

NEW YORK STATE OFFICE FOR THE AGING

2 Empire State Plaza, Albany, NY 12223-1251

Andrew M. Cuomo, Governor

Greg Olsen, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION

Number 12-PI-16 Revised

Supersedes

Expiration Date

DATE: October 19, 2012 (Reissued)

TO: Area Agency on Aging Directors

SUBJECT: Systems Integration Funding Announcement and Grant Application

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ACTION REQUESTED

To apply for Systems Integration Funding for the period of April 1, 2012 to September 30, 2014, Area Agencies on Aging (AAAs) must complete and submit the attached application for funding (Attachment 1), companion workplan (Attachment 2), and annualized line item budget (Attachment 3) to the New York State Office for the Aging (NYSOFA).

RESPONSE DUE DATE

Applications must be submitted electronically to NYSOFA by **November 21, 2012**.

The electronic application must consist of Attachments 1, 2 and 3. In addition, one original signed cover page must be mailed in hard copy. Email and mailing address are as follows:

Email to Celeste Farhart at:

Celeste.Farhart@ofa.state.ny.us

Mail:

Celeste Farhart

New York State Office for the Aging

Two Empire State Plaza, 4th Floor

Albany, NY 12223-1251

PURPOSE

To transmit guidance on the Systems Integration Initiative and provide opportunity for AAAs/NY Connects participation through the submission of a grant application to the New York State Office for the Aging (NYSOFA).

BACKGROUND:

NY Connects: *Choices for Long Term Care* (NY Connects) is New York State's federally recognized Aging and Disability Resource Center (ADRC). NY Connects is statutorily mandated through the New York State Elder Law §203(8) and complies with federal statute as prescribed by the 2006 Reauthorization of the Older Americans Act. Existing in 54 counties, the locally based NY Connects programs are playing an increasingly pivotal role in expanding access to long term services and supports at the community level; having served over a half million individuals and families regardless of age or payor source since the program's inception. In program year October 2010-September 2011, NY Connects provided Information and Assistance to over 200,000 individuals. Almost half of the contacts to NY Connects subsequently received additional assistance with linkages to services. In addition to providing service over the phone or in the office, NY Connects provided almost 15,000 home visits to provide information, assist with applications for services, and help with linkages to services and supports.

Further, local NY Connects programs have consistently provided public education on the availability of the program and the value of future planning for long term needs and have facilitated local Long Term Care Councils (LTCC) charged with initiating tangible reform in many areas of the long term services and supports system. Currently, there are over 1,600 active LTCC members.

By building on the strong foundation established for NY Connects, New York has been able to expand access to long term services and supports for individuals and families through the receipt of additional Federal funding awards to develop and/or expand various areas of focus. These have included consumer directed options through the Community Living Program and Veteran Directed Home and Community Based Services Program; the provision of Options Counseling; targeted outreach and assistance to low income Medicare beneficiaries; respite services across the lifespan for individuals of all ages and disabilities; and evidence-based programs such as the Chronic Disease Self-Management Program and the Care Transitions Intervention. All of these federal funding opportunities have required state awardees to have an ADRC in place and/or be an integral part of the design. The Systems Integration Grants are the most recent federal grant awards that NYSOFA has received as a result of having the NY Connects program in New York State.

In September of 2011, the NYS Office the Aging was awarded two, three year grants from the Administration on Aging (AoA)/Administration for Community Living (ACL) to advance "Systems Integration." New York was one of four states to receive funding. Through this Initiative, NYSOFA will work with local NY Connects programs, AAAs, and regional Alzheimer's Association Chapters to create a more coordinated system that will

inter-connect existing programs and services relative to the “core components” listed below and build “dementia capability” into the NY Connects program infrastructure. To be dementia capable, NY Connects programs must have trained and knowledgeable staff able to screen for cognitive impairment, provide Information and Assistance, make appropriate referrals and linkages, and/or offer Options Counseling on the full range of home and community based services. Under this system, NY Connects will serve as a hub of communication, referral, and linkages to services. As such, the locality must have a NY Connects program to participate.

THE SYSTEMS INTEGRATION INITIATIVE

Core Components

To achieve systems integration, AAAs and NY Connects will formally partner with their local Alzheimer’s Association Chapter to inter-connect systems around specific core components of the initiative. The core components operationalize the Initiative into tangible focus areas of activity. Some components overlap among the AAAs/NY Connects and Alzheimer’s Association networks and others are unique and specific to each network. The core components include the following:

- Information & Assistance on Full Range of Long Term Services and Supports
- Options Counseling
- Dementia Screening
- Care Transitions
- Expanded Capacity for the Chronic Disease Self-Management Program and as appropriate, other approved Evidence-Based/Evidence-Informed Interventions
- Caregiver Supports
- Consumer Directed Services
- Streamlined Eligibility for Public Benefits Access

Local programs will receive extensive guidance from NYSOFA on how and when to address each of the core components.

Grant Implementation Structure

The AoA Systems Integration Initiative is organized into two distinct but inter-related grants labeled as, “Part A” and “Part B”. Part A pertains to, “Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers” and Part B to, “Creating Dementia Capable, Sustainable Service Systems for Persons with Dementia and Their Family Caregivers.” Part A builds on the work of the AAAs and NY Connects programs and Part B on the work of the Alzheimer’s Association Chapters. Each grant has its own set of discrete and unique activities while also inter-connecting through mutual populations served and shared areas related to the previously listed core components. To implement these two parallel and intersecting grants, NYSOFA will phase-in key activities required of both Parts A and B (i.e., of AAAs, NY Connects, and Alzheimer’s Chapters in that region). See attached Local Systems Integration Project Workplan (Attachment 2) and Part A Listing of Key Activities for AAA/NY Connects (Attachment 5).

Available Support and Resources

The Quality and Technical Assistance Center

The Systems Integration Initiative will be supported at the State and local levels by the Quality and Technical Assistance Center (QTAC) that is operated by the Center for Excellence in Aging and Wellness at the State University of New York at Albany.

The QTAC will provide:

- (1) an on-line infrastructure to support communication among project partners;
- (2) webinar capacity to support information dissemination, technical assistance;
- (3) training and a learning community to support the activities of workgroups and facilitate access to systems integration materials;
- (4) data, quality assurance, and evaluation support, including collection of data; and,
- (5) completion of reports.

Throughout the duration of the grant period, AAAs/NY Connects programs will be required to provide requested information to support quality assurance, evaluation and compilation of reports and to attend trainings hosted by NYSOFA and the QTAC. In addition, opportunities and educational forums will be offered for continued education on the core grant components and related topics.

Training topics will address but may not be limited to: Options Counseling and strength-based approaches; services and supports for individuals with dementia and their caregivers; evidence-based and evidence-informed health promotion and wellness programs; care transitions activities; the New York State myBenefits Pre-Screening Website and other strategies to streamline eligibility for public benefits access; consumer directed approaches and available programs; information exchange among partners and across systems; data, reporting, quality assurance, and evaluation; and business planning and sustainability of programming. The majority of training will be provided using webinar technology to reduce burden on participants (e.g., access to archived/previously recorded webinars).

