on Aging (AoA)/Administration for Community Living (ACL) (2014-2017) is a continuation of the successful partnership of a Core Team that includes the New York State Office for the Aging (NYSOFA), the Monroe County Office for the Aging (MCOFA) and the New York State Caregiving and Respite Coalition (NYSCRC) sponsored by Lifespan of Greater Rochester NY Inc. Each member of the Core Team has developed work plans to define their respective roles in meeting the objectives of the grant and integrating and coordinating their work. The Core Team is working to expand available respite using both volunteer and consumer-directed models, integrating the Lifespan Respite Program into the state Long Term Services and Supports System (LTSS), and integrating information on respite services into the NY Connects Resource Directory. The Core Team will continue to reach out to Stakeholders across the state including many who were part of a "THINK GROUP" formed during the first grant period to help "think" about current respite available and respite not currently available but needed across the state.

The Lifespan Respite program is designed to:

1. Expand available respite by (a) implementing a workforce development initiative targeting respite volunteers, and (b) developing protocols for local area agencies on aging to implement respite voucher programs
2. Integrate the Lifespan Respite Program into the state LTSS and integrate respite services into the NY Connects Resource Directory database, and
3. Develop a Statewide Action Plan for Lifespan Respite Care sustainability.

- **Systems Integration: Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers**

The Systems Integration initiative was initiated in 2011 as a result of Administration on Aging funding that was organized into two separate but related grants labeled, "*Part A, Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with*

*Disabilities and Family Caregivers” and “Part B, Creating Dementia Capable, Sustainable Service Systems for Persons with Dementia and Their Family Caregivers”.*

Parts A and B have unique and distinct deliverables while also sharing the same overarching goal, objectives, and a defined set of core components. Systems Integration aims to embed the core components within and across the NY Connects network while also establishing a dementia capable system through formalizing the connection between NY Connects and the Alzheimer’s network of services (i.e., Alzheimer’s Association Chapters and the Alzheimer’s Disease Assistance Center of Long Island) and applying a standard definition of dementia capability to all core components. The core components include: Information & Assistance on Full Range of Long Term Services and Supports (LTSS); Options Counseling; Dementia Screening; Care Transitions (formal evidence-based programs and informal local partner activities to support successful transition from facility to home); Expanded Capacity for Chronic Disease Self-Management Program and as appropriate, other approved Evidence-Based/Evidence-Informed Interventions for Individuals with Dementia; Caregiver Supports (targeting those who care for individuals with dementia); Consumer Directed Services; and Streamlined Eligibility for Public Benefits Access.

Dementia Capability has been defined through an active work group process that has engaged the participating NY Connects and Alzheimer’s partners and various State level partners. The final adopted definition addresses the capacity of NY Connects (and possibly other human services staff) to identify and communicate with individuals who have or may have dementia, have an adequate knowledge base of services and resources available to this population; and have the capacity to link individuals to those services and resources.

Although the grant funding is time limited, core components and dementia capability will be integrated and sustained among the entire network of Area Agencies on Aging (AAA) and NY Connects programs.

### **Section C. Participant-Directed/Person Centered Planning**

Participant-Directed/Person Centered Planning was incorporated into Home and Community Based Services (HCBS) for three Area Agencies on Aging (AAAs) as a result of the 2008 Nursing Home Diversion and Modernization Program (NHDMP), and was expanded to ten AAAs as a result of the 2009 Community Living Program (CLP). Through these grants, NYSOFA and partner AAAs were able to demonstrate the impact and importance of flexible, person centered service delivery from both a systems and an individualistic perspective.

Over the past few years, NYSOFA has taken steps to expand participant-directed service options. There have been several key initiatives underway that allowed for replication and sustainability of participant directed services and supports. NYSOFA allows AAAs to provide participant-directed in-home services using OAA Title III-B and Title III-E dollars. All OAA funding conditions apply to participant-directed in-home service provided using Title III-B and Title III-E funds. In 2011, NYSOFA amended the regulations for the Expanded In-home Services for the Elderly Program to also allow for participant-directed care. In addition to regulatory changes, NYSOFA issued a number of technical assistance resource documents (e.g. FAQs and operating manuals), participated in teleconferences, conducted trainings and provided individualized support to the AAAs that were interested in establishing participant directed services and supports. By January 2015, 23 AAAs were equipped to provide participant directed HCBS.

In the next four years, NYSOFA's goal is to increase the number of AAAs providing participant directed services in order to expand consumer control and to address many of the identified gaps in the LTSS system (e.g. workforce shortage, caregiver burden, consumer satisfaction).

To accomplish this, NYSOFA will:

- Provide additional outreach and technical assistance to AAA Directors who have not yet incorporated participant direction into their programming. Efforts will include the continued sharing of developed resources (e.g. program manuals, Q&As, care plan and enrollment forms) and technical assistance will continue to be offered on a case by case basis.
- Encourage case managers to participate in state trainings relative to participant direction, such as the consumer directed web-based training module developed under the Systems Integration grant. Provide additional face to face training on philosophies behind participant direction and how it impacts case management. Build upon the findings of the 2009 CLP Evaluation by adding a comparative analysis of consumer satisfaction among consumers being served in participant directed models versus traditional model.
- Continue to promote the peer to peer learning model established under the CLP that received national recognition for Systems Change in order to enable AAAs to further expand their use of ancillary services and participant direction.

#### Section D. **Elder Justice**

Elder Justice is a broad term but at its essence it means assuring that vulnerable older adults are protected from crime, protected from abuse, neglect and financial exploitation, have access to legal interventions and have a network that can provide services and supports and link to other service systems to meet their needs holistically.

- **Elder Justice – Legal Assistance Program**

Older adults face a variety of legal issues that affect their ability to live independently and with dignity. A central tenet of the Older Americans Act is to ensure access to benefits and services by the most vulnerable older adults. Since 1984, legal assistance has been designated as a priority service for which Area Agencies on Aging are required to spend an adequate proportion of their OAA Title III-B funds.

Statewide, in accordance with federal and State law (Title 9 NYCRR §6654.12) each AAA enters into a contract to provide legal assistance and coordinate OAA funded legal assistance with legal assistance available through the Legal Services Corporation grantee and the local legal community.

As the breadth of issues and the number of New York's older citizens with greatest economic and/or social need increase, access to legal assistance is more critical than ever before. Just as the legal needs of the aging population are changing, so too must the legal assistance program change. Legal assistance funded under the OAA addresses legal issues related to income, health care, nutrition, housing, utilities, protective services, guardianship avoidance, abuse, neglect, exploitation and age discrimination.

In accordance with OAA §731, NYSOFA has designated an individual to be the State Legal Assistance Developer to provide State leadership in securing and maintaining the legal rights of older adults; encourage and facilitate networking among the AAAs and Title III-B Legal Assistance Providers; and provide technical assistance, training and other supportive functions to AAAs, Legal Assistance Providers, State and local Long-Term Care Ombudsmen, and others as appropriate. The Legal Assistance Developer plays a crucial role in resource development, targeting, and quality assurance.

- **Elder Justice – Legal Services Initiative**

NYSOFA developed the Legal Services Initiative (LSI) to strengthen and expand access to legal services for New York's older adults, people of all ages with disabilities, and the informal caregivers of these population groups. The LSI is a public/private collaboration among the NYS Office for the Aging, NYS Office of Court Administration, NYS Bar Association, and NYS Office for People With Developmental Disabilities, together with facilitation assistance by Robert Abrams, Esq., a private attorney, and consultative assistance from a 113-member Think Group.

The Initiative's impetus stems from numerous anecdotal reports regarding the status of legal services for the Initiative's three targeted population groups. The anecdotal reports include:

- Residents being unaware of their legal rights.
- Residents largely unaware that a legal basis underlies many of the serious problems consumers experience in their daily lives.
- Consumers not knowing where or how to find appropriate legal assistance.
- Many older adults, individuals with disabilities, and caregivers entering the court systems without the benefit of legal representation.
- Many residents unable to afford, or think they cannot afford, the costs of legal help.
- Where legal help *is* available and affordable, residents having limited/no access to this help.
- Members of the legal and judicial communities need training about the traits, conditions, and circumstances characterizing the Initiative's three population groups, which has an impact on their ability to effectively communicate and interact with these individuals and on court proceedings and case outcomes.
- Resources are limited in existing community-based legal service programs established to serve individuals in social and economic need.

To gather information about the status of legal assistance in New York and to replace anecdotal reports with hard data, six statewide surveys were conducted of the following individuals:

1. New York State residents aged 18 and older.
2. Attorneys practicing in New York State.
3. Directors of the State's 59 Area Agencies on Aging regarding the federally mandated Legal Assistance Program for individuals aged 60 and older.
4. Community-based Providers who are contracted by the Area Agencies on Aging to deliver legal services under the Legal Assistance Program.
5. Attorneys staffing New York State's Mental Hygiene Legal Service, which provides legal assistance and representation for individuals with developmental and/or intellectual disabilities and, recently, for released sex offenders with mental health issues who are likely to re-offend.
6. Judges and justices in the State's Unified Court System.

