New York State Plan on Aging

2011-2015

New York State
OFFICE for the AGING

A Message from the Acting Director

Dear Colleague in Aging:

Governor Andrew Cuomo and I are pleased to present the New York State Plan on Aging for the period October 1, 2011 – September 30, 2015. The New York State Office for the Aging (NYSOFA) is a leader in working to address diverse challenges and promote opportunities inherent in dynamic population change. Our broad-based affiliations and partnerships are helping us to plan, develop and implement innovative programs and services, strengthen our core programs and develop strategies that assist older New Yorkers to age successfully in their communities, support caregivers, promote volunteerism and civic engagement and help communities plan for their own unique demographic change drivers.

It is our mission as the State Office for the Aging, in partnership with the network of public and private organizations that serve our older population, to assist older New Yorkers to be as independent as possible for as long as possible through delivery of high quality, person- and family-centered, cost-effective programs and services. Our efforts to address the challenges presented by a growing older population are rooted in the deepest principle of our aging services philosophy: to promote the independence of older adults by serving them – where they want to be served and where it is most cost-effective to serve them – in their homes and communities. NYSOFA takes this mission very seriously and we will continue to work at the community, county, State and federal levels to ensure that the voices of our constituents and their families are integral to our program and policy development.

The area agencies on aging and network of aging service providers have done a tremendous job in leveraging resources, stretching their dollars, developing innovative ways to provide services and developing and strengthening community partnerships to help them carry out their work. The longstanding history of the network to provide cost-effective and quality services that help older adults remain independent is becoming more and more recognized for its value. Over the past few years, the Administration on Aging (AoA), in partnership with the Centers for Medicare and Medicaid Services (CMS) has empowered the aging network across the country to test new models of care and strengthen partnerships with the medical community. We have developed programs that prevent Medicaid spend-down and nursing home placement, reduce preventable hospital readmissions, strengthen caregiver and respite services, teach older adults how to manage chronic conditions, provide services to our veterans, combat Medicare fraud, provide intensive options counseling for long-term care and strengthen our NY Connects: *Choices for Long Term Care Program* (New York's federally recognized Aging and Disability Resource Center {ADRC}). The recognition of the role of the aging network in health and long-term care is becoming more evident by the innovative work we are being asked to pilot and the requirement of broad-based partnerships.

Our Four Year Plan is designed to guide our service-delivery and policy development system, form the basis for restructuring policies, and serve as a benchmark for our work to assure our

accountability. While NYSOFA has been charged with the development of this plan, the Office has sought input from the Area Agencies on Aging, consumers, service providers, and educators, among others. NYSOFA's goals are to use the Plan as a management tool to guide our work and priorities. I wish to thank the many groups and individuals across the state who contributed to the Plan, and invite their continued involvement as we work together to respond to the many challenges and opportunities in the years ahead.

Greg Olsen, Acting Director
New York State Office for the Aging

Executive Summary

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. 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 of daily living. While there are many challenges in the coming years related to the growth of the older population, there are tremendous opportunities to utilize the strengths and skills of older adults to help address problems and to be leaders in helping communities implement changes to make communities more livable.

The New York State Office for the Aging's (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. 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 to maximize their ability to age in their community and avoid higher levels of care and publicly financed care. Older Americans Act core programs addressed in the Plan include:

Transportation - Transportation is a critical component in the array of access services provided by the Area Agencies on Aging (AAAs) and their local partners in New York State. The New York State Office for the Aging's policies on transportation support the intent of the *Olmstead v L.C.* Supreme Court decision to maximize opportunities for older people and people of all ages with disabilities to live in their own homes and to be able to access the wider community.

Information and Assistance - By providing information through the Aging Network regarding relevant programs and services, including long-term care, that meet specific needs and/or by reviewing and addressing complex situations, older New Yorkers and their caregivers are able to become connected and able to more efficiently access vital supports in their community.

NY Connects: *Choices for Long Term Care* (NY Connects) - NY Connects is a locally based point of entry system that provides one stop access to free, objective and comprehensive Information and Assistance on long-term care options.

Case Management - Case management is at the center of wellness and autonomy for older adults. Person-centered case management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an older person's health and human service needs.

Legal Assistance - Older adults are confronted with many legal problems and issues. Both the breadth of issues and the changing demographic profile make the need for legal services more critical than ever before.

Supporting Aging in Place - Significant demographic, public policy, economic, environmental, and social "change-drivers" are transforming both the resident profiles of New York's communities and the circumstances and conditions under which communities are planning and implementing the tasks and activities that affect a residents' quality of life. The New York State Office for the Aging's Livable New York is a statewide initiative to develop tools to help

communities' better plan for the needs of their older adults, people of all ages with disabilities, families, and caregivers.