Local Implementation Resources and Opportunities for Input

In addition to participation in QTAC activities, AAAs/NY Connects will be engaged to collaborate with State and local partners on shared areas of work and interest, participate in work group activities, and form partnerships for successful implementation and sustainability of Systems Integration activities. These opportunities will be facilitated by NYSOFA and the Oneida County Office for Aging which will serve as a local implementation administrator/advisor to all participating AAAs/NY Connects. A variety of user-friendly and cost effective formats will be used to support this work, including but not limited to online learning communities, webinars, and web-based training modules. Additional details and guidance will be forthcoming.

Principle Grant Requirements

A. Program Delivery Adjustments and Enhanced Linkages

Participating NY Connects programs will need to adjust or enhance operations to accomplish the following for this grant initiative: expand the scope of Information and Assistance to include specific programs/services related to the core components; formalize the delivery of Options Counseling; implement cross referral mechanisms; modify the NY Connects intake screen; and provide assistance with understanding and/or completing applications for public benefits (when appropriate).

Expanded Scope of Information and Assistance

The provision of Information and Assistance on the full range of long term services and supports has always been a cornerstone of the NY Connects program. Through this grant, additional programs, services, and resources will need to be incorporated into this function to address select core components. These include available Chronic Disease Self-Management Programs and other evidence-based programs, formal care transitions programs that are operating within the community, dementia care programs for individuals and their caregivers, respite and caregiving programs across the lifespan (i.e., regardless of the age of the care receiver), and consumer directed options¹ (as available in your locality).

Options Counseling

All participating NY Connects programs will be required to complete required training, provide Options Counseling as a formal program component, and incorporate forthcoming National Standards on Options Counseling, when issued by AoA/ACL.

Cross Referral

To reflect the collaborations and partnerships required of systems integration, cross referral mechanisms must be developed to support access to: Alzheimer's Association Chapters and their network of programs and services for individuals with dementia and their caregivers; available Chronic Disease Self-Management Programs and other evidence-based programs; existing and newly available care transitions programs; and caregiver supports and consumer directed options, where available. Reciprocally, these programs and providers should be educated on the availability and value of NY Connects and be provided with information on how and when to refer individuals to the NY Connects program.

Dementia Capability

To best meet the needs of the growing population of individuals with dementia and their caregivers, NYSOFA, other state agencies, Alzheimer's chapters, NY Connects, AAAs

¹ Consumer directed programming continues to expand and become available to an increased number of consumers in New York State. NYSOFA has made these options available through the Community Living Program funded by the Administration on Aging/Administration for Community Living, the Veteran Directed Home and Community Based Services funded by the Veteran's Administration, and by incorporating a consumer directed in-home services option under the Expanded In-Home Services for the Elderly Program. Consumer directed programs are also provided by the New York State Department of Health and the Office for People with Developmental Disabilities via Medicaid or Medicaid waiver funding (e.g., Consumer Directed Personal Assistance Program).

and other stakeholders will work together to develop strategies to make the long term services and supports system more dementia capable.

As a first step, NY Connects programs will incorporate select dementia screening elements into the NY Connects intake process to facilitate the delivery of Information and Assistance and make informed referrals to appropriate services and supports. These indicators will be developed with guidance from the Alzheimer's Association and with input from the aging network/NY Connects through voluntary workgroup participation.

Expanded Access to Public Benefits

Through systems integration, NY Connects programs will formally engage in activities to streamline eligibility for public benefits. At minimum, NY Connects programs will provide Information and Assistance on available public benefits programs (e.g., Medicaid, Medicare, food stamps, HEAP), promote the New York State myBenefits pre-screening website (see attachment 9) and offer general assistance with understanding and/or completing Medicaid eligibility applications. NY Connects programs may also provide follow-up to assure applications are completed and submitted, connect with staff in other departments/agencies to ascertain the status of submitted applications, and track the status of completed service connections (i.e., when and which services were authorized/activated).

B. Information Gathering Activities to Support Systems Integration

There will be two distinct grant activities that require the collection and application of local information. The first involves a one-time baseline status update (inventory) relative to the local availability of the core grant components. The second is a longer term process whereby NY Connects programs will update the NY Connects Long Term Care Resource Directory to reflect individual program and provider listings relative to select core components.

Baseline Status of Core Components

NYSOFA and the QTAC will provide guidance and a standardized data collection tool to support this work. The data collection tool will solicit local program and LTCC input on and verification of the status of core components resulting from NYSOFA's review of the following documents: (1) 2012- 2016 Four Year Plan and 2012-2013 Annual Implementation Plan; (2) the NY Connects 2011-2012 Grant Application; and (3) the NY Connects qualitative reporting data submitted by the local AAA/NY Connects. For areas not addressed by this State level review, the tool will collect necessary updates on the status of remaining core components. The results of the assessment will then be used to guide and inform necessary updates to the NY Connects Long Term Care Resource Directory.

NY Connects Long Term Care Resource Directory Updates

As part of the NY Connects program, staff update and maintain local program and provider listings for the NY Connects Long Term Care Resource Directory. To support enhanced cross referral within Systems Integration, NY Connects programs will

participate in the baseline status assessment described above and also conduct a specialized review of listings relative to select core grant components (i.e., Alzheimer's Association programs and services, existing or newly available care transitions programs, Chronic Disease Self-Management Programs, other evidence-based and/or evidence-informed interventions as appropriate/available, consumer directed services, and respite services across the lifespan). NY Connects programs will apply the findings from the baseline status assessment and specialized review of listings to make necessary changes and updates to the Resource Directory as needed.

C. Education and Outreach:

NY Connects programs will utilize grant funding to further promote NY Connects as a community resource for long term services and supports and also conduct public education, marketing, and outreach on the availability of programs and services relative to the core components. Special emphasis must be placed on hard-to-reach and diverse populations, individuals with dementia, and the caregiving population.

D. Data Collection and Reporting

NYSOFA has recently made several new additions and improvements to the NY Connects data collection and reporting system that will capture most of the needed data to reflect Systems Integration activities. These requirements include new demographic data elements, narrative and quantitative reporting on Options Counseling and care transitions, as well as several new topics and categories within the Information and Assistance data report (e.g., health promotion programs such as Chronic Disease Self-Management Programs and other evidence-based programs, dementia services, Options Counseling, assisting with applications for publicly funded services/programs, and assisting with discharges from hospitals). All of these data elements are currently captured within the existing web-based NYSOFA Reporting System (<http://www.reporting.aging.ny.gov/>).

There will also be a limited number of additional reporting specifications to address core grant components not captured within the current system. These include data that are collected as part of the required NY Connects Screening Elements but are currently not reported to NYSOFA and other elements that will be added to the intake/screening process (e.g., dementia indicators). NYSOFA and the QTAC will provide technical assistance and guidance to NY Connects program staff and software vendors as these activities progress. In addition, NYSOFA and/or the QTAC may contact your program with ad hoc data requests and/or to request your participation in sampling studies to support evaluation and compliance with NYSOFA's reporting requirements to the AoA/ACL.