The six surveys were analyzed and findings were recorded in a document entitled, *Legal Services Initiative: Six Statewide Surveys*.

A statewide 113-member Think Group was identified, which is composed of knowledgeable and experienced individuals representing the legal and judicial communities; law schools; service providers; members of the aging, disability, caregiver, and health fields; members of state and local government, and consumers. The Think Group convened for an all-day work session, during which they developed a set of strategies, policies, and activities that will be used as a basis for taking steps to achieve the Initiative's goals. The Think Group's output was organized into an implementation tool entitled, *Blueprint for Action: Strategies for Achieving the Legal Services Initiative's Goals*.

In the coming year(s), as a means of advancing the Initiative's goals, the Initiative's partnership members, Think Group members, and other interested individuals and organizations will develop and implement multiple strategies to address the limitations and gaps in legal assistance identified through the six surveys and the work of the Think Group. NYSOFA's efforts to strengthen the aging network's Legal Assistance Program is a major activity under the Legal Services Initiative.

- **Elder Justice – Long Term Care Ombudsman Program**

The Long Term Care Ombudsman Program serves as an advocate and resource for the more than 160,000 older adults and persons with disabilities who reside in New York's long-term care facilities, including nursing homes and adult care facilities. Ombudsmen help residents and their families understand and exercise their rights to quality care and a high quality of life. The program advocates for residents at both the individual and systems levels by receiving, investigating and resolving complaints made by or on behalf of residents, promoting the development of resident and family councils, and informing governmental agencies, providers and the general public about issues and concerns impacting residents of long-term care facilities.

The New York State Long-Term Care Ombudsman Program has been in existence since 1972. The Older Americans Act, which is administered by the federal Administration on Aging (AoA), requires each state to establish an Office of the State Long-Term Care Ombudsman and to employ a qualified, full-time person to serve as the State Ombudsman. In New York, the program is administratively housed within NYSOFA, and advocacy services are provided through a network of 32 local ombudsman programs hosted by county-based Area Agencies of Aging (AAAs) and non-profit organizations. Each local ombudsman program has a paid coordinator who recruits, trains and supervises a corps of volunteers (currently 906 statewide) that provide a regular presence in nursing homes and adult care facilities.

Program priorities continue to include: increasing resident/consumer access to effective and timely advocacy services; empowering more residents and their families to resolve concerns without the need for outside intervention when appropriate; and, improving systemic advocacy efforts to address facility-wide or statewide issues and problems experienced by residents.

- **Elder Justice – Elder Abuse Education and Outreach Program**

Elder abuse includes physical, emotional and sexual abuse; financial exploitation; and neglect (including self-neglect). It is found in all communities and is not limited to individuals of any particular race, ethnic or cultural background, or socio-economic status. Often this abuse is hidden and goes unrecognized, and because the definition of elder abuse varies from state to state, both the incidence and prevalence of elder abuse have been difficult to articulate with great confidence on the national level. New York State funds the Elder Abuse Education and Outreach Program to provide education and outreach to the general public, including older persons and their families and caregivers in order to identify and prevent elder abuse, neglect, and exploitation. The program includes two components: grants to local agencies to establish or expand upon existing local elder abuse education and outreach programs in their communities, and grants that are broad-based and have statewide focus, designed to support a statewide effort to increase awareness and prevention of elder abuse.

The following services and activities are designed to address the various forms of elder abuse:

- Public awareness presentations on elder abuse, scams, and frauds to senior groups, civic groups, and fraternal orders.
- Professionals and non-professionals who work with, or are in regular contact with older people, are trained at a variety of events to better recognize abuse in domestic settings and to facilitate intervention.
- Direct intervention is provided in cases of elder abuse, including scam and fraud cases.
- Intensive case management, geriatric addiction services and financial management are provided to vulnerable older adults.
- Abused older adults are assisted through guardianship and limited power of attorney.

- **Elder Justice – Elder Abuse Prevention Interventions**

Funded under the 2012 Prevention and Public Health Fund (PPHF) through the Affordable Care Act, the Elder Abuse Prevention Interventions (EAPI) is a three-year grant initiative established to pilot an intervention that prevents and addresses financial exploitation and elder abuse. The EAPI initiative in New York brings together entities with unique resources and skills, forming coordinated, enhanced multi-disciplinary teams (E-MDTs) to provide improved and effective cross-systems collaboration and specialized responses, resulting in restored safety and security to older adults.

EAPI project partners are the New York State Office for the Aging (project lead); New York State Office of Children and Family Services – Adult Protective Services (training of financial professionals), and two pilot areas; Manhattan and the Finger Lakes (seven counties: Monroe, Cayuga, Livingston, Ontario, Seneca, Wayne, and Yates.)

A unique component of the pilot intervention is the use of forensic accountants as part of the E-MDT, as well as the use of specialists from a variety of disciplines with unique skills, not only to

consult and share expertise, but to organize active joint investigations and interventions with an emphasis on investigating and stopping potential and existing financial exploitation and other forms of abuse. The EAPI intervention is a resource for professionals serving individuals within the target population (adults aged 60 and older) who display detectable signs of financial exploitation, and have at least one of the following characteristics: (1) health or mental health problems and/or physical impairments; (2) possible cognitive impairment issues and/or dementia; (3) social isolation and/or inadequate social support.

Draft Draft Draft

## Goals, Objectives, Strategies and Expected Outcomes

NYSOFAs continued commitment to effective and responsive management remains one of the agency's priorities. As a result, over the course of the next four years, the agency will administer consistent performance management practices that will include but not be limited to, standardized metrics, improved outcomes, and targeted projections. NYSOFA will review POMP, NCI-AD, and other NY governor's initiatives and integrate where necessary as part of its performance management framework.

The 2015-2019 State Plan includes goals, objectives, strategies, and expected outcomes but with a mixed methodology approach. Some expected outcomes include outputs which can be conceptualized as products, where other expected outcomes illustrate the expected benefit.

NYSOFA will continue to work towards developing a performance management system that will align with our priorities as we transition to the next level in overall performance management.

**Goal #1: Empower older New Yorkers, their families and the public to make informed decisions about, and be able to access, existing health, long term care and other service options.**

### Access Services – Information and Assistance

#### **Objectives:**

- 1.1 Increase the availability of information and assistance provided by the AAAs through the increased use web based applications.
- 1.2 Foster effective and efficient means by which information can be shared between the AAA and the providers where callers are referred.
- 1.3 Increase the ability of the AAAs and their community partners to share information quickly as to create a “no wrong door” in the provision of service directly to consumers in their time of need.
- 1.4 Increase the capacity to provide I & A to older adults and their caregivers through the recruitment and retention of volunteers.
- 1.5 All OAA funded I & A programs operated through the AAAs will function with a uniform set of protocols.
- 1.6 Maintain a network of highly trained I & A staff statewide who are knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on program and services which can assist them in living independently in their community.
- 1.7 Clarify the operational relationship and opportunities for collaboration of Older Americans Act (OAA) funded I & A and the provision of I & A through New York Connects, the Health Insurance Information, Counseling and Assistance Program (HIICAP), and the Long Term Care Ombudsman Program (LTCOP), state and national organizations who provided I & A to older adults and caregivers.
- 1.8 Information and Assistance services will be accessible and inclusive of person with disabilities and individuals with limited English proficiency. Disabilities including by

not limited to mobility, hearing, speech and visual impairments may be accommodated with assistive technology and individuals with limited English proficiency may be accommodated with telephonic interpretation.

**Strategies:**

- Create a single statewide web directory and system to allow older adults, persons of all ages with disabilities and their caregivers to find information on programs and services, complete benefits applications for programs such as SNAP and HEAP which will be shared across all providers systems to reduce duplication.
- Work with the Association on Aging – NY to assess the training needs of I & A staff statewide and develop and conduct trainings to meet identified needs.
- Work jointly with NY Connects staff to train I & A staff establishing minimum training standards for all staff providing I & A to older adults, persons of all ages with disabilities and their caregivers through the AAAs network.
- Identify new statewide partners to establish opportunities for collaboration, cross training and coordination of provision of I & A to older adults and their caregivers.
- Provide ongoing training and technical assistance focused on expanding outreach and providing I & A services to underserved populations including minorities, low income individuals, frail individuals, and vulnerable individuals (this category includes rural residents, individuals with limited English proficiency, LGBT, persons at risk of institutionalization, caregivers of individuals with developmental disabilities, individuals with Alzheimer’s disease and other forms of Dementia) to ensure that these clients are served to the maximum extent feasible.
- Explore the coordination of recruitment and training of I & A volunteers with HIICAP and LTCOP programs to build capacity.