Nutrition Program for the Elderly - The nutritional needs of older adults become more critical with advancing age, especially when recuperating from acute and chronic health problems. 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, nutrition education, nutrition counseling and related services, and healthful foods.

Disease Prevention and Health Promotion Services - Since the introduction and increased promotion of Medicare preventive and screening benefits, the New York State Office for the Aging has worked to increase consumer awareness and use of these benefits among New Yorkers. The Affordable Care Act provides even more opportunities to improve the overall health of older New Yorkers by expanding coverage for many prevention benefits.

Supporting Caregivers - Informal caregivers are an invaluable resource for their loved ones and play a primary role in helping them to remain independent and avoid more intensive, higher levels of care. AARP estimates that the value of this unpaid care, if purchased at the market rate, would be about $25 billion per year. New York's Area Agencies on Aging provide a multifaceted system of support services for informal caregivers of older people, as well as for grandparents and other older relatives caring for children.

Civic Engagement and Volunteerism - Research shows a strong relationship between volunteering and health and wellness: those who volunteer have lower mortality rates, greater functional ability, and lower rates of depression later in life than those who do not volunteer. 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.

Community Involvement - 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.

Enhancing Older Americans Act Core Services

Lifespan Respite Grant Program - New York is one of twelve states awarded a Lifespan Respite grant to develop and enhance coordinated, accessible, community-based respite care programs to family caregivers of children or adults of all ages with special needs.

Evidence-Based Disease and Disability Prevention Grant Program - More than 80 percent of New York State residents age 60 and older have one or more chronic diseases. The New York State Office for the Aging, the New York State Department of Health and the State University of New York at Albany's Center for Excellence on Aging and Community Wellness are working to make available self-management programs statewide.

Aging and Disability Resource Center (ADRC) Grant Programs - The purpose of the grant is to develop a care transitions program to facilitate smooth and effective transitions from hospital to home. This ADRC grant is being implemented in two NY Connects counties to standardize NY Connects' Long Term Care Options Counseling service, and develop a Consumer Supports Navigator Program which are the key components in achieving the grants objective.

Evidence-Based Care Transitions Model: Care Transitions Intervention℠ - The program will serve a population of older adults diagnosed with a chronic disease who are currently in the

hospital or have recently been discharged, as well as their caregivers. The reduction in preventable re-hospitalizations will result in lower health care costs, improved quality of care, increased patient satisfaction, support for caregivers, and skills for future self advocacy.
Community Living Grant Program - The program helps those individuals at imminent risk of nursing home placement and Medicaid spend-down to maintain their independence and remain in their communities by offering consumer directed models of care.
Veterans Directed Home and Community-Based Services Program - The program strives to keep veterans of all ages who are at-risk of nursing home placement in their homes by giving them more control over the services and goods they receive. Under this program, qualified veterans can hire whomever they choose to provide personal care services, as long as the person is not legally or financially responsible for the veteran.

Effective and Responsive Management

Data Quality, Collection, and Analysis - Reliable data about customers served, services provided, and expenditures are essential in a well-managed, cost-effective network of services for older adults. Equally important, information about customer needs and preferences enables service providers to tailor programs and care plans to meet the unique requirements of the customers.
Equal Opportunity, Diversity Management - The New York State Office for the Aging's revised targeting policy and targeting efforts for 2011-2015 will focus on strengthening the statewide Network's capacity to serve the diverse populations of New York State.
Intergovernmental Collaboration - The New York State Office for the Aging has formalized relationships with other State agencies to address cross-agency issues that will help older adults be served in program areas that traditionally are not under the direct purview of the Agency, such as mental health, alcohol and substance abuse, developmental disabilities, etc.
Emergency Preparedness - The involvement of various levels of government is necessary in order to adequately prepare for, prevent, and respond to emergencies and declared disasters, including floods, fires, ice storms, flu epidemics, or acts of terrorism.

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 articulates measurable outcomes that can be achieved given the Agency's present resources. 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. Throughout, the State Plan focuses 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.

Verification of Intent

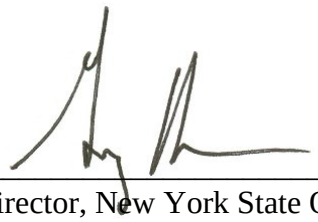
I hereby authorize the New York State Office for the Aging, as the designated State Unit on Aging for the State of New York, to develop a state plan, submit it to the Assistant Secretary for the United States Administration on Aging for approval, and administer such plan upon approval.

Date: July 1, 2011

Andrew M. Cuomo, Governor
State of New York

The State of New York, Office for the Aging, hereby submits the New York State Plan on Aging for the period October 1, 2011 to September 30, 2015 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.