Budget Direction and Use of Funds

The Systems Integration Grant Allocation Schedule (see attachment 4) serves to guide local budget development. The supporting budget schedule pages contained within the Systems Integration Grant Budget automatically calculate the total for each section and also populate these totals into the front Budget Category and Summary page (see

attachment 3). The completed Systems Integration Grant Budget, as part of the grant application, must be consistent with the Standard Assurances and Program Narrative and adhere to the following directions:

1. Allowable costs must be incurred by the AAA during the budget period of April 1, 2012 to September 30, 2014. The budget must be completed relative to this time period. A budget modification is required to NYSOFA if there is a re-allocation of 10 percent of an approved budget line or \$1,000, whichever is greater. Budget modifications can be submitted for approval as needed throughout the duration of the budget period and will follow the same process used for submission and necessary amendment of the NY Connects program budget.

2. Funds are to be used solely for the purposes of the Systems Integration Grant. Local programs are to include personnel costs whenever feasible. It is understood that the fiscal allocation is not intended to cover the total cost of program operations. As a result, a county may individualize the budget to include the appropriate operating expenses of its choice.

3. Subcontractor costs are allowable in the budget. Include type of subcontract and description in the budget (in Supporting Budget Schedule Section 6). A copy of each subcontract or consultant agreement must be submitted to NYSOFA before reimbursement will be made.

4. All Information Technology (IT) costs are to be itemized and explained sufficiently (in Supporting Budget Schedule Section 7) to determine that only the IT costs attributable and allocable to Systems Integration activities are charged to this funding.

5. Allowable costs must be incurred by the AAA and paid before reimbursement claims may be submitted to NYSOFA. Due to the recent implementation of the new Statewide Financial System (SFS), vouchering forms and procedures have changed. The original "State Aid Voucher" has been removed and a new form entitled, "Claim For Payment," has been implemented. Once applications have been submitted and approved, a package containing electronically linked claiming forms with instructions will be e-mailed directly to each AAA. These forms will also be made available on AAARIN.

ATTACHMENTS

- Attachment 1: Systems Integration Application for Grant Funding
- Attachment 2: Local Systems Integration Project Workplan
- Attachment 3: Budget Pages
- Attachment 4: Systems Integration Grant Allocation Schedule
- Attachment 5: Part A: Key Activities Listing for AAA/NY Connects
- Attachment 6: Evidence-Based Program Summary Table
- Attachment 7: Care Transitions Resource Document
- Attachment 8: CDSMP Resource Document
- Attachment 9: Overview of myBenefits Prescreening Website

PROGRAMS AFFECTED:

- | | | | | |
|-------------------------------------------------|----------------------------------------|----------------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Title III-B | <input type="checkbox"/> Title III-C-1 | <input type="checkbox"/> Title III-C-2 | | |
| <input type="checkbox"/> Title III-D | <input type="checkbox"/> Title III-E | <input type="checkbox"/> CSE | <input type="checkbox"/> SNAP | <input type="checkbox"/> Energy |
| <input type="checkbox"/> EISEP | <input type="checkbox"/> NSIP | <input type="checkbox"/> Title V | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP |
| <input checked="" type="checkbox"/> NY Connects | | | | |

CONTACT PERSON: Stacey Agnello

TELEPHONE: 518-474-8976

**New York State Office for the Aging
NY Connects Systems Integration Grant
Application for Funding**

Grant Period: April 1, 2012 - September 30, 2014

Area Agency on Aging: _____

Director: _____

Address: _____

_____ Zip: _____

Phone: (____) _____

Email: _____

Contact person: _____

Phone: (____) _____

The Area Agency on Aging agrees to comply with all applicable State and Federal laws and regulations as well as all of the conditions included in your Annual Implementation Plan and this application for funding as approved.

Name of person authorized to enter into agreement
with the New York State Office for the Aging

Title: _____

Signature of Authorized Person _____ Date: _____

SYSTEMS INTEGRATION GRANT - STANDARD ASSURANCES

The Area Agency on Aging (AAA), as grantee, understands that this Grant Agreement represents the completed grant application of the AAA, as approved by the New York State Office for the Aging (NYSOFA), and the AAA agrees to comply with New York State and Federal laws and regulations that are applicable to this Grant Agreement and to comply with the following requirements that govern the AAAs use of grant funds for the activities funded under this grant:

The AAA agrees that the Application Narrative, Workplan, and Budget, included in this Grant Agreement as approved by NYSOFA, are part of this Grant Agreement and shall not be modified without the written consent of NYSOFA. The AAA shall furnish NYSOFA required supportive documentation for any such changes by utilizing the forms and procedures included in 05-PI-09, Modification Procedures for Grant Applications, dated June 15, 2005.

1. The AAA agrees to fulfill the reporting requirements of NYSOFA under this Grant Agreement. This includes quarterly submission of required reports as prescribed by NYSOFA through the web-based NYSOFA Budget and Reporting system.
2. The AAA agrees that the Grant Agreement may not be assigned by the AAA or its right, title or interest therein assigned, transferred, conveyed, or disposed of without the previous consent, in writing, of NYSOFA.
3. The AAA must submit appropriate state vouchers for reimbursement of expenses incurred in the conduct of this Grant Agreement on a monthly or quarterly basis in such form as required by NYSOFA. The final voucher for expenses incurred in the conduct of this Grant Agreement must be submitted to the Office as soon as possible but no later than thirty (30) days after the ending date of the grant period.
4. The AAA agrees that state vouchers submitted for reimbursement of expenses incurred in the conduct of this Grant Agreement will not include any expenses which have been, or will be, reimbursed from other sources (e.g., other state or federal funds).
5. The AAA agrees to use the funds obtained under this Grant Agreement only for items of expense that are applicable to the activities set out in its Application Narrative and Budget. Allowable items of expense shall be reasonable, allocable, and necessary to carry out the activities described in the Grant Agreement.
6. The AAA understands that the 2006 NY Connects (POE) Program Standards and the Standard Assurances for the current NY Connects Program Year are still applicable and agrees to operate the NY Connects Program in accordance with such Standards and Standard Assurances.
7. The AAA agrees NY Connects staff and other appropriate staff as designated by the AAA will participate in the required training on the core components specified for the Systems Integration Grant.
8. The AAA agrees that the NY Connects program will incorporate dementia screening elements within the NY Connects Screen/Intake form, as prescribed by NYSOFA.

9. The AAA agrees that NY Connects programs will implement Administration on Aging (AoA)/Administration for Community Living (ACL) national standards on Options Counseling, participate in Options Counseling trainings and make linkages to consumer directed services, where available.
10. The AAA agrees to collect information from local stakeholders on the status of availability/ accessibility of individual grant-related core components.
11. The AAA agrees to maintain and at a minimum, annually update the resource listing of local long term services and supports, programs and providers in the NY Connects Long Term Care Resource Directory relative to the core components specified for the Systems Integration Grant. The listings will comply with the NY Connects Inclusion/Exclusion Criteria.
12. The AAA agrees to implement cross referral mechanisms to support the core components including, but not limited to: Alzheimer's Association Chapters and their network of programs and services; available Chronic Disease Self-Management Programs and other evidence-based programs; existing and newly available care transitions programs; and caregiver supports and consumer directed options, where available.
13. The AAA agrees to engage in activities to streamline eligibility for public benefits (e.g., promote myBenefits pre-screening website, provide application assistance, follow up on eligibility determination status, etc.).
14. NYSOFA may terminate the Grant Agreement immediately, upon written notice of termination to the Grantee, if the Grantee fails to comply with the terms and conditions of this Grant Agreement and/or with any laws, rules, regulations, policies or procedures affecting this Grant Agreement.