Objective	Expected Outcome	Target Date
1.1	A single vendor will be selected to develop and implement a statewide web based application for all AAA’s to allow for information sharing in real time and across all service providers.	2015 - 16
1.2 1.3	A web based system will be created to allow older adults and their caregivers to get assistance through a seamless “no wrong door” system.	2015-19
1.4	A new force of volunteers trained based on a general I & A will be available to assist and help expand the reach of I & A services both on the state and local level.	2015-19
1.5	A uniform set of standard protocols for the provision of I & A services will be established and utilized by all AAAs making the provision of I & A services.	2016-17
1.6	All I & A staff statewide will be trained and knowledgeable about programs and services in their service area through a standardized training program.	2015-19

1.7	Collaborations will be established among programs and providers of I & A services on a state and local level resulting in the reduction of resource duplication, leveraging of existing resources, and capacity building of I & A services available to older adults and their caregivers.	2015-19
1.8	Information and Assistance services will be accessible and inclusive of persons with differing abilities and persons with limited English proficiency.	2015-16

**Access Services – NY Connects**

**Objectives:**

- 1.9 Expand NY Connects No Wrong Door (NWD) to non-participating counties to ensure state wideness.
- 1.10 Implement NY Connects/NWD partnerships statewide via contracts with between 4-6 regional disability organizations
- 1.11 Provide technical assistance to the newly established NY Connects/NWD programs to ensure successful implementation of the NY Connects/NWD core functions.
- 1.12 Provide technical assistance to NY Connects/NWD programs to support the provision of core functions to additional populations including persons served by the Office of Developmental Disabilities (OPWDD) and the Office of Mental Health (OMH).
- 1.13 Provide technical assistance to NY Connects/NWD programs to support the adherence to the revised NY Connects Program Standards and the BIP State Operating Protocols.
- 1.14 Implement enhanced NY Connects Resource Directory.
- 1.15 Implement quality assurance, evaluation, and sustainability protocols for BIP program expansion and enhancement.
- 1.16 Engage in and support long term care systems reform at the State and local level.

**Strategies:**

- Issue grants to establish NY Connects/NWD in the remaining counties and City of New York that currently do not have the program.
- Issue grants to establish NY Connects/NWD via 4-6 regional disability organizations.
- Develop and issue appropriate Technical Assistance Memorandums, Informational Memorandums, and Program Instructions to the NY Connects programs to support the enhancement and expansion of NY Connects/NWD that is required of BIP.
- Provide contract management to NY Connects/NWD programs through report review and assistance, regularly hosted teleconferences and webinars, and periodic check-ins with local NY Connects program staff.
- Provide necessary training to NY Connects/NWD staff on required program development and enhancement.
- Ensure NY Connects/NWD program compliance with accessibility accommodations for people with special needs and individuals who speak languages other than English.
- Ensure the implementation of a State automated toll-free telephone number.

- Provide technical assistance to all local NY Connects programs to ensure that the redesigned NY Connects Resource Directory is being fully utilized.
- Monitor compliance with the NY Connects Resource Directory to ensure that provider listings are maintained and updated.
- Implement and monitor new data collection and reporting system for NY Connects/NWD and ensure alignment with No Wrong Door data collection processes.
- Develop and administer a statewide public education campaign and ensure NY Connects programs utilize materials that adhere to the prescribed New York State branding, design, and logo requirements.
- Explore Medicaid Administrative Claiming and Medicaid time studies to assist with the development of sustainability plans.
- Collaborate with State partners on long term services and supports system reforms and share progress with local NY Connects programs to guide and assist with parallel local level reform activities.

Objective	Expected Outcome	Target Date
1.9	A NY Connects/NWD program is operational in every county in New York State Connects in New York State.	2016
1.10	A NY Connects/NWD program partnership with between 4-6 regional disability organizations will be implemented.	2016
1.11	All NY Connects programs will have the information and support needed to effectively operate and sustain their programs.	Ongoing
1.11 1.12	All NY Connects programs will have demonstrated capacity to serve all required populations.	2016
1.13	All NY Connects programs will be fully functional and compliant with the NY Connects Program Standards and No Wrong Door Operational Protocols.	2016
1.14	All NY Connects programs will have a fully utilized Resource Directory.	2016
1.15	NY Connects programs will develop and adhere to evaluation quality assurance, and sustainability plans to maintain operation of core functions.	2017
1.16	Long term care systems reform has been conducted at the State and local level.	Ongoing

### **Access Services – Case Management**

#### **Objectives:**

- 1.17 Provide training and technical assistance to aging services provider’s case managers to support the continued provision of case management.
- 1.18 Increase cultural competency and understanding of Sexual Orientation and Gender Identity of older adults.
- 1.19 Develop a case manager certification program in NYS.

#### **Strategies:**

- Develop and issue Technical Assistance Memorandums, Informational Memorandums and Program Instructions to the network of aging services providers.
- Assess training needs of case managers and develop training based on identifiable needs.
- Provide case manager training at the Aging Concerns Unite Us conference, Adult Abuse Training Institute and through web-based and in person trainings.
- Offer behavioral health training to case managers to help them identify, screen and make appropriate referrals.
- Offer dementia capable training developed through the Systems Integration grant to assure that case managers have the knowledge and skills to appropriately assist individuals with dementia.
- Continue training related to the recently developed questions pertaining to Sexual Orientation and Gender Identity that are a part of the Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS).
- Develop protocols that will inform case managers of their roles and responsibilities relative to referrals and Information and Assistance as they interface with the NY Connects specialist(s) when delivering services to individuals who contact the aging network through the “No Wrong Door” system.
- Study the feasibility of implementing a statewide system to certify case manager working in the aging services network.

Objective	Expected Outcome	Target Date
1.17	Area Agency on Aging and network case managers will provide case management services that are dementia capable, person-centered, flexible, cost-conscious and quality driven for older adults and their caregivers.	On-Going
1.18	Case Managers will be culturally competent and have skill and understanding of Sexual Orientation and Gender Identity of older adults.	On-Going
1.19	NYSOFA will determine the feasibility of implementing a case manager certification in NYS	On-going

### **Access Service – Transportation**

#### **Objectives:**

- 1.20 Enhance AAA collaboration with other agencies in their planning and service area to improve coordination and sharing of available transportation resources.
- 1.21 Encourage communities to replicate innovative transportation models.
- 1.22 Promote safe driving among older adults.

#### **Strategies:**

- Provide informational and educational presentations to strengthen the capacity of AAAs to collaborate with other agencies in their planning and service area to enhance coordination and sharing of transportation resources.

- Provide informational to communities on tested innovative models of transportation that are replicable.

Objective	Expected Outcome	Target Date
	State Plan 2015-2019	
1.20	The number of Community Call Centers that include the AAA to coordinate scheduling by bringing together disparate call taker functions under one-mobility management scenario will be increased by two counties.	2016
1.21	Information will be provided to all AAA's regarding replicable innovative transportation models.	2016
1.22	NYSOFA will work with county offices for the aging, other state agencies and local stakeholders to reduce drugged driving among older adults and to increase utilization of driver safety training programs.	On-going

### **Access Services – Health Insurance, Information, Counseling and Assistance Program**

#### **Objectives:**

- 1.23 Provide ongoing education, technical assistance and training to the HIICAP programs to provide high quality, objective, one-on-one counseling to Medicare beneficiaries and their caregivers.
- 1.24 Ensure that HIICAP continues to assist individuals in accessing the Medicare Savings Program and Medicare health and wellness, prevention and screening benefits.
- 1.25 Provide outreach and education to those identified by CMS, ACL and the National Council on Aging (NCOA) who are low-income, live in rural, non-English speaking communities.
- 1.26 Ensure that local program client data and public outreach reporting data is up-to-date and accurately recorded
- 1.27 Increase the current volunteer network.
- 1.28 Expand counselor training and certification to other network staff to increase certified counselor pool.

#### **Strategies:**

- Provide up-to-date training on Medicare rules and policy during 2-Day Annual Coordinator's Conference and seven regional trainings prior to Medicare's Annual Election Period (AEP).
- Provide educational information through recorded webinars to HIICAP counselors and volunteers.
- Provide program and Medicare updates through monthly coordinator conference calls and agency HIICAP Update notices.
- Increase the availability of educational information to HIICAP Counselors, such as program fact sheets, low-income guidelines through a "soon to be developed" HIICAP Corner's Page located within the Agency's website.

- Increase public awareness of Medicare changes and health care reform through local program newsletters, press releases, outreach events, enrollment events, and other electronic media activity avenues.
- Provide materials available in alternative formats and other languages to reach disabled, rural and non-English speaking beneficiaries.
- Increase the number of local counseling sites and partners.
- Increase the HIICAP program's volunteer-base through a one-time Innovations contract.
- Increase the number of HIICAP counselors by encouraging cross training of other aging services network staff.
- Increase the technical knowledge to all HIICAP counselors and volunteers on the federal SHIPtalk NPR reporting system by providing webinars.
- Increase HIICAP's performance measures by providing direct technical assistance, written material and learning webinars.