Greg Olsen, Acting Director, New York State Office for the Aging June 27, 2011

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Introduction

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 the elderly 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) 2011-2015 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 three focus areas:

- Older Americans Act Core Programs,
- AoA Discretionary Grants, and
- Consumer Control and Choice.

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.

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 2010, 33 counties had populations where older people (aged 60 and over) constituted less than 20 percent of the total population; by 2020, 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. Overall, the state population is projected to be over 23 percent older people, compared to the national projection of 22 percent in 2020 (see data note 1).

New York State
62 Counties
Change in Population Aged 60 and Over
2010 to 2020

Proportion of County Population Aged 60 and Over	Number of Counties with Specified percent of Older Persons	
	2010	2020
Less than 20%	33	4
20% to 24%	26	32
25% to 29%	1	22
30% and over	2	4

Source: Woods & Poole Economics, Inc., 2011 State Profile (see data note 1)

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 high fertility rates of the State's large and expanding ethnic populations have shaped New York's population and will continue to do so in the future.

New York's total population is over 19 million individuals, and with 3.7 million individuals aged 60 and older, the State ranks third in the nation in the number of older adults. 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 2008 American Community Survey, nearly 22 percent of the population is foreign-born, with 29 percent of the population speaking a language other than English at home.

Racial/Ethnic Diversity and Foreign Immigration

Over the last decade, 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.

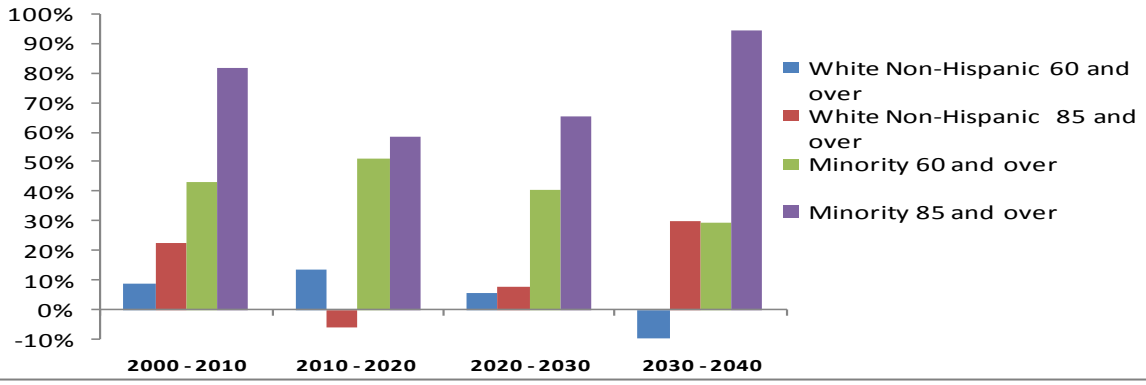
Over the last decade, the minority population aged 60 and over grew by 43 percent, compared to 8 percent for the non-minority population. This high growth rate will continue over the next three decades:

- 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.

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.

Projected Growth of the Minority and Non-Minority Population in New York State 2000 to 2040



Source: Woods & Poole, 2009

(See data note 2)

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 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 make an interstate move during a five year period, 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 the local economy. Further, there is a loss of skilled and experienced community volunteers/workers, and community-based caregivers. 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, or their 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 the 20 percent level, the official poverty rate among older adults is 13 percent nationally, and 18 percent in New York State (CPS, 2007) (see data note 3). Although pockets of poverty remain, for example, among older women living alone, the overall picture is one of good progress.

In many ways, New York is a study in contrasts. In terms of income, the State's 2005 median household income was $49,480; yet, 14.5 percent of the population was living in poverty. While economic security is a reality today for more older people than perhaps ever before, 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 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.

Health care costs disproportionately impact older persons and increase with the onset of chronic health conditions as they age. While more elders 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.

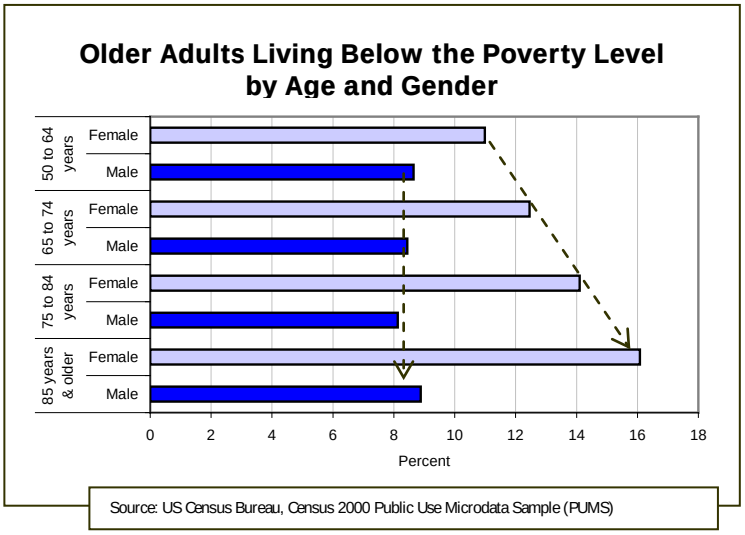
Household and housing costs also impact disproportionately on older adults. According to the 2000 Census, while comprising 12.5 percent of the household population, people 65 and older are 21.8 percent of all householders, owning or renting a disproportionate share of the State's occupied housing units – over 1.5 million of the State's 7.1 million homes.