Systems Integration Grant Application Narrative

Instructions: Please read the descriptions for each section and answer each application question to reflect all activities that will be implemented to fulfill grant requirements. If applicable, include and delineate specific activities that will be accomplished via subcontract as part of each response.

The final section in this Application (question 6) requires you to review and ensure compliance with the attached work plan (attachment 2) that specifies the minimum required activities to be undertaken throughout the duration of the grant period. You may choose to review the work plan document in tandem with your preparation of responses to the sections that follow in the Application Narrative. Responses should be provided relative to the entire grant period, April 1, 2012 – September 30, 2014.

SERVICE CONNECTIONS, COLLABORATIONS AND PARTNERSHIPS:

A core principle of systems integration is to solidify the connection to and among long term services and supports through formalizing or enhancing internal processes/program delivery mechanisms and expanding or enhancing partnerships and collaborations at the community level. The following questions (1-4) address these activities relative to select core grant components.

1. Expanding Access to Public Benefits

Through systems integration, NY Connects programs will be required to formally engage in activities to streamline eligibility for public benefits. Most NY Connects programs already perform this function in various capacities. At minimum through this grant award, NY Connects programs must provide Information and Assistance on available public benefits programs (e.g., Low Income Home Energy Assistance Program (LIHEAP), Medicaid, Medicare Savings Programs), promote the New York State myBenefits pre-screening website (see attachment 9 for additional information), and offer general assistance with understanding and/or completing Medicaid eligibility applications.

Question: Please describe what, if any, role the NY Connects program and/or AAA currently has in providing Information and Assistance, pre-screening, application assistance and/or follow-up with applicant or Local Department of Social Services (LDSS) or other entity designated to assess and determine Medicaid eligibility and/or other public programs. Please specify current partners (i.e., LDSS, third party benefit enrollers), tasks (i.e., provision of information about benefits, assistance in completing applications, and checking for proper documentation) and any tools currently utilized.

Response:

2. **Dementia Capability**

As a result of this grant funding, the NY Connects programs will now formally partner with Alzheimer's Association Chapters to enhance linkages with the dementia network of services in New York State. Many NY Connects programs provide Information and Assistance on available programs and services for individuals with dementia and their caregivers and have relationships with providers of dementia services. Through this grant, all NY Connects programs participating in the Systems Integration Grants will now work more closely with its regional Alzheimer's Association Chapters to enable individuals with dementia and their caregivers to obtain increased access to consumer-friendly information and assistance, available services and programs by interconnecting these systems.

Question: Please describe the existing scope of Information and Assistance that is provided relative to dementia services and programs in your area and if applicable, how Information and Assistance will be expanded for systems integration. Also describe the existing relationship with your regional Alzheimer's Association Chapter that provides services to your county's residents, including if there are any Memoranda of Understanding (MOUs), referral protocols or other formal mechanisms that currently exist. If the relationship is fairly limited, specify encountered barriers and/or proposed strategies that may enhance the partnership going forward.

Response:

3. **Evidence-Based and Evidence-Informed Interventions**

Many NY Connects programs and Area Agencies on Aging serve in various roles and capacities to support evidence-based and evidence-informed health promotion and wellness programming in New York State.

Question: In addition to providing Information and Assistance on these programs, please describe how your AAA and/or NY Connects will work to expand access to the Chronic Disease Self-Management Program and other evidence-based and/or evidence-informed programs (see attachments 6 and 8). Some evidence-based programs are designed for caregivers. If applicable, be sure to address these programs in your response.

Response:

4. **Care Transitions Activity**

Through systems integration, NY Connects programs can contribute to care transitions activity in various capacities and levels of involvement (see attachment 7). At minimum through this grant initiative, NY Connects programs must maintain current and accurate information on available care transitions programs to support Information and Assistance and establish partnerships that support care transitions activity (i.e., serving as an available resource to assist with hospital to home transitions or via partnership in a formal care transitions program such as the Care Transitions Intervention). Partners may include but are not limited to local hospitals, health care providers, Regional Health Information Organizations, academic facilities, and regional coalitions/consortiums.

Question: Please describe how your NY Connects program will expand its knowledge base on care transitions activities that are occurring within your locality, how it will contribute to the expansion of access to care transitions activity in your locality, the partners that you will engage, and by what methods. Please specify any care transitions activities you are currently engaged in and the partners involved.

Response:

SUSTAINABILITY

5. Systems integration requires business planning to consider the best use of existing resources, explore new partnerships, resources and ways of managing programs, and learn how best to position services to increase the ability to sustain programming. There have been previous trainings provided to the AAAs on business planning and additional training will be offered on its application to systems integration within the grant period.

Question: Please describe any relevant business planning training attended and/or activities that have been undertaken to more effectively plan for sustaining programs. In addition to training that will be offered by NYSOFA/QTAC, please describe any activities that are planned in the immediate future (i.e., within the next 12-15 months) to increase your capacity for business planning or/and to advance on-going business planning efforts in your county to better sustain aging services and/or the NY Connects program.

Response:

WORKPLAN

6. Please review and assure compliance with the attached workplan that delineates the activities to be undertaken throughout the duration of the grant period.

Local Systems Integration Project Work Plan

Goal: The goal of this initiative is to ensure that older adults, individuals with disabilities and family caregivers have clear and ready access to a sustainable, integrated system that offers a comprehensive set of high quality, evidence-based services that can help them remain independent and healthy in the community.

Objectives	Key Tasks	Apr-Jun 12	Jul-Sept 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sept 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sept 14	
1. Strengthen and expand NY Connects as a no wrong door point of access to long term services and supports.	a. Information and Assistance: Provide comprehensive, objective information on a range of public and private long term care benefits, services and supports that meet the identified needs of a consumer and assist with linkages to those benefits, services and supports where indicated.											
	b. Public Education: Conduct public education, marketing, and outreach on the availability of NY Connects to hard to reach populations, including individuals with dementia and their caregivers.											
	c. Systems Integration Orientation and Training: Participate in cross training provided by NYSOFA, the QTAC, and the Alzheimer’s Association.											