Objective	Expected Outcome	Target Date
1.23 1.24 1.25	Total Client contacts and public and media events will increase by two percent, annually.	Ongoing
1.25	Client Contact information will increase two percent, annually with performance measures on reporting age, low-income status, low-income assistance and time spent with counseling.	Ongoing
1.27	Total number of trained counselors will increase by two percent, annually.	Ongoing
1.27 1.28	100 additional volunteers will be added to the counseling network	2019

**Goal #2: Enable older New Yorkers to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.**

### **In-Home Services – Expanded In-Home Services for the Elderly Program**

#### **Objectives:**

- 2.1 Provide technical assistance and training to AAAs to support the delivery of EISEP to older adults and their caregivers.
- 2.2 Increase the number of AAAs providing consumer directed EISEP.
- 2.3 Expand the use of Ancillary services through EISEP funding for clients.

#### **Strategies:**

- Assess the training needs of the Aging network and provide a comprehensive overview of the EISEP program at the 2015 Aging Concerns Unite Us conference and annual Adult Abuse Training Institute.

- Facilitate quarterly EISEP case manager conference calls to discuss relevant topics, and share good practice models.
- Disseminate a set of technical assistance questions and answers to support the various aspects of EISEP (i.e. administration, case management, assessment, services, eligibility, cost share, consumer directed, and discharge).
- Provide additional outreach and technical assistance to encourage AAA Directors to incorporate consumer direction into their EISEP program.
- Encourage EISEP case managers to participate in state trainings relative to consumer direction, such as the consumer directed web-based training module developed under the Systems Integration grant.
- Build upon the findings of the 2009 Community Living Program Evaluation by adding a comparative analysis of consumer satisfaction among EISEP participants being served in consumer directed models versus traditional model.
- Promote the peer to peer learning model established under the Community Living Program that received national recognition for Systems Change in order to enable AAAs to further expand their use of ancillary services and consumer direction.
- Explore ways to increase the use of assistive technologies under Ancillary Services as a means to support individuals and reduce the reliance on more costly services and personnel.
- Provide technical assistance and training on the amended regulations (2009) that expanded Ancillary services through EISEP funding for clients with regard to allowable services, items/goods and other supports that maintain or promote the individual's independence.
- Revise EISEP Rates Policy to afford provide more flexibility in allowing AAA's to negotiate provider rates that are equitable with the rates providers are receiving through other payer sources.
- Provide technical assistance as needed to AAAs as they plan for and establish provider rates.

Objective	Expected Outcome	Target Date
2.1	AAAs will have the information and support needed to effectively and efficiently manage and deliver EISEP services and supports to older adults and caregivers.	On-Going
2.1	An EISEP training and TA tract will be implemented as 2015 ACUU Conference.	2015
2.2	Increase the number of AAAs providing consumer directed EISEP from twenty-three to forty.	2019
2.1	Personal care provider rates will be at a competitive market value across LTSS system.	On-going
2.3	Increase AAAs use of the allowable Ancillary services funding through EISEP for clients who would benefit from allowable services, items/goods and other supports.	2019

**In-Home Services – Community Services for the Elderly Program**

**Objectives:**

- 2.4 Provide replicable good practices to AAA’s as they work to develop appropriate community service projects that will improve coordination and the delivery of services for older residents within each county.
- 2.5 Use CSE funds to bridge gaps in programs and services

**Strategies:**

- Work with the Association for Aging in NYS to identify, collect and distribute good program practices for meeting identified and/or emerging needs.

Objective	Expected Outcome	Target Date
2.4	Innovative programs implemented by the AAA’s will be identified and shared with all the AAA’s	On-Going
2.5	Local program and service needs will be met through flexibility of CSE funding.	On-Going

**Supporting Aging in Place – Livable New York**

**Objectives:**

- 2.6 Implement a three-step Academy process to provide training and technical assistance to municipalities that express a commitment to assess residents' perceptions of livability.
- 2.7 Employ the Initiative's principles to plan and implement planning, zoning, housing, and community-design models/strategies to improve the "livability" of their neighborhoods

**Strategies:**

- Develop a request for proposal for communities interested in implementing the Livable NY Academy.
- Engage stakeholders, including state agencies and not for profits who may be interested in partnering to implement the Livable NY Academy.
- Provide seed funding that supports the Livable NY Academy process in appropriate communities.

Objective	Expected Outcome	Target Date
2.6	Develop and implement a Request for Proposal process that will implement step1 the Academy process	2015
2.6	Assist up to 5 communities in implementing step 1 of the Academy process.	2016

2.6	Develop an instrument to measure residents' perceptions of their community's level of livability.	2015
2.6	Assist up to 5 communities in implementing step 2 of the Academy process	2016
2.7	Plan, develop, and implement Step 3 of the initiative's Academy process.	2016 - 19

### **Supporting Aging in Place – Naturally Occurring Retirement Communities**

#### **Objectives:**

- 2.8 Increase resident participation in program planning, implementation and evaluation in the Naturally and Neighborhood Naturally Occurring Retirement Community (NORC/NNORC) of the programs promoting a sense of empowerment and community among seniors.
- 2.9 Provide assistance to NORC/NNORC programs on how to increase resident participation in program planning, implementation, and evaluation.
- 2.10 Implement Health Indicators/Performance Improvement in all NORC/NNORC programs.
- 2.11 Provide ongoing training and technical assistance to NORC/NNORC programs.
- 2.12 Re-Issue RFP for NORC and NNORC to modernize the program.

#### **Strategies:**

- Program standards will be developed and implemented by the NORC/NNORC programs.
- Develop and implement a monitoring tool to evaluate NORC/NNORC programs based upon standards.
- Ongoing technical assistance and training will be provided to programs.
- Health Indicators/Performance Improvements will be implemented in all NORC/NNORC programs.

<b>Objective</b>	<b>Expected Outcome</b>	<b>Target Date</b>
2.8 2.9	A minimum of 25 percent of the NORC/NNORC programs will demonstrate an increase in senior resident participation in program planning, implementation and evaluation.	2017
2.10	Health Indicators/Performance Improvement will be implemented in all NORC/NNORCs	2018
2.11	NORC/NNORC programs will receive ongoing training and technical assistance.	2016 - 19
2.12	An RFP will be issued that will modernize the programs, provide for the inclusion of Health Indicators/Performance Improvement and ongoing training and technical assistance.	2015-2019

### **Activities for Health, Independence and Longevity – Foster Grandparent Program**

#### **Objectives:**

- 2.13 Increase participation in the Foster Grandparent Program through the recruitment of new volunteers and the retention of existing volunteers.
- 2.14 Ensure the Foster Grandparent Program is accessible to people of all backgrounds by increasing participation by culturally diverse volunteers and those from underserved communities.

**Strategies:**

- Provide additional guidance to programs to encourage new and/or innovative methods of recruitment and outreach as well as retention strategies for the program.
- Develop strategies to assure existing volunteers are retained.
- Work collaboratively with the Corporation for National and Community Service to enhance opportunities for volunteers.
- Request statistical data from all programs to determine existing level of diversity in Foster Grandparent Programs.
- Provide guidance to programs concerning recruitment methods targeted to individuals of diverse cultural backgrounds and provide technical assistance as needed.
- Foster Grandparent Programs will conduct targeted outreach to culturally diverse and other underserved older individuals as well as participating schools and other organizations working with the Foster Grandparent.

Objective	Expected Outcome	Target Date
2.13	The number of new volunteers recruited will be increased by a minimum of five percent from State Fiscal Year 2014-2015 levels.	2017
2.13	Existing volunteers will remain with the program for a minimum of one year.	2017
2.14	The number of new volunteers from culturally diverse backgrounds or underserved areas will be increased by at least five percent from State Fiscal Year 2014-15 levels.	2017

**Activities for Health, Independence and Longevity – RSVP**

**Objectives:**

- 2.15 Increase participation in the Retired Senior Volunteer Program (RSVP) through the recruitment of new volunteers and the retention of existing volunteers.
- 2.16 Ensure the Retired Senior and Volunteer Program is accessible to people of all backgrounds by increasing participation by culturally diverse volunteers and those from underserved communities.

**Strategies:**

- Provide additional guidance to programs to encourage new and/or innovative methods of recruitment and outreach as well as retention strategies for the program.
- Develop strategies to assure existing volunteers are retained.
- Work collaboratively with the Corporation for National and Community Service to enhance opportunities for volunteers.
- Request statistical data from all programs to determine existing level of diversity in RSVP Programs.

- Provide guidance to programs concerning recruitment methods targeted to individuals of diverse cultural backgrounds and provide technical assistance as needed.
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- RSVP Programs will conduct targeted outreach to culturally diverse and other underserved older individuals.