People aged 65 and over living alone comprise 46.5 percent of all householders in that age group, and own or rent 716,000, or 1 of 10 occupied housing units in the State. Approximately 21 percent of these householders are living in poverty on incomes of under $8,259.

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 2009 American Community Survey (ACS), 2009 Public Use Micro data Sample (PUMS) (see data note 4) for older adults, approximately 70% of households that are home owners and 55% of households that are renters spend up to 1/3 of their income on housing expenses.

Gender

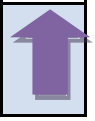
Women's experiences of aging are greatly influenced by the roles they assume and the resources available to them. Women spent less time in the workforce than their male counterparts. This translates into lower pay rates, lower personal earnings, and lower retirement income compared with men. Also, the greater longevity among women compared to men tends to translate into women spending more time living alone as they age, are more likely to be the primary caregiver to a spouse and more likely to be in need of long-term care services, and therefore, Medicaid financed support. Approximately 18 percent of women aged 50 to 64 live alone, and this more than triples among women aged 85 and older (56 percent). More women than men assume caregiving responsibilities for older family members. According to a 2004 National Alliance for Caregiving and AARP's study, the average caregiver is 46 years old, female, married, working outside the home, and earning an annual income of $35,000. 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.

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

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.

By 2015, NYSOFA projects (based on Woods & Poole, 2002) (see data note 5) people aged 65 and over with functional impairments will grow by a rate of 17.1 percent to number 854,956, with 692,521 living in the community, and 162,435 (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 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.

U.S. Population: Disability	
Age Group	% of Group with All Types of Disabilities
5-20	8%
21-64	19%
65 and over	42%

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 approximately one in four (27 percent) older adults have sufficient resources to pay for long-term care expenses totaling $150,000 over the course of a three-year period, leaving almost *three* in four who could *not* do so. 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.

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.

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 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 American Community Survey, 2009 estimates, 5.16 percent (or 135,028 persons) of State's aged 65 and over population live in group-care facilities. Historically, about 80 percent of that number (or about 108,022 persons) would live in nursing homes.

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 5.16 percent (or 135,028 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 (ACS 2009 One-Year Estimates) 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 increasing more important to support those with chronic conditions and functional limitations. For most, residential facilities are not appropriate as the individual may not require that high a level of skilled care. 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 acute care, 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 $42 billion annually into New York State. Baby boomers and older adults account for 40% of all income 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 many challenges in the coming years related to the growth of the older population, there are tremendous opportunities to utilize the strengths and skills of older adults to help address problems, to be leaders in helping communities implement changes to make communities more livable, to work with peers to prevent readmission to hospitals, to teach peers how to manage complex chronic conditions, to provide one-on-one assistance to understand the complexities of Medicare and other health insurance, to be ombudsman in long-term care facilities to protect residents rights and ensure quality of care and many other innovative ways to make a positive difference. 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. 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.

Data notes:

1) All projections, unless otherwise noted, are from Woods & Poole Economics, Inc.: *2011 State Profile*, based on Bureau of the Census *2010 Population Estimates*.
2) Existing minority chart based on Woods & Poole Economics, Inc., *2009 State Profile*, based on the Bureau of the Census *2008 Population Estimates*, an existing chart reproduced for the purposes of this document: minority sub-group projections have not indicated a need for revision to this chart given the difference between the 2010 Census 100% counts and the trend of the Bureau of the Census *Population Estimates* between 2001 and 2010.
3) Data for tables not available from Bureau of the Census, Census 2000, *Summary Files (SF) 1 through 4*, are derived from the Census 2000 *Public Use Micro data Sample* (PUMS) or from the *Current Population Survey, March Supplement*.
4) Current-data estimates that are based on county counts (in lieu of PSA counts) are based on the Bureau of the Census, American Community Survey [ACS], 2005-2009 Estimates; data for tables not available from Bureau of the Census are derived from the ACS 2005-2009, *Public Use Micro data Sample.*
5) Existing disability chart based on Woods & Poole Economics, Inc., 2002 State Profile based on the Bureau of the Census 2001 Population Estimates, an existing chart reproduced for the purposes of this document: no more-appropriate disability projections exist since production of this chart, with disability data based on 2000 Census data.