Objectives	Key Tasks	Apr-Jun 12	Jul-Sept 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sept 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sept 14
	d. Skill Based Training: Participate in required skill based trainings as provided by NYSOFA, the QTAC, and the Alzheimer’s Association Chapters.										
	e. Options Counseling: Implement Options Counseling as a formal component of NY Connects programs.										
2. Assure access to a comprehensive, sustainable set of high quality services relevant to the population residing in the state’s service area.	a. Establish a baseline inventory of available programs and services relative to the core components: Using a NYSOFA/QTAC issued standardized framework, NY Connects program staff and/or the Long Term Care Council will verify and/or collect information from local stakeholders on the status of availability/accessibility of the core components.										
	b. Improve access to the Core Components: Institute cross referral mechanisms to support enhanced access to programs and services relative to the following select core components: Available CDSMPs, Alzheimer’s Association Chapters and services, available Care Transitions programs, caregiver supports, and available consumer directed services.										

Objectives	Key Tasks	Apr-Jun 12	Jul-Sept 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sept 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sept 14
	<p>c. Update the NY Connects Long Term Care Resource Directory: Building on the findings from the NYSOFA/QTAC baseline inventory of core components, NY Connects programs enter applicable new listings of programs and services into the NY Connects Long Term Care Resource Directory (e.g., CDSMP, and Care Transitions programs).</p>										
	<p>d. Dementia Screening Elements: Implement NYSOFA prescribed dementia screening elements within the NY Connects Screen.</p>										
	<p>e. Expand Access to Public Benefits: NY Connects staff engage in activities to streamline eligibility for public benefits. At minimum, staff are able to provide information and assistance on the myBenefits pre-screening website and provide general application assistance on available public programs.</p>										
	<p>f. Expand Access to Evidence-Based (EB)/Evidence-Informed (EI) Interventions: Activities are undertaken to expand capacity in and referrals to CDSMP and other evidence-based programs (as described in grant application narrative response).</p>										

Objectives	Key Tasks	Apr-Jun 12	Jul-Sept 12	Oct-Dec 12	Jan-Mar 13	Apr-Jun 13	Jul-Sept 13	Oct-Dec 13	Jan-Mar 14	Apr-Jun 14	Jul-Sept 14
	g. Data Collection: Implement and maintain required data collection elements for systems integration and submit required reports via the NYSOFA Budget and Reporting system.										
3. Sustain streamlined system integration and infrastructure improvements.	a. Sustainability: With guidance from NYSOFA/QTAC, develop a plan to sustain core components and streamlined access to long term services and supports.										
	b. Expand Public Education to Promote the Availability of the Core Components of the SI Initiative: Conduct public education, marketing, and outreach on the availability of NY Connects program and applicable services/programs related to the core components. Efforts must target hard-to-reach populations with a special emphasis on individuals with dementia and their caregivers.										

**SYSTEMS INTEGRATION GRANT
BUDGET CATEGORY AND SUMMARY**

PLEASE ENTER
ALLOCATION
AMOUNT



AAA: _____

Contract Period: April 1, 2012 - September 30, 2014

Budget Category		Budget Amount
1	Personnel	\$ -
2	Fringe Benefits	\$ -
3	Equipment	\$ -
4	Travel	\$ -
5	Maintenance and Operations	\$ -
6	Subcontractors and/or Consultants	\$ -
7	Other Expenses	\$ -
8	Total Budget (Sum of Lines 1-7)	\$ -

Note: Total budget amount on Budget Summary should equal total budget amount on last page.

SYSTEMS INTEGRATION GRANT Supporting Budget Schedule

AAA: _____

1. Personnel - AAA salaries are listed here. (DSS and other **county** partners' salaries are listed in the subcontract section, as applicable.)

	Complete for Each Position (Name, Title, Location)	Annual Salary	Hours worked on NY Connects per week	Chargeable to the program	
			Total Hours worked per week	% of Time	Amount
1	N				
	T				
	L				
2	N				
	T				
	L				
3	N				
	T				
	L				
4	N				
	T				
	L				
5	N				
	T				
	L				
6	N				
	T				
	L				
7	N				
	T				
	L				
8	N				
	T				
	L				
9	N				
	T				
	L				
10	N				
	T				
	L				
11	N				
	T				
	L				

TOTAL Personnel

Note: If employee is paid a salary, then list the annual salary. If employee is not on salary, then list the hourly rate. When reporting the rate of pay on vouchering forms, the format (i.e., salary or hourly rate) must match this budget (although the actual salary or the hourly rate paid may be different than budgeted).

2. Fringe Benefits- Fringe Benefits should be directly proportional to that portion of personnel costs that are NY Connects related. Provide a clear justification if the expenses are not proportionally allocated.

Fringe Benefit Rate:	%		TOTAL Fringe
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SYSTEMS INTEGRATION GRANT Supporting Budget Schedule

AAA: _____

3. Equipment: List all equipment items whether purchased or leased. For all leased equipment, a copy of the lease agreement must be submitted before reimbursement will be made. Provide a detailed description for all equipment with a unit cost of \$1,000 or more. For equipment with a unit cost of less than \$1,000, list the items and the total for these items under Miscellaneous Equipment.

ITEM AND DESCRIPTION	QUANTITY	UNIT PURCHASE PRICE	ANNUAL RENTAL PER UNIT	AMOUNT CHARGEABLE TO PROGRAM
MISCELLANEOUS EQUIPMENT - LIST ITEMS				
Enter sub-total cost from misc items →				
TOTAL Equipment				

4. Travel: List travel costs. Outline reason for travel and indicate the number of staff traveling	
Mileage: _____ miles @ _____ per mile	
Parking & Tolls	
Public Transportation	
Rental Vehicles (specify destination:)	
Other Travel Costs (specify)	
Reasons for Travel:	
TOTAL Travel	

SYSTEMS INTEGRATION GRANT Supporting Budget Schedule

AAA: _____

5. Maintenance & Operations (in the space provided, detail each expense)

Equipment Maintenance and Repair:			
Postage:			
Printing & Photocopying:			
Rent: For "% charge to Prg" below, enter the percentage as a whole number (e.g., enter 5 for 5%, do not enter .05)			\$ -
_____ (Monthly rent)	_____ (% charge to prg)	_____ (No. of months)	
Location:			
Owner:			
Supplies:			
Telephone:			
Utilities:			
TOTAL Maintenance and Operations			\$ -

SYSTEMS INTEGRATION GRANT Supporting Budget Schedule

AAA: _____

6. Subcontractors/Consultants: List each subcontractor or consultant and amount below. A copy of each subcontract or consultant agreement must be submitted to NYSOFA before reimbursement will be made. Complete and submit a Subcontractor Supporting Budget Schedule for each subcontractor that will receive 25% or more of your grant amount. For Consultants, please list unit rate (e.g., \$25 per hour) and Number of Units in the columns provided. (Note: If you hire a translator, language and/or sign interpreter, include the expense here.) DSS or other county partners' salaries are to be listed in this section.

Subcontractor/Consultant and description of service (List them individually)	# of Units (Consultant)	Total
TOTAL Subcontractors/Contractors		

7. Other Expenses: List specific item and cost.

Itemize all Public Education costs. Promotional materials in the form of informational brochures and the like are acceptable expenses. The cost of "give aways" cannot exceed \$500.

Itemize all Information Technology (IT) costs and provide a justification. This includes such things as the number of licensing user fees, for whom and associated cost, licensing agreement amount, maintenance cost, reporting upgrading fees and/or, NY Connects website costs. An itemized bill from the vendor will be accepted as documentation, as long as it breaks out the costs appropriately.