Objective	Expected Outcome	Target Date
2.15	The number of new volunteers recruited will be increased by a minimum of five percent from State Fiscal Year 2014-2015 levels.	2017
2.15	Existing volunteers will remain with the program for a minimum of one year.	2017
2.16	The number of new volunteers from culturally diverse backgrounds or underserved areas will be increased by at least five percent from State Fiscal Year 2014-15 levels.	2017

**Activities for Health, Independence and Longevity – Senior Community Service Employment Program**

**Objectives :**

- 2.17 Enhance employment opportunities for older New Yorkers by promoting older workers as a solution for businesses seeking a trained, qualified, and reliable workforce.
- 2.18 Utilize Labor Market Information (LMI) to facilitate the transition of SCSEP participants into unsubsidized, in-demand employment.
- 2.19 Increase recruitment of those individuals with the greatest economic need and with poor employment prospects.

**Strategies:**

- Require all SCSEP sub-grantees to utilize training provided by local One-Stop Career Centers.
- Utilize LMI information to identify and match individuals with in-demand employers.
- Encourage sub-grantees to speak to growth employers to determine the specific skill sets required by potential candidates.
- Provide program guidance to insure sub-grantees continue to give special attention to recruiting and training those most in need.

Objective	Expected Outcome	Target Date
2.17	Older New Yorkers employment prospects will increase by promoting older workers as a solution for businesses seeking a trained, qualified, and reliable workforce will be increased.	On-Going
2.18	Labor Market Information will be used to match skills of SCSEP participants with job openings.	On-Going

2.19	SCSEP core performance measure, established by USDOL, for Service to Most in Need, will meet or exceed by 2.5% its targeted goal.	On-Going
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**Activities for Health, Independence and Longevity – Volunteerism**

**Objectives:**

- 2.20 Enhance the rates of older adults participating in volunteer service.
- 2.21 Reduce the rate of social isolation among older adults.
- 2.22 Increase community organizations use of the state volunteer website [newyorkersvolunteer.org](http://newyorkersvolunteer.org) to match volunteers with meaningful volunteer experiences.
- 2.23 Develop positive outreach messages on aging including the economic, intellectual and social value of older adults.

**Strategies:**

- Increase interagency collaborations.
- Promote listing volunteer opportunities on [newyorkersvolunteer.org](http://newyorkersvolunteer.org)
- Prepare statistics about the social and economic contributions of older adults to their communities.
- Identify best practices regarding civic engagement activities.
- Develop PSA's for county use to recruit volunteers.

Objective	Expected Outcome	Target Date
2.20	There will be a 5% statewide increase in the number of older New Yorkers who volunteer based on SFY 2013-14 levels.	2015-19
2.21	There will be a reduction in isolation among older adults through efforts to increase volunteerism.	On-Going
2.22	There will be an increase in the number of volunteer postings on <a href="http://www.newyorkersvolunteer.org">www.newyorkersvolunteer.org</a>	On-Going
2.23	Positive messaging will be developed and distributed that portray aging and the contributions of older adults positively.	On-Going

**Nutrition Services – Nutrition Program for the Elderly**

**Objectives:**

- 2.24 Maintain and expand the provision of healthy, balanced congregate and home delivered meals.
- 2.25 Ensure that the nutrition programs are available to older individuals in greatest economic and social need throughout the state.
- 2.26 Ensure the nutrition program assists older adults in accessing other benefits and services.
- 2.27 Support local efforts to expand nutrition services within communities through partnerships and contracts with managed long term care plans
- 2.28 Encourage nutrition provider network to purchase locally grown fruits and vegetables and commodities.
- 2.29 Update the nutrition standards and regulations.
- 2.30 Continue to increase use of nutrition counseling and nutrition education and other evidence based interventions that promote healthy living.

**Strategies:**

- Implement 2015 Dietary Guidelines statewide when released by HHS & USDA.
- Annually monitor AAAs for compliance with nutrient requirements and dietary guidelines for meals.
- Annually monitor compliance of State requirement concerning the use of a registered dietitian in each local nutrition program.
- Conduct annual food safety training statewide for program coordinators, registered dietitians and meal site and preparation kitchen staff.
- Provide appropriate ongoing technical assistance and explore the development of additional methods to expand capacity to provide assistance to local programs.
- Maximize the distribution of annual Senior Farmers Market Nutrition Program (SFMNP) coupons to eligible older New Yorkers.
- Continue existing collaborations with various public and private partners including advocacy groups concerning nutrition services.
- Provide appropriate ongoing technical assistance to local programs concerning nutrition education and nutrition counseling.
- Provide appropriate technical assistance and information to local programs to assist older adults to make greater use of Medicare preventive benefits, particularly immunizations, flu shots, mammograms and other preventive screenings.
- Identify effective ways to provide assistance and Centers for Medicare Services (CMS) data to Area Agencies on Aging to encourage greater emphasis on implementing evidence-based nutrition and health promotion programs.
- Facilitate partnerships between local farmers and growers associations and the nutrition programs.
- Develop a process to engage stakeholders to update the states nutrition program standards and regulations

Objective	Expected Outcome	Target Date
2.24	Encourage AAA network to consider (a.) the expansion of Title III congregate dining options such as the restaurant programs (for either breakfast or lunch) and to sites that offer additional health activities & WI-FI.	On-going
2.27	Expand the use of locally grown 'in season' produce within the nutrition programs throughout the state.	On-going
2.26	Provide application assistance for public benefits – especially USDA SNAP and HEAP – at congregate dining sites as often as possible. Also support the use of congregate sites for tax preparation assistance and Medicare counseling as available	On-going
2.24	Work on creative solutions to halt the decline in congregate dining in Upstate New York counties by working with a key number of AAA's on a pilot program to review dining options and indicators.	2017
2.24	Encourage more regional approaches to issues that come up in the administration of the nutrition programs – such as lack of meal providers for contracts; decreasing volunteers; expanding home	

2.25	delivered meal programs; facing increased costs with limited program dollars; and other topics.	2016-17
2.29	Ensure that the 2015 Dietary Intake Guidelines for Americans (DRI's) are implemented by all nutrition programs upon release.	On-Going
2.24 2.25	Encourage the use of multi-cultural menus and dining options to ensure that nutrition programs for the elderly are reaching as wide and diverse audience as possible.	On-going
2.25	Continue to work with AAA's to accept USDA SNAP funds for donations at meal sites and for home-delivered meals.	On-going
2.27	Work with AAA's that are contracting with Managed Long Term Care plans for congregate & home-delivered meals; provide technical assistance in the planning for these services as a way of expanding traditional meals programs for those not part of MLTC's.	2015-16
2.30	Reduced risk or threat of acute and chronic diseases, such as diabetes and heart disease, as a result of regularly offering nutrition screening (to determine nutritional risk), nutrition education, and nutrition counseling to all participants and caregivers.	On-going
2.30	Wider availability of physical fitness activities for older adults.	On-going
2.30	Increased prevention and management of chronic disease associated with diet and weight resulting from wider integration of nutrition activities with health and wellness programs.	On-going
2.30	Increase by five percent the use of Medicare preventative and health screening benefits. (Source: CMS published claims data)	Each Year

**Supporting Caregivers – National Family Caregiver Support Program**

**Objectives:**

- 2.31 Assist informal caregivers - spouses, adult children, other family members, friends and neighbors in their efforts to care for older persons who need help with everyday tasks.
- 2.32 Older persons with chronic illnesses or disabilities are able to remain in their own homes in the community because of caregiver support services.
- 2.33 Aging network will become dementia capable through partnerships with regional Alzheimer's Association chapters.
- 2.34 NY Connects/NWD will be able to direct caregivers to appropriate programs that can assist them.
- 2.35 New models will be developed to increase access to caregiver supports.
- 2.36 Trained volunteers providing respite will increase.

**Strategies:**

- Providing training/technical assistance to caregiver providers as needed.
- AAAs will share good practices with other AAAs or community organizations.
- NYSOFA will develop a consumer directed model for all caregiver related services.

Objective	Expected Outcome	Target Date

<b>2.31</b>	Caregiver's will be better able to continue their caregiver role while receiving services through this program.	Ongoing
<b>2.32</b>	The number of older adults in New York who remain in their home in the community will remain consistent or grow because their caregivers are receiving support through this program.	Ongoing
<b>2.33</b>	The aging network will become dementia capable.	2017
<b>2.34</b>	A comprehensive list of caregiver resources and providers will be available in a single statewide database.	2016
<b>2.35</b>	Consumer directed and other models will be shared with AAAs	2016
<b>2.36</b>	Volunteers providing respite will increase by 5% from SFY 2014-2015 levels	2017

### **Supporting Caregivers – Social Adult Day Services**

#### **Objectives:**

- 2.37** Annually monitor Social Adult Day Services (SADS) programs directly funded by the New York State Office for the Aging (NYSOFA) for compliance with the state regulations.
- 2.38** Annually monitor the Area Agencies on Aging (AAAs) that fund SADS to determine compliance with program requirements and regulations.
- 2.39** Support professional development activities that provide technical assistance for new start-ups and statewide training on SADS best practices.