THE AGING NETWORK IN NEW YORK STATE

The cornerstone of aging services can be found within the Older Americans Act (OAA). The programs supported by OAA funds are key to providing older New Yorkers with a high quality of life and maintaining older adults in their preferred living environment. New York State's investment in core programs and working to find new and better ways of delivering services demonstrates the New York State Office for the Aging's (NYSOFA) commitment to work to deliver services and foster community involvement to improving the lives of older persons so that they may fully participate in all aspects of society and community life, be able to maintain their health and independence, and remain in their own homes and communities for as long as possible demonstrates the commitment this state has to its older residents.

Through the 1965 federal OAA and subsequent amendments, NYSOFA established and administers funds to a network of 59 local Area Agencies on Aging. AAAs are primarily based within county government. In 52 counties, the AAA is a unit of county government (including two counties, Warren and Hamilton, which have combined to support one AAA). In four additional counties, the AAA is part of the voluntary sector. In New York City, the New York City Department for the Aging (DFTA) serves the five boroughs that comprise the City. Two Native American Reservations, the St. Regis Mohawk and the Seneca Nation of Indians Reservations, also have AAAs.

The 59 AAAs utilize a local service delivery subcontractor network of 1,443 community-based organizations to deliver a wide array of services in their communities. In addition, thousands of volunteers, mostly older persons, are working in the network delivering various services to older people who need them such as transportation, respite, health insurance counseling and assistance, home-delivered meals, etc. Together, New York's Aging Network consists of a vast array of diverse public and private organizations and volunteers serving older New Yorkers and their families in every county, town, village, hamlet, and community throughout the state.

OAA funds are used by New York's Network of 59 AAAs to provide supportive services, including, personal care, in-home services, transportation, adult day care, legal assistance, home and congregate meals, comprehensive and objective information, assistance and screening, and a range of additional services. OAA funds are also used by the Aging Network to provide a continuum of services designed to assist older adults and support their caregivers and families. Services provided are targeted to those older individuals with greatest economic need, those with greatest social need, those residing in rural areas, Native Americans, and older low-income minority individuals as well as those with limited English proficiency.

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

- Older Americans Act (OAA) Core Programs,
- AoA Discretionary Grants, and
- Consumer Control and Choice.

OLDER AMERICANS ACT CORE PROGRAMS

Access Services

Transportation

Transportation is a critical component in the array of access services provided by the Area Agencies on Aging and their local partners in New York State. All AAAs currently provide directly, or through contract, transportation to help enable older persons to access needed services and maintain their dignity, independence, and ties to their communities. Older adults utilize transportation services to participate in community programs, engage in employment opportunities, access medical care, go grocery shopping and enjoy the same activities necessary for daily living that younger individuals do. State and federal resources will continue to be targeted for this critical core service. To facilitate efforts at the local level and to increase access to transportation through better coordination and efficiencies, the New York State Office for the Aging is engaged in initiatives with other State agencies to expand service capacity through the development of other resources, and thereby reduce the amount of Older Americans Act (Title III-B) and State funds (Community Services for the Elderly Program (CSE), Supplemental Nutrition Assistance Program (SNAP) and State Transportation) used by AAAs to meet the growing need for transportation.

NYSOFA's policies on transportation support the intent of the *Olmstead v L.C.* Supreme Court decision to maximize opportunities for older people and people of all ages with disabilities to live in their own homes and to be able to access the wider community. The task for developing a plan of action to comply with this decision in New York has been assigned to the Most Integrated Setting Coordinating Council (MISCC). NYSOFA is a participating member of the Council and is actively engaged in the workings of the Council's Transportation Workgroup, which is led by New York State Department of Transportation (DOT).
The Transportation Workgroup has been working to eliminate service gaps and enhance transportation networks to meet the requirements of the Americans with Disabilities Act; the purpose of which is to provide greater economic independence, healthy living and an improved quality of life. Through this interagency collaboration, NYSOFA is working with DOT and other State agencies to establish a Mobility Manager/Health and Human Service Transportation Coordinator within each county in New York State and to implement the use of mobility management strategies to improve the availability and accessibility of transportation services.
NYSOFA is engaged in the MISCC Transportation Workgroup's effort to establish Community Call Centers that coordinate scheduling by bringing together disparate call taker functions under one-mobility management scenario.