Public Education:

Information Technology:

Other (Specify):

TOTAL Other		

8. Total Budget: (numbers 1-7)

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New York State Office for the Aging
Systems Integration Grant: Area Agencies on Aging Partners

Allocation Schedule - Part A
April 1, 2012 - September 30, 2014

<u>County</u>	<u>Allocation</u>
Albany County	\$53,000
Allegany County	36,800
Broome County	36,800
Cattaraugus County	36,800
Cayuga County	36,800
Chautauqua County	36,800
Chemung County	36,800
Chenango County	36,800
Clinton County	36,800
Columbia County	36,800
Cortland County	36,800
Delaware County	36,800
Dutchess County	53,000
Erie County	64,000
Essex County	36,800
Franklin County	36,800
Fulton County	36,800
Genesee County	36,800
Herkimer County	36,800
Jefferson County	36,800
Lewis County	36,800
Livingston County	36,800
Madison County	36,800
Monroe County	64,000
Montgomery County	36,800
Nassau County	64,000
Niagara County	36,800
Oneida County	53,000
Onondaga County	64,000
Ontario County	36,800
Orange County	64,000
Orleans County	36,800
Otsego County	36,800
Putnam County	36,800
Saratoga County	36,800
Schenectady County	36,800
Schoharie County	36,800
Schuyler County	36,800
St. Lawrence County	36,800
St. Regis Mohawk	10,500
Steuben County	36,800
Suffolk County	64,000
Sullivan County	36,800
Tioga County	36,800
Tompkins County	36,800
Ulster County	36,800
Washington County	36,800
Wayne County	36,800
Westchester County	64,000
Wyoming County	36,800
Yates County	36,800
Grand Total	<u>\$2,089,500</u>

March 29, 2012

Systems Integration Grant

Part A: Listing of Key Activities for Area Agencies on Aging (AAA)/NY Connects

1. **Local Stakeholder Input:** NY Connects Long Term Care Councils (LTCCs) use a NYSOFA/QTAC developed standardized framework to collect information from local stakeholders on the status of availability/accessibility of individual grant-related core components.ⁱ
2. **Dementia Screening Elements:** NY Connects programs incorporate dementia screening elements within the NY Connects Screen/Intake form.
3. **Evidence Based (EB)/Evidence Informed (EI) Interventions:** NY Connects programs work to expand capacity in Chronic Disease Self-Management Program (CDSMP) and other evidence based programs, as determined by NYSOFA.
4. **Cross-Training and Dementia Capability:** NY Connects programs participate in cross-training on core components with corresponding Alzheimer's Association (AA) Chapters to integrate systems and increase dementia capability.ⁱⁱ
5. **Inventory:** NY Connects programs inventory local programs and services relative to the core components for inclusion in the NY Connects Long Term Care Resource Directory.
6. **Access to Public Benefits:** NY Connects programs engage in activities to streamline eligibility for public benefits (e.g. promote myBenefits pre-screening website, provide application assistance).
7. **Options Counseling Delivery:** NY Connects programs implement Administration on Aging (AoA)/Administration for Community Living (ACL) national standards on Options Counseling and make linkages to consumer directed services, where available.
8. **Options Counseling and Care Consultation Collaboration:** NY Connects programs and AA Chapters work to better understand the strengths of existing Options Counseling and Care Consultation efforts, support cross referrals, find areas for further collaboration and through cross training extend such options throughout the State.
9. **Cross Referral:** NY Connects have cross referral mechanisms embedded within programming to support the core components (e.g., referrals to CDSMP, AA Chapters, available Care Transitions programs).
10. **Education and Outreach** NY Connects programs conduct public education, marketing, and outreach to hard-to-reach populations, including individuals with dementia, on availability of core components, and to expand NY Connects as a central point of access to community services.
11. **Data Collection** NY Connects programs collect and submit data on activities and outcomes as specified by NYSOFA/QTAC.

ⁱ **Core Components of Systems Integration Grants (Across NY Connects and AA Chapters):** Information & Assistance on Full Range of Long Term Services and Supports; 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 care for individuals with dementia); Consumer Directed Services; and Streamlined Eligibility for Public Benefits Access

ⁱⁱ “Dementia capable” includes: 1) trained and knowledgeable staff able to screen for cognitive impairment and to offer information and assistance; and, 2) a full range of home and community based services consistent with “The Resources for Individuals and Families Toolkit.”

Evidence-Based Health Promotion Program Summary Table

General Health and Wellness	Physical Activity	Falls	Nutrition	Mental Health/Addictions	Medication Management
**Enhance Wellness http://www.projectenhance.org/	*Active Living Every Day http://www.humankinetics.com/ppALED	*A Matter of Balance http://www.mainehealth.org/mh_body.cfm?id=432	Eat Better, Move More http://nutritionandaging.fiu.edu/You_Can/07.2YouCanGuidebook.pdf	**Healthy Ideas http://www.healthyagingprograms.org/resources/ReplicationReport_HealthyIDEAS.pdf	**Medication Management Improvement System http://www.homemeds.org/
*Stanford University based Chronic Disease Self-Management Programs (CDSMP) http://patienteducation.stanford.edu/programs/cdsmp.html	Eat Better, Move More http://nutritionandaging.fiu.edu/You_Can/07.2YouCanGuidebook.pdf	Step-by-Step http://www.healthysanbernardinocounty.org/modules.php?op=modload&name=PromisePractice&file=promisePractice&pid=508	**Healthy Eating for Successful Living for Older Adults http://www.healthyagingprograms.org/content.asp?sectionid=72&ElementID=311	*PEARLS-Program to Encourage Active, Rewarding Lives for Seniors http://www.pearlsprogram.org/	
	*Enhance Fitness http://www.projectenhance.org/	**Stepping On http://www.dhs.wisconsin.gov/aging/CDSMP/SteppingOn/index.htm	*Healthy Eating Everyday http://www.humankinetics.com/ppHEED	**Prevention & Management of Alcohol Problems in Older Adults: A Brief Intervention http://www.healthyagingprograms.org/content.asp?sectionid=71&ElementID=338	
	**Healthy Moves http://www.picf.org/landing_pages/22.3.html	**Tai Chi: Moving for Better Balance http://www.arthritis.org/tai-chi.php			
	**Fit and Strong http://www.fitandstrong.org/				
Other:	Other:	Other:	Other:	Other:	Other:

*Programs where there has been a concerted effort in NYS to build capacity and experience around the delivery of the program.

** Programs that are Administration on Aging (AoA)/ Administration for Community Living (ACL) pre-approved or recognized evidence-based disease prevention (EBDP) programs.

Ways in Which Area Agencies on Aging (AAAs)/NY Connects May Support Care Transitions

What are Care Transitions?