#### **Strategies:**

- Through annual on-site monitoring visits and quarterly reporting, state funded SADS will demonstrate compliance with requirements and receive technical assistance as needed.
- NYSOFA will review AAA completed monitoring tools of SADS that are funded by the AAAs and technical assistance will be provided as needed.
- NYSOFA will provide technical assistance and oversight to the SADS Professional Development contractor to promote standardized program tools and best practices.

#### **Expected Outcomes:**

<b>Objective</b>	<b>Expected Outcome</b>	<b>Target Date</b>
<b>2.37</b> <b>2.38</b>	All NYSOFA funded SADS programs and county funded SADS programs will meet state minimum standards	Ongoing
<b>2.37</b> <b>2.38</b>	Caregivers and care recipients who utilize adult day services will receive quality services that meet state standards.	Ongoing
<b>2.39</b>	The SADS Professional Development contractor will continue to provide training and technical assistance to new and existing SADS programs.	Ongoing

## Supporting Caregivers – Respite

### Objectives:

- 2.40 Provide programming to ensure that informal caregivers will benefit from utilizing respite services.
- 2.41 Increase, through collaboration with other state agencies and stakeholders, additional respite options.
- 2.42 Train volunteers to provide respite services.

### Strategies:

- Administer the thirteen New York State-funded respite program grants, monitor their caregiver outcomes and provide technical assistance to grantees to ensure caregivers are benefiting from respite services.
- Monitor and provide technical assistance to the AAAs on their provision of respite services through other funding streams.
- Work with New York State Caregiving and Respite Coalition (NYSCRC) to expand the pool of trained respite volunteers.

Objective	Expected Outcome	Target Date
2.40	Informal caregivers will self-report that they personally benefited from utilizing respite care services for their loved ones	2016 - 2017
2.41	AAAs will provide a variety of types of respite including in-home, congregate settings and overnight care.	Ongoing
2.42	Volunteers will be identified and trained to provide respite	Ongoing

**Goal #3: Empower older New Yorkers to stay active and healthy through Older Americans Act services and those offered under Medicare.**

## Disease Prevention and Health Promotion Services

### Objectives:

- 3.1 Increase availability of EBIs to older adults throughout NYS.
- 3.2 Increase capacity of AAAs to deliver, or partner with others in delivering, EBIs.
- 3.3 Increase the use of all Medicare preventive and health screening benefits, focusing on flu and pneumococcal vaccinations and certain cancer screenings such as colorectal and mammography and the Welcome-to-Medicare and annual wellness exams among all beneficiaries.
- 3.4 Realize a New York State integrated and sustainable infrastructure for CDSME led by New York State Office for the Aging (NYSOFA) and NYS Department of Health

(NYSDOH) and managed in collaboration with the Quality and Technical Assistance Center at the University at Albany (QTAC).

- 3.5** Provide support to the QTAC to continue to serve as the principal training, technical assistance, monitoring, and evaluation provider of CDSMEs in New York State.
- 3.6** Reach 8,720 individuals with chronic conditions and/or disabilities within the 2012-2015 three year grant period and continue to attain a similar or increased level of reach annually thereafter.
- 3.7** Expand CDSME reach to people with disabilities, HIV/AIDS and diabetes.
- 3.8** Embed CDSMEs in multi-site partners in ways that maximize potential for Medicare, Medicaid, private insurer and Title IIID reimbursement/funding.
- 3.9** Provide technical assistance and training to Area Agencies on Aging and NY Connects programs on evidence based health promotion and wellness programs, including CDSMEs.
- 3.10** Secure other federal and State resources to support continued delivery, expansion, and sustainability of CDSMEs.

**Strategies:**

- Issue Technical Assistance to NYS AAAs to enhance their understanding of Evidence-Based Health Promotion.
- Encourage the sharing of best practices and lessons learned among NYS AAAs.
- Convene regular administrative and operational meetings and sharing of resources among the New York State Evidence-Based Interventions Leadership Team that consists of NYSOFA, NYSDOH and the QTAC.
- Provide contract monitoring and support to the QTAC for CDSME funded activities.
- Develop and issue appropriate Technical Assistance Memorandums, Informational Memorandums, and Program Instructions to the Area Agencies on Aging and NY Connects.
- Encourage NY Connects to support referrals to CDSMEs and/or contribute to program delivery.
- Encourage Area Agencies on Aging to utilize Older American Act Title IIID funding to support the delivery of CDSMEs in their localities.
- Provide training to the Area Agencies on Aging and NY Connects through use of the QTAC Online Learning Community and other QTAC provided formats.
- Work with State and federal partners to secure grants and other resources to support CDSME.

Objective	Expected Outcome	Target Date
3.1	Increase types and numbers of EBIs offered in NYS to older adults.	On-Going
3.2	Increase understanding of Evidence-Based Health Promotion, including strategies for the delivery of EBIs, by AAA staff.	2015-19
3.2	Increase number of AAAs offering an EBI (directly or through contract) as indicated by their Annual Implementation Plan. Strive to have 100% of AAAs offering an (highest-level) EBI.	2016
3.2	Increase the number of older adults served by AAAs (directly or through contract) as EBI participants.	2016-19

3.2	Increase the number and types (including non-traditional) of partners the AAAs collaborates with by way of their partnerships to deliver EBIs.	On-Going
3.3	Increase by five percent the use of Medicare preventive and health screening benefits. (Source: CMS published claims data)	On-Going
3.4	CDSME state level activities are coordinated and sustained by the Evidence-Based Interventions Leadership Team.	Ongoing
3.6	As demonstrated by QTAC supplied data, eight thousand seven hundred-twenty individuals with chronic conditions and/or disabilities will have participated in CDSMEs.	2015
3.7	As demonstrated by QTAC supplied data, individuals with disabilities, HIV/AIDS and diabetes will have been recruited for CDSMEs and have participated in one or more classes	Ongoing
3.8	Area Agencies on Aging will have utilized Older American Act Title IIIID funding to support the delivery of CDSMEs in their localities.	Ongoing
3.9	Area Agencies on Aging and NY Connects will have the information and support to contribute to the delivery of CDSMEs.	Ongoing
3.10	NYSOFA will have applied for or requested funding from federal and/or State sources to support CDSME.	2019

**Goal #4: Embed ACL discretionary grants with OAA Title III core programs.**

Integration of grants within OAA Core Programs	Measurable objectives	Target Date
<b>Community Living Program (CLP)</b>	Consumer-directed personal care and other long term services and supports (LTSS) are available as an option for all aging network program participants and caregivers.	2019
<b>Systems Integration</b>	Core systems integration components* are embedded and implemented in all AAAs.  [Core systems integration components are: Information & Assistance on Full Range of LTSS; Options Counseling; Dementia Screening; Care Transitions; Expanded Capacity for Chronic Disease Self-Management Program and as appropriate, other approved Evidence-Based/Evidence-Informed Interventions for Individuals with Dementia; Caregiver Supports (targeting those who	2019

	care for individuals with dementia); Consumer Directed Services; and Streamlined Eligibility for Public Benefits Access.]	
<b>Systems Integration</b>	Dementia capability is defined, and NY Connects, Alzheimer’s partners, and State agency partners have agreements for its use and implementation.	2019
<b>ADRC</b>	Older adults have access to information and assistance services that support their LTSS needs through NY Connects.	2016
<b>BIP</b>	All individuals have access to information and assistance services to support their LTSS needs in each jurisdiction of NY.	2017
<b>Care Transitions</b>	Encourage an environment that facilitates and increases local partnerships to support Care Transition* programs in communities across New York State.  (Care Transitions defined in the SI initiative as “formal evidence-based programs and informal local partner activities to support successful transition from facility to home.”)	2019

**Lifespan Respite**

**Objectives:**

- 4.1 Expand available respite by (a) implementing a workforce development initiative targeting respite volunteers, and (b) developing protocols for local area agencies on aging to implement respite voucher programs.
- 4.2 Integrate the Lifespan Respite Program into the state LTSS and integrate respite services into the NY Connects Resource Directory database.
- 4.3 A web-based caregiver self-assessment tool will be developed.
- 4.4 Develop a Statewide Action Plan for Lifespan Respite Care sustainability.

**Strategies:**

- The Core Team will continue to build on the strong working relationship developed during the prior (2010 – 2013) Lifespan Respite grant initiative.
- The NYSCRC Director will continue proactive efforts to build recognition of NYSCRC as a partnership of dedicated organizations and individuals committed to supporting respite for the millions of informal caregivers throughout the state. The NYSCRC Director, working closely with NY Connects, will help to connect caregivers with respite and information, training and support services critical to successfully caring for a loved one at home.