NYSOFA is committed to policies that seek to advance the coordination of transportation services opportunities for constituents of all ages, and thus efforts at the state and local level to achieve coordination are encouraged. Transportation coordination has received greater emphasis by the Federal Transit Administration (FTA). Regulations established by the FTA require that any project for funding through Section 5310 (provides formula funding to States for the purpose of assisting private nonprofit groups in meeting the transportation needs of the elderly and persons with disabilities when the transportation service provided is unavailable, insufficient, or inappropriate to meeting these needs) be derived for a locally developed, coordinated public transit-human services transportation plan. The plan must be generated through a process that

includes representatives of public, private, and non-profit transportation and human service providers. As a Section 5310 interagency partner of DOT, NYSOFA plays a role in this initiative through an RFP process and by working with the AAAs to encourage and support their participation in local planning efforts. Further, NYSOFA is working with AAAs and other community partners to identify innovative and replicable practices that can be shared statewide to facilitate local changes that can increase access to services and stretch and leverage resources more effectively.

For these policies and programs to be successful and to meet the growing demand for transportation services, a variety of sufficient and appropriate transportation options are necessary, including strategies for maintaining the ability of older drivers to continue to drive independently and safely longer. The New York State Department of Motor Vehicles projects the number of licensed motorists age 65 years and older in the state to grow by 60 percent, from 1.5 million to 2.4 million by 2015. Through grants received from the New York State Governor's Traffic Safety Committee, NYSOFA utilizes National Highway Traffic Safety Administration funding to support the provision of outreach, information, education and assistance to help older drivers so that they may remain safe behind the wheel when appropriate, or access transportation alternatives when they are not. NYSOFA is also committed to developing and testing other transportation models that promote community building and volunteerism and that are not reliant on public funding to ensure access to the community for older individuals.

Through the statewide NY Connects: *Choices for Long-Term Care* program, which serves as the counties single point of access or "no wrong door" system to provide free and objective information and assistance on long-term care services for persons of all ages with disabilities regardless of payor source, local long-term care councils have identified transportation as a priority and have developed local plans to address this community need.

Information & Assistance

In order to empower older New Yorkers, their families, and other consumers to make informed decisions about, and be able to easily access existing health and long-term care options services that best address their needs, the New York State Office for the Aging has established various methods for constituents to receive prompt and thorough information and assistance. By providing information through the Aging Network regarding relevant programs and services that meet specific needs and/or by reviewing and addressing complex situations, 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 information and assistance is one of the most critical services provided by the Area Agency on Aging and their network of local providers. Information and assistance can be provided in many forms over a wide spectrum, from a straightforward answer to an older person's question about the time a senior center opens, to a much more complex situation involving heating assistance or home repairs or to an older person and/or their caregiver seeking information to help navigate the long-term care system. Access to quality information is vital and is the most provided, as it is the portal in which all services of the AAA are provided. Throughout New York State's network of 59 AAAs and their local service delivery

subcontractor network of 1,443 local community-based organizations, Information and Assistance is funded through various federal, State and local funding sources. In SFY 2009-2010, nearly 600,000 units of service were provided throughout New York's Aging Network. Information is provided to older persons and their caregivers on services available through the AAA and within the local communities, assisting individuals by linking them to the services and opportunities that are available within their community.

NY Connects

Given the complex nature of long-term care needs and the myriad of available services, NY Connects: *Choices for Long-Term Care*, was established through New York State appropriation in 2006 to further expand access to services. The NY Connects program provides a locally coordinated system of information and assistance on long-term care options available to the age sixty and older population, individuals of all ages with physical disabilities and the informal caregiving population. Additionally, NY Connects targets the private pay population through local public education and outreach activities, as early intervention and prevention can delay or prevent need for more intensive/costly services. NY Connects staff who provide information and assistance are long-term care specialists, qualified to serve the multifaceted needs of a complex population and trained accordingly as per extensive state prescribed requirements. NY Connects staff must employ a comprehensive screening process to explore long-term care options and possible avenues of direction, specifically tailored to each individual's unique needs. This enables more efficient use of staff and more timely connection to the appropriate mix of services. For consumers for whom existing services are inadequate or unavailable, NY Connects staff are required to problem solve to locate alternative resources to the best of their ability. As experienced long-term care professionals, NY Connects staff also serve as a resource to individuals and service providers during transitions from one care setting to another (e.g. hospital to home). In addition to providing long-term care information and linkages to services, the nyconnects.org website will be expanded in 2011 to include the NY Connects Long-Term Care Resource Directory. Finally, each NY Connects program has established a local Long-Term Care Council to identify gaps in long-term care services and develop solutions.

Similarly, Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (OBRA) (Public Law 101-508, codified at 42 USC 1395 b-4) authorizes the Centers for Medicare & Medicaid Services (CMS) to make grants to States to fund State Health Insurance Assistance Programs (SHIPs). In New York, this program is the Health Insurance Information Counseling and Assistance Program or HIICAP. This program is administered locally by 59 Area Agencies on Aging (AAAs), which provide extensive health insurance counseling to Medicare beneficiaries, their caregivers and families. The program seeks to strengthen the abilities of the Area Agencies on Aging to provide one-on-one health insurance counseling, promote Medicare preventive services, assist clients with the selection of Medicare prescription plans, and, conduct thousands of outreach events each year on how to use Medicare benefits. Staff and volunteers provide unbiased information to Medicare beneficiaries so that they are able to make informed health insurance choices.