- Care transitions refer to the shift experienced by individuals from one provider or setting to another (e.g., from hospital to home or nursing home, or from a facility to home with services and supports).
- There are several evidence-based models currently in practice within health and human services settings. Please refer to the summary table below for details on the most commonly implemented programs across the country.
- Transitions for individuals with chronic disease are often prone to errors as a result of poor communication and coordination between providers, medication discrepancies, lack of follow up, and so forth.
- Older adults will experience up to 13 million transitions across the continuum of care every year, making them especially at-risk for poor quality care and potential rehospitalization.

The Aging Network plays an essential role in ensuring safe transitions for older adults. There are several ways in which AAAs/NY Connects programs may support care transitions programs:

Establishing referral pathways: create and support seamless referral pathways that provide a bridge between the acute and long term care communities, (i.e., Formal Agreements/ Memorandums of Understanding).

Collaboration with hospitals and discharge planners: establish or enhance existing partnerships with local hospital discharge planners so they are aware of the importance of the Aging Network and the services and supports it provides to keep older adults safe in the community.

Connect with existing care transitions programs: survey communities to increase awareness of existing care transitions activities and establish or enhance partnerships to assist in the delivery of care transitions (i.e., Community Based Care Transition Program/Section 3026 partnerships).

Educate consumers: provide public education on the availability and importance of care transitions.

Capitalize on learning opportunities: participate in care transitions educational opportunities and networking sessions as available.

Evidence Based Care Transitions Models Side by Side

The following tables detail four hospital-to-home care transitions models and two models of care coordination that center on primary care. The ADRC Technical Assistance Exchange (TAE) gathered the information presented here through a review of published articles about each model, a review of materials used in each model, and interviews with the founders of the models.

The models share the following elements:

- Interdisciplinary Communication/Collaboration
- Patient/Participant Activation
- Enhanced Follow-up

These tables can be accessed online at

http://aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/toolkit/docs/AOA_080_Chart6_ExEvidBasedCare.pdf

Hospital-to-Home Transitions Models

Model	Care Transitions Intervention (CTI, commonly called the “Coleman Model”)	Transitional Care Model (TCM, commonly called the “Naylor Model”)	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
Short Description	<p>Transition Coach helps patients and families learn transition-specific self-management skills by:</p> <ul style="list-style-type: none"> • Conducting a hospital visit to introduce the program and tools such as the Personal Health Record (PHR) • Conducting one home visit 24-72 hours post-discharge <ol style="list-style-type: none"> 1. Actively engages patients in medication reconciliation and how to respond to medication discrepancies; helps them develop a clear, easily understandable medication regimen and enter into Personal Health Record 2. Uses role-playing and other tools to transfer skills to patients and family members on how to communicate care needs effectively during encounters with health care professionals 3. Reviews any “red flags” that indicate a worsening condition, and strategies for how to respond <ul style="list-style-type: none"> • Making three follow up phone calls focused on reviewing the progress toward established goals, discussing any encounters with other health care professionals, reinforcing the importance of maintaining and sharing the personal health record, and supporting the patient’s self-management role 	<p>• Transitional Care Nurse:</p> <ul style="list-style-type: none"> • Visits patient in the hospital to: <ol style="list-style-type: none"> 4. Conduct an in-hospital assessment (including the patients’ functional status) 5. Collaborate with care-team members to reduce adverse events and prevent functional decline 6. Develop a streamlined, evidenced-based plan of care • Conducts home visit within 24 hrs of discharge to assess safety in completing ADLs and IADLs, recommend adaptations to the environment, and refer to other services • Accompanies patient on first visit with the physician post-discharge and subsequent visits if needed • Facilitates physician-nurse collaboration across episodes of care • Conducts weekly home visits for first month • Makes telephone contact for each week an in-person visit is not scheduled • Is on call seven days per week for home visits and telephone access • Provides active engagement of patients and family caregivers with focus on meeting their goals • Provides communication to, between, and among the patient, family caregivers, and health care providers. 	<p>BOOST includes specific interventions to mitigate high risk patients’ risks for adverse events:</p> <ul style="list-style-type: none"> • A standardized discharge process • Efforts to improve patient/caregiver preparedness • Medication safety • Follow-up care <p>Tool for Addressing Risk: a Geriatric Evaluation for Transitions: TARGET is a 4-part tool that includes:</p> <ul style="list-style-type: none"> • Risk stratification process using eight elements • Risk-specific intervention plan linked to the 8P risk score summary • Universal set of expectations for all patients being discharged from the hospital to home (the Universal Checklist) • General Assessment of Preparedness (GAP), a component list of issues important to providers and patients (and their caregivers) surrounding the readiness of patients for transition out of the hospital 	<p>A hospital-based social work model designed for older adults discharged home from an inpatient hospital stay to safely transition back to the community by providing:</p> <ul style="list-style-type: none"> • Intensive care coordination that starts in the hospital and continues after discharge to the community • Aging Resource Centers (ARC) inside hospitals that provide a dedicated space for older adults and their caregivers to explore community resources, health information and caregiving materials, and to develop community care plans prior to discharge. <p>Pre-discharge: Bridge Care Coordinators (BCCs) identify older adult patients who may be at risk for post-discharge complications and meet with them and/or their caregivers to identify unmet needs and to set up services prior to discharge. BCCs also prepare for discharge by reviewing medical records or meeting with an interdisciplinary team within the hospital.</p> <p>Post-discharge: BCCs call consumers 2 days after discharge to conduct a secondary assessment and intervene on identified needs, including understanding discharge instructions, transportation issues, physician follow-up, burdened caregivers, problems with home health care, difficulty obtaining and/or understanding medications.</p> <p>Follow-up: The BCC follows up with consumers at 30 days post-discharge to track their progress and address emerging needs.</p>

Hospital-to-Home Transitions Models, continued

Model	Care Transitions Intervention (CTI, commonly called the “Coleman Model”)	Transitional Care Model (TCM, commonly called the “Naylor Model”)	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
Target population	<p>Individuals 65 years or older, although applicable to younger populations as well. Patients should be community-dwelling adults with a working telephone. Appropriate for persons with depression or dementia provided they have a willing and able family caregiver.</p>	<p>Evaluation included cognitively intact older adults (program tested with patients 65 or older) with two or more risk factors among the following:</p> <ul style="list-style-type: none"> » Poor self-health ratings » Multiple chronic conditions » History of recent hospitalizations. <p>Currently being tested among cognitively impaired hospitalized older adults and long-term care recipients transferring to and from acute care hospitals</p>	<p>High-risk patients, particularly older adults</p>	<p>Older adults age 60+ years (and their caregivers) discharged home from the hospital, and who fulfill two of the following criteria:</p> <ul style="list-style-type: none"> » Discharged with a home health referral » Lives alone » Hospitalized in the past 6 months » Caregiver assessed as “stressed” or “overburdened” » Determination of need (DON) of 29 or higher
Length	<p>Four weeks</p>	<p>One to three months</p>	<p>During hospital stay with outpatient follow-up visit and or a 72-hour follow-up call for particularly high risk patients</p>	<p>During hospital stay and 30 days post-discharge</p>
Training	<p>In order to ensure model fidelity to achieve desired outcomes, to be recognized as an official Care Transitions Intervention, staff must attend a one-day training delivered either on-site or in Aurora (Denver)</p>	<p>The team at University of Pennsylvania has developed a series of web-based training modules that prepare nurses to become Transitional Care Nurses, as well as training on the clinical information system. It takes, on average, one month to orient a new Transitional Care Nurse.</p>	<ul style="list-style-type: none"> • 2 day training session for quality improvement teams to learn about the intervention, exchange ideas with other sites and work with their mentor to establish an action plan • Participation in the web-based BOOST National collaborative • Teach-Back training, video and curriculum for local use to train clinicians to improve communication with patients. 	<p>Bridge Training Module</p>