<b>Objective</b>	<b>Expected Outcome</b>	<b>Target Date</b>
4.1	250 trained volunteers will satisfactorily provide respite to 500 caregivers and their families.	2017

4.1	A sustainable, replicable model of training for respite volunteers will be established.	2017
4.1	Consumer-directed voucher model being established under the OAA III-E program will result in an increase in respite services delivery.	2017
4.2	The number of caregivers using NY Connects will increase.	2017
4.3	A self-assessment tool for caregivers will be designed and pilot tested on the NYSCRC web site.	2016
4.3	The finalized self-assessment tool will be available on the NYSCRC web site and may be available on the NY Connects web site.	2016
4.4	An Action Plan to sustain the Lifespan Respite program in New York State and sustain the New York State Caregiving and Respite Coalition (NYSCRC) beyond the grant period will be developed by the Core Team for this grant working with an advisory group of key stakeholders.	2017

## **Care Transitions**

### **Objectives:**

- 4.5 Provide technical assistance and training to all AAAs/NY Connects on the core components.
- 4.6 Maintain and/or convene work groups dedicated to continued integration and refinement of core components into ongoing AAA/NY Connects operations.
- 4.7 Continue to implement/expand applicable intake/screening, tracking, reporting, and monitoring requirements in NY Connects/AAAs to track and measure implementation of core components.
- 4.8 Provide technical assistance and training to all NY Connects/Area Agencies on Aging on the adopted definition of dementia capability for its application to the core components.
- 4.9 Collaborate with State and local level Alzheimer's partners and others to continue advancement of dementia capability among NY Connects, AAAs (including contractors), and other providers of long term services and supports (LTSS).
- 4.10 Implement intake/screening, tracking, and reporting requirements in NY Connects/AAAs for dementia capability to track and measure application of dementia capability to core components.
- 4.11 Enhance caregiver supports in core components through caregiver screening mechanisms.

### **Strategies:**

- Develop and issue appropriate Technical Assistance Memorandums, Informational Memorandums and Program Instructions on the core components of systems integration.

- Continue the advancement and integration of core components within all AAAs/NY Connects through work groups on Options Counseling, Care Transitions, and Evidence-Based Services, and other work groups as needed, for approaches and decisions about systematic implementation.
- Embed core component reporting measures into the existing NY Connects reporting system, and build capacity into the No Wrong Door (NWD) system currently under development.
- Develop and issue appropriate Technical Assistance Memoranda, Informational Memoranda, and Program Instructions on the adopted definition of dementia capability and the recommendations/requirements for its application to the core components for implementation in AAAs/NY Connects.
- Continue the advancement and integration of dementia capable LTSS through a work group to engage State and local partners about systematic implementation of dementia capability in AAAs/NY Connects, and relevant expansion to the larger LTSS system.
- Develop and integrate dementia ‘screening’ questions as part of NWD screen.
- Explore the addition of dementia capability monitoring components to the AAA and/or NY Connects reporting system(s).
- Explore the addition of monitoring components of dementia capability in AAAs/NY Connects through the on-site Annual Evaluation process.
- Provide an online training portal to AAAs/NY Connects and other aging network partners on an ongoing basis through the Quality and Technical Assistance Center (QTAC ) at UAlbany’s Center for Excellence in Aging and Community Wellness.
- Develop and implement caregiver support services screening mechanisms, including self-questionnaire and questions as part of NWD screen.

Objective	Expected Outcome	Target Date
4.5	NY Connects/AAAs and contractor staff will meet the required training requirements on providing dementia capable LTSS.	2016
4.6	Work Groups for specified core components will have convened and produced recommendations for advancement/expansion.	2017
4.7	Reporting measures on all core components will have been incorporated into the NY Connects/AAA reporting system(s) and/or No Wrong Door (NWD) mechanism.	2017
4.8	NY Connects and case management staff will meet training requirements with demonstrated competencies in dementia capability.	2017
4.8	NY Connects screening processes provide access to dementia capable services.	2017
4.8	NY Connects screening processes provide access to caregiver support services	2017

4.9	AAA contractors will be required to participate in training on dementia capability according to NYSOFA requirements.	2018
4.10	AAAs/NY Connects will design and implement a tracking system to monitor outcomes of referrals for dementia specific services.	2019
4.10	All NY Connects/AAAs will have implemented all core components.	2019
4.11	AAAs/NY Connects will demonstrate dementia capability of core components.	2019

**Goal #5: Ensure the rights of older New Yorkers and prevent their abuse, neglect and exploitation.**

### **Elder Justice – Legal Assistance Program**

#### **Objectives:**

- 5.1 Identify, strengthen, and enhance collaboration of legal assistance and advocacy programs at the State and local levels as these relate to older New Yorkers' ability to exercise rights.
- 5.2 Identify and mitigate gaps in the current systems to ensure the rights of older adults.
- 5.3 Facilitate individual access to advocacy and representation to protect individual rights.
- 5.4 Educate stakeholders on the rights of older adults.

#### **Strategies:**

- Maintain and build upon partnerships developed through the Legal Services Initiative.
- Establish a work group to: review current state regulations and program standards; develop model approaches for outreach, access to legal assistance, monitoring, reporting, and program assessment; develop a uniform reporting format; and review and implement strategies proffered by the Legal Services Initiative Think Group members, as appropriate.
- Provide technical assistance to the AAAs in their efforts to coordinate OAA funded legal assistance with Legal Services Corporation (LSC) projects and to collaborate with the local legal and advocacy communities (including the private bar and non-profit organizations providing legal assistance), and the local long-term care ombudsman program to protect the rights of older adults.
- To detect and prevent problems that would jeopardize the independence and dignity of the older adult, the State Legal Assistance Developer will collaborate with LSC grantees, legal assistance providers, and other elder rights advocacy programs for the development and dissemination of educational materials and education activities/workshops to increase awareness of and understanding by older New Yorkers,

their families, and caregivers about the legal issues they might encounter (including problems related to fiduciary relationships, housing, health care, and long-term care).

Objective	Expected Outcome	Target Date
5.1	Expand partnerships at State and local levels to coordinate delivery of legal assistance to older New Yorkers with greatest economic and/or social need	On-going
5.2	AAAs will be able to expand access to legal assistance by older adults with greatest economic and/or social need through identification and greater utilization of existing resources among the local legal and advocacy communities to protect the rights of older New Yorkers	On-going
5.3 5.4	There will be reliable sources of information available for older adults, caregivers and those who interact with them to better enable them to protect their rights, recognize legal issues, and identify resources for legal assistance as needed.	On-going

**Elder Justice – Legal Services Initiative**

**Objectives:**

- 5.5 To gather information about the status of legal assistance in New York via six statewide surveys conducted of the following individuals:
  - a) New York State residents aged 18 and older.
  - b) Attorneys practicing in New York State.
  - c) Directors of the State's 59 Area Agencies on Aging regarding the federally mandated Legal Assistance Program for individuals aged 60 and older.
  - d) Community-based Providers who are contracted by the Area Agencies on Aging to deliver legal services under the Legal Assistance Program.
  - e) Attorneys staffing New York State's Mental Hygiene Legal Service, which provides legal assistance and representation for individuals with developmental and/or intellectual disabilities and, recently, for released sex offenders with mental health issues who are likely to re-offend.
  - f) Judges and justices in the State's Unified Court System.
  
- 5.6 Identify "Think Group" to develop a set of strategies, policies, and activities that will be used as a basis for taking steps to achieve the Initiative's goals.
  
- 5.7 Think Group members, and other interested individuals and organizations will develop and implement multiple strategies to address the limitations and gaps in legal assistance identified through the six surveys and the work of the Think Group.

Objective	Expected Outcome	Target Date
5.5	Six survey instruments developed, six statewide surveys implemented, all survey results analyzed, and a report of findings written and posted to the Legal Services Initiative's web site—for availability to the public.	2015
5.6	Think Group members identified, convened and output organized into a written report and posted to the Legal Services Initiative's web site—for availability to the public.	2015
5.7	Actions, steps, and activities will be planned, developed, and implemented by the various work groups of the Think Group.	Ongoing

**Elder Justice – Long Term Care Ombudsman Program**

**Objectives:**

- 5.8 Strengthen LTCOP program through regionalization model.
- 5.9 Enhance the capacity and efficiency of local ombudsman programs and representatives to provide effective individual and systems advocacy.
- 5.10 Improve resident and family access to information and assistance which helps them understand and exercise their rights, secure the benefits to which they are entitled, and resolve problems in the most efficient and effective way possible.
- 5.11 Increase the number of volunteers working with LTCOP.