On July 15, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was approved by Congress and became law. Section 119 of MIPPA provides for beneficiary outreach and funding for State Health Insurance Programs (SHIP), Area Agencies on Aging and Aging and Disability Resource Centers (ADRC-NY Connects in New York State) to work collaboratively to reach low-income Medicare beneficiaries. By partnering the State SHIP Program (HIICAP) with the local NY Connects programs, MIPPA efforts are coordinated so that Medicare beneficiaries likely to be eligible for the Medicare Part D Low-Income Subsidy (LIS) Program or Medicare Savings Program (MSP) have multiple avenues for information and application assistance. The LIS and MSP programs assist older adults by lowering the cost of Medicare premiums, co-pays and deductibles which allow older adults to use their limited resources on other necessities of daily living. This provides older adults with a level of economic security as they face health care expenses that continue to rise. Funding for this Act also includes direct LIS and MSP application assistance with an emphasis on Medicare Part D outreach to rural areas.

NYSOFA's Senior Citizens' Help Line was established in 1974 to provide toll-free access, from in and out of state, to anyone seeking information about programs and services for older adults in New York State. As an additional resource for information and assistance, older adults and their caregivers can interface with NYSOFA directly through a toll-free telephone Help Line staffed by Aging Services Assistants, as well as through written correspondence with NYSOFA's Constituency Liaison. The Help Line provides assistance with a wide array of questions and issues faced by older New Yorkers, and assists those callers through a comprehensive referral system. The Help Line supplements and complements the information and assistance services provided by local AAAs. The Help Line phone number is widely distributed by other federal and State agencies and frequently appears as a resource in public and private publications, newsletters and websites of various sources. The Help Line has also been identified as a primary resource for communicating important messages to constituents and NYSOFA staff when contingency plans are activated during times of emergency and business disruptions.

Other programs that provide information and assistance for specialized populations include the Long-Term Care Ombudsman Program (LTCOP) and SMP (Senior Medicare Patrol).

Case Management

Case management is at the center of wellness and autonomy for older adults. OAA Title III-B, the Expanded In-home Services for the Elderly Program (EISEP) and Community Services for the Elderly program-funded person-centered case management provided by Area Agencies on Aging and/or their local sub-contract providers statewide, is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an older person's health and human service needs. Case management provides advocacy, access, assessment, planning, communication, education, resource management, and service coordination. 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.

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. Congress amended the OAA in 1984, designating legal services as a priority service for which Area Agencies on Aging are required to spend an adequate proportion of their OAA Title III-B funds. In 1987, the OAA was amended to require the states to specify a minimum percentage of Title III-B funds for legal services. Currently, New York's minimum percentage is 7 percent.

Statewide, each AAA enters into a contract to provide legal services. NYSOFA promulgated regulations, consistent with the federal regulations, for the administration of the legal assistance program at the local level (Title 9 NYCRR §6654.12) and issued the 1994 Program Instruction, "Statewide Standards for the Delivery of Legal Assistance," for administration of the program by the AAAs.

Section 731 of the OAA requires the State Agency to provide the services of an individual who shall be known as a State Legal Assistance Developer. The Legal Assistance Developer provides State leadership in securing and maintaining the legal rights of older adults; encourages and facilitates networking among the AAAs and Title III-B Legal Assistance Providers; and provides 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 must play a crucial role in training, service coordination, resource development, targeting, and quality assurance. The Developer also is critical to championing the rights of older people and to ensuring that the promise of OAA legal services is fulfilled.

Older adults are confronted with many legal problems and issues including housing/rent, employment, consumer debt, financial exploitation scams and predatory lending practices, contracts and public benefit issues. In addition, an older adult may be in need of legal assistance regarding his or her rights as a Medicare beneficiary (such as choosing a prescription drug program) or assistance in avoiding the need for a future guardianship (e.g., power of attorney or appointment of a representative payee). They may be victims of identity theft, consumer fraud, scams, and financial exploitation which in turn can lead to other legal problems including bankruptcy, foreclosure, eviction, and Medicaid eligibility issues. Although New York State substantially amended the law pertaining to powers of attorney to address concerns about misuse by the attorney-in-fact, recent studies indicate that financial exploitation of older adults is an increasing problem. Both the breadth of issues and the changing demographic profile (that is, an increasing number of New York's older citizens have limited English proficiency) make the need for legal services more critical than ever before. Just as the legal needs of the aging population are changing, so too must the legal assistance program change.