Hospital-to-Home Transitions Models, continued

Model	Care Transitions Intervention (CTI, commonly called the “Coleman Model”)	Transitional Care Model (TCM, commonly called the “Naylor Model”)	Better Outcomes for Older Adults through Safe Transitions (Boost)	The Bridge Program
Staff Qualifications	Transition Coach needs strong interpersonal and communication skills, the ability to make the shift from doing things for patients to facilitating skill transfer so that patients can do more for themselves.	Transitional Care Nurse in published studies was an advanced practice nurse (had a masters degree in nursing with advanced knowledge and skills in serving older adults). Currently evaluating outcomes with bachelors-prepared nurses.	Hospital-based multidisciplinary teams	Master’s prepared social workers deployed at hospitals
Estimated costs	From research study: The total annual intervention cost was \$74,310 (\$196 per patient)	From research study: The total annual intervention cost was \$115,856 (\$982 per patient)	NA	NA
Website	http://www.caretransitions.org	http://www.transitionalcare.info/	http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/03BestPrac/03_Literature.cfm	www.transitionalcare.org

The Chronic Disease Self-Management Program (CDSMP)

There are several evidence-based programs for which the Administration on Aging (AoA)/Administration for Community Living (ACL) has provided funding in the past with a goal of developing infrastructure within the aging network to better support widespread availability. For more information on how AoA/ACL defines evidence-based and on its commitment to self-management programs see:

http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Title_IIID/index.aspx and http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Evidence_Based/index.aspx.

These evidence-based programs include the various forms of the Chronic Disease Self-Management Program (CDSMP). As well as the CDSMP program itself, delivery options include Tomando Control (a cultural translation of CDSMP), the Diabetes Self-Management Program (DSMP and DSMP-S), and the Arthritis Self-Management Program.

The basic delivery approach for CDSMP programs is:

- A six week workshop, 2 ½ hour per week co-led by two trained “peer” leaders (someone who themselves has a chronic condition and who may be a staff member, a volunteer peer or both);
- Offered in the prescribed manner consistent with training and leaders manual;
- Provides an interactive learning environment in which participants can practice and master self-management techniques; and,
- Provides information on general health topics affecting persons with a variety of chronic conditions.

Consistent with the goals of the Systems Integration Grant to make evidence-based programs available to at least fifty percent (50%) of the State, Area Agencies on Aging(AAAs) are encouraged to work with existing partners to support existing capacity or help develop new capacity in the CDSMP offerings.

Contact the NYS CDSMP Quality & Technical Assistance Center by email at QTAC@albany.edu or by phone at (518) 442-5530 for information about existing CDSMP resources in your county and region.

ROLES for AAAs

AAAs may participate in offering, supporting and building CDSMP resources in the following ways:

Training master trainers: Assigning one or more AAA staff or including in subcontracts with providers for one of more of their staff to attend a 4.5 day training to become a

master trainer in CDSMP. After March 2012 there will be an annual opportunity to train new master trainers.

- AAA/contractor would cover all travel costs for their attendees.
If successfully trained, AAA/contractor would agree to release that staff member from other duties to:
- co-lead two six week workshops (2 ½ hour per week) within six months of training (to complete requirements)
- offer a four day leader training at least once a year for up to 16 potential leaders (maintains certification).

Costs of leader training would be covered by AAA/contractor or shared with other participating agencies.

Training leaders (staff and/or volunteers): Recruiting staff and/or volunteers to attend a four day leader training.

If the person is successful in the training, AAA/contractor would then support their leading

- two six week workshops (2 ½ hour per week) within six months of the training, and
- at least one workshop annually thereafter (maintains certification).

Recruitment & Referral: organizing six week workshops for at least 12 people with chronic illnesses including early stage dementia and/or their caregivers and/or referring persons with chronic illnesses including early stage dementia and caregivers to CDSMP workshops in the area being held by other organizations.

Providing a site for the program: hosting workshops (whether led by AAA staff or by others) on Chapter premises. This would include managing workshop logistics.

Offering reimbursement for respite and/or transportation costs: Supporting participants in CDSMP workshops with consumer-directed respite, escort or transportation.

Working with QTAC to ensure fidelity and collection of related data: assign a staff person to ensure collection and forwarding of questionnaires at the beginning and end of each workshop.

myBenefits

myBenefits

The vision behind *myBenefits* is to provide a single internet portal for New York State's families and community partners to connect with benefits, services and work supports – an e-government hub for health and human services. Ultimately, myBenefits will allow individuals and families to learn about and apply for an array of programs, customized to fit their unique circumstances, by answering one set of simple questions online.

The *myBenefits* site was launched on May 30, 2008 at the internet site www.myBenefits.ny.gov. The first component was an internet self-screening tool to determine potential eligibility for a number of work support programs, based on entry of minimal, anonymous household information. More than 740,865 users (an 89% completion rate) have completed prescreenings for food stamps, earned income tax credits, Home Energy Assistance Program (HEAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), free and reduced price school meals, Temporary Assistance (TA), Medicaid, Family Health Plus, Child Health Plus, the Elderly Pharmaceutical Insurance Coverage (EPIC), HealthyNY and other programs; over 80% of users are eligible for at least one program. The pre-screening component also provides a self-sufficiency calculator to illustrate the value of work and work supports.

New York residents can choose to apply online for food stamp benefits through *myBenefits*. More than 211,535 public internet e-applications have been submitted – in many districts, over 30% of all food stamp applications. The online option offers program access outside Local Departments of Social Services (LDSS) business hours (40% of e-apps) and reaches families who meet the food stamp Working Families criteria (33% of e-apps). Also, in 30 districts, community partners have facilitated some of the on-line food stamp applications through myBenefits, and assisted applicants to gather and submit verification of their eligibility. Recipients of food stamp benefits can view information about their case through myBenefits, and use printouts of that information to prove their eligibility for programs including free school meals, WIC and subsidized housing. In November 2011, we began piloting online applications for Home Energy Assistance (HEAP) and, in 2012, will pilot online recertifications for temporary assistance and food stamps, and online reporting of changes in household circumstances.

Each future version of myBenefits adds functionality to promote work supports and ease processing tasks for the worker. Examples of future enhancements include the following:

- Add new programs to the myBenefits pre-screening;
- Add six additional languages to the myBenefits prescreening, e-application and e-recertification; and,
- Allow myBenefits users to submit images electronically as attachments to applications, recertifications, and undercare changes; with myWorkspace documentation tracking, this will streamline the verification process. Barcoded forms for onsite scanning will further streamline document management.