**Strategies:**

- Re-organize the statewide Ombudsman Program network by establishing regional ombudsman programs to provide volunteer management and advocacy services to protect the health, safety, welfare and rights of residents in long-term care facilities.
- Provide technical assistance to help local programs improve volunteer recruitment and retention, including recruitment of volunteers from culturally diverse backgrounds.
- Establish regular communication, including training activities, with other Elder Rights programs, especially legal services, to promote greater coordination and to develop formal/informal referral protocols.
- Coordinate with agencies and organizations that assist residents with addressing their individual and common concerns with facility administration, in order to improve resident care and quality of life.

Objective	Expected Outcome	Target Date
5.8	Develop an RFP to create a regionalized LTCOP model.	2015
5.9	The percent of verified abuse, neglect and exploitation complaints that are satisfactorily resolved will increase from 68 percent to at least 80 percent of the state average for all complaints.	2017
5.10	The percentage of nursing homes that receive regular visits from a local ombudsman representative will increase to at least 90 percent.	2020
5.10	Enhanced coordination/training with legal service providers (Title III), the Health Insurance Information, Counseling and Assistance Program (HIICAP) and other advocacy services, and an increase in the number of older adults and their families appropriately referred to those services for assistance.	On-going
5.11	Volunteers will increase by 5% over SFY 2015-2016 levels.	2018

### **Elder Justice – Elder Abuse Education and Outreach Program**

#### **Objectives:**

- 5.12 Continue to support activities that educate the public and professionals about elder abuse, provide direct social work investigation and intervention, and support the New York State Coalition on Elder Abuse.
- 5.13 Improve coordination at both the State and local levels in order to better serve older adults who are eligible for/in receipt of Protective Services for Adults.
- 5.14 Strengthen state and local partnerships to increase identification and reporting of suspected abuse.

#### **Strategies:**

- Continue to implement an annual plan for the Elder Abuse Education and Outreach Program. Partner with the Office of Children and Family Services (OCFS) on an annual Adult Abuse Training Institute for adult protective services and AAA case managers.
- Update the Memorandum of Understanding (MOU) between the New York State Office for the Aging (NYSOFA) and (OCFS) on Protective Services for Adults.
- Facilitate the development of MOUs between local Offices for the Aging and local Departments of Social Services that cover key areas for coordinating Protective Services for Adults and aging funded services.
- Inventory local or regional elder abuse coalitions, task forces, shelters and interdisciplinary teams to identify resources and best practices that can be duplicated in areas that do not have coordinated elder abuse activities.

Objective	Expected Outcome	Target Date
5.12	Services and activities, including the conducting of public awareness presentations, training of professionals and non-professionals working with older people, and provision of social work interventions to elder abuse victims and geriatric addiction services to older persons in an 11 county region will continue.	On-Going
5.13	The New York State Coalition on Elder Abuse and its work, including the dissemination of news bulletins, and acting as a resource and clearinghouse for elder abuse related information will continue.	On-Going
5.13	A new MOU will be produced between the New York State Office for the Aging and the Office of Children and Family Services, reflecting a commitment to work together to facilitate and support better coordination of services on the local level between adult protective services and aging services.	2015
5.14	A new/revised local MOU will be produced between adult protective services and aging services that cover information in key areas necessary for good coordination and referrals between local Area Agencies on Aging and Departments of Social Services.	2016
5.14	Through the AAAs Area Implementation Plan, reports will be provided to NYSOFA to identify resources and best practices that can be duplicated in areas that do not have coordinated elder abuse activities. Resources will be listed in the Statewide Resource Directory utilized by NY Connects.	2017 2018

### **Elder Justice – Elder Abuse Prevention Interventions**

#### **Objectives:**

- 5.15 Develop a model for an E-MDT, incorporating forensic accountants with specialists who will work collaboratively as team members to address complex cases of elder financial exploitation, while also addressing other forms of abuse that may be present in those cases.
- 5.16 Implement the E-MDT model in New York County (Manhattan) and Finger Lakes region (including Monroe, Cayuga, Livingston, Ontario, Seneca, Wayne and Yates counties).
- 5.17 Create E-MDT policies and procedures to establish protocols for implementation of the two pilot teams.
- 5.18 Develop strategies for using technology and other innovative methods for the implementation of the E-MDT.
- 5.19 Conduct training for personnel from the financial industry (banks, accountants, tax preparers, etc.) to promote early detection and referral of high-risk cases, and for community organizations on how to refer and present cases to the E-MDT.
- 5.20 Develop methods for data collection that will be useful in measuring performance and evaluating outcomes of the pilot intervention.
- 5.21 Participate in an evaluation to determine the effectiveness of the new E-MDT model, in accordance with AoA/ACL and under direction of the contracted evaluator.
- 5.22 Disseminate results for possible replication.

**Strategies:**

- Document E-MDT procedures for eligibility determination, cross-collaboration, referral and screening of cases, case consultation, review and sharing of case information, role of forensic accountants, joint investigation, use of technology, and management of cases.
- Develop strategies for using technology and other innovative methods for the implementation of the E-MDT.
- Develop and implement training curriculum tailored to the financial industry (banks, accountants, tax preparers, etc.) Cover roles of E-MDT Coordinator, APS, DA offices, laws governing protections for financial professionals who report suspicious activity.
- Design eligibility, intake, tracking, and outcome forms to be translated into a data collection system for use by E-MDT coordinators and for federal program evaluation.
- Design evaluation components for cross-state and state-specific evaluation with federal program evaluator and partners.
- Develop materials for sustainability and that can be used in sites that wish to replicate the model.

<b>Objective</b>	<b>Expected Outcome</b>	<b>Target Date</b>
	<b>State Plan 2015-2019 proposed</b>	
<b>5.15</b>	E-MDTs are effective in bringing together individuals from different disciplines to develop action plans for appropriate cases in a timely manner through participation of those individuals.	2016
<b>5.16</b>	The E-MDT will be a field-tested model for an enhanced elder abuse prevention and intervention with a focus on prevention and intervention in financial exploitation cases that can be adapted to urban/suburban and rural environments.	2016
<b>5.17</b>	EAPI initiative will yield appropriate identification of cases for E-MDT review.	2016
<b>5.15</b>	EAPI initiative will yield appropriate identification of cases for Forensic Accountant role in E-MDT review.	2016
<b>5.15</b>	EAPI initiative will yield prompt intervention in complex financial exploitation cases.	2016
<b>5.16</b> <b>5.17</b>	EAPI will yield appropriate strategies for resolution or prevention of co-occurring forms of elder abuse.	2016
<b>5.16</b> <b>5.17</b>	EAPI will yield appropriate strategies for restitution and recovery of lost assets.	2016
<b>5.16</b> <b>5.17</b>	EAPI will yield appropriate prosecution of criminal acts.	2016
<b>5.16</b> <b>5.17</b>	EAPI will yield appropriate referrals to and linkages with supportive services.	2016
<b>5.19</b>	The EAPI initiative will produce a model for collaborative partnerships among elder abuse specialists in aging services organizations, Adult Protective Services forensic accounting, financial institutions, health care, mental health, criminal justice and legal services in order to achieve results in instances of financial exploitation.	2016
<b>5.20</b>	The EAPI will produce a system for data collection and evaluation of the MDT process.	2016
<b>5.22</b>	Results will be disseminated for possible replication	2017

**Goal #6: Ensure the network is prepared to respond in emergencies and disasters.**

**Objectives:**

- 6.1** Ensure that NYSOFA staff is trained and prepared to assist in emergency/ disaster preparedness activities.
- 6.2** NYSOFA will develop protocols for AAAs to inform when there is a service disruption or program closure associated with a weather event, manmade or natural disaster.
- 6.3** Explore the development and implementation of local special needs registry that enhances the ability of local governments to reach out and assist older adults and persons with disabilities during a disaster of emergency.
- 6.4** Ensure all AAAs are included in emergency planning activities.

**Strategies:**

- Provisions of updates on disasters to affected counties and collection of status reports from the AAAs in these areas.
- Ensure that NYSOFA staff are trained in emergency preparedness protocols and NIMS.
- Partnerships with DHSES and Disaster Preparedness Commission, and Area Agencies on Aging.
- Continue assisting DHSES with disaster recovery operations when requested.
- Continue participating on various standing committees and ad hoc work groups when requested.
- Assist in the development of state and local plans for assisting special – needs populations.
- Continue to work with the AAAs in emergency preparedness planning and relief/ recovery efforts.
- Provide services during emergency situations – including home delivered and congregate meals.

<b>Objective</b>	<b>Expected Outcome</b>	<b>Target Date</b>
<b>6.1</b>	All NYSOFA staff will be trained in NIMS	On-going
<b>6.2</b>	Protocols will be developed to inform NYSOFA of program disruptions in event of emergency/disaster	2016
<b>6.3</b>	Exploration of special needs registry will be explored.	2017
<b>6.4</b>	All AAAs will report they are included in local/regional emergency planning activities will increase by 10%	2019

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