In-Home Contact and Support Services

Expanded In-home Services for the Elderly Program

The Expanded In-home Services for the Elderly Program was established in 1986 under Chapter 894 of the Laws of 1986. It is a uniform, statewide program of non-medical in-home services, case management, non-institutional respite care, and ancillary services for functionally impaired older adults who are in need of community-based long-term care services and who are not eligible for similar services under other government programs, including Medicaid. It provides frail older persons access to a well-planned, coordinated package of in-home and other supportive services designed to support and supplement informal care. The overall goal of the program 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. To be eligible for the program a person must be: at least 60 years old; impaired in at least one "Activity of Daily Living" (such as eating, dressing, bathing, or toileting), or two "Instrumental Activities of Daily Living" (such as meal preparation, housekeeping, or shopping); in need of assistance; and able to be maintained safely at home.

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 service delivery. It brings order to the confusing array of services and benefits that are needed and available in a community to assist individuals in need of long-term care.
- In-Home Services – Consists 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.

The Program includes a cost-sharing element so that those who can afford to pay towards the cost of their services do so. All clients have their income protected up to approximately 150 percent of the poverty level. Clients whose monthly income exceeds this threshold ($1,375 and $1,852 per month for an individual and couple, respectively, in calendar year 2011) are required to cost-share according to a State established sliding scale. Cost-sharing applies to all services provided under EISEP except for case management and ancillary services (e.g., bathtub seat) that are on loan to the client.

Community Services for the Elderly Program

In the late 1970's, the New York State Office for the Aging became increasingly aware of older New Yorkers experiencing unnecessary placement in institutional care. Considerable research had proven institutional settings to be counter-productive to the sustained viability of persons who had the desire and the capability, with some support services, to thrive at home, in their communities. It was evident that the absence of effective community support services, as well as a nursing home bias, often resulted in unnecessary institutional care. In response, the New York State Legislature enacted the Community Services for the Elderly Act as section 541 of Article 19-J of the Executive Law of New York State (now, New York State Elder Law, Article II, Title 1). The Act established the Community Services for the Elderly (CSE) Program.

To accomplish the purposes of CSE, the Act mandated the provision of community support services and authorized State Aid to Localities for planning and coordination, for the creation of new and/or expansion of existing services, and for the establishment of new mechanisms to improve service-delivery systems. Such services include, but are not limited, to adult day services, in-home services, case management, home delivered meals, information and assistance, in-home contact and support, assisted transportation/escort, transportation, legal services, and other services designed to maximize older persons' independence within their homes and communities. CSE is the most flexible program managed by Area Agencies on Aging and their subcontractors. 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.

Supporting Aging in Place

Livable New York Initiative

While all core programs support the goal of aging in place, the New York State Office for the Aging, in cooperation with seven affiliate partners, developed *Livable New York*, a statewide initiative to develop tools to help communities' better plan for the needs of their older adults, people of all ages with disabilities, families, and caregivers. Once fully implemented, communities will 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. *Livable New York's* purpose is to assist communities to take active steps to create livable communities that best reflect the state's rapidly changing resident population with an understanding that the elements that make up a livable community are good for all ages. The directive underpinning this initiative derives from Chapter 58 of the New York State Laws of 2007, which added a new subdivision 14 to Section 24-d of New York State Elder Law. The subdivision requires that mixed-use, age-integrated communities be fostered across the state.

Significant demographic, public policy, economic, environmental, and social "change-drivers" are transforming both the resident profiles of New York's communities and the circumstances and conditions under which communities are planning and implementing the tasks and activities

that affect residents' quality of life. In the face of such forces, municipalities are searching for assistance to employ proven, often innovative planning, zoning, housing, and community-design models/strategies to improve the "livability" of their neighborhoods - to create communities that all residents say are good places to live, work, grow up, and grow old. Livable New York's aim is to provide that assistance. This initiative's products, training, and technical assistance adhere to the following principles that are meant to create a sustainable framework for community planning, design, and development:

- Future oriented planning, based on projected demographic, social, and public policy changes to assure that the definition of issues and the design of solutions accurately reflect the continuing evolution of a community's resident profile and a community's circumstances;
- An inclusive, collaborative planning and implementation approach to take maximum advantage of the expertise, resources, and diverse perspectives residing within a community's multiple professions, disciplines, and citizen groups, as well as to deepen all community members' investment in the successful outcome of the community's efforts;
- A cross community approach for defining issues and identifying solutions, which includes all ages, all cultures, and all abilities to fully capitalize on the creativity, capacity, and innovative ideas inherent in diversity;
- Broad resident participation to gain the benefits derived from greater community empowerment, to strengthen a "sense of community," and to stabilize a community's population base; and
- Community driven planning and development for greater assurance that a community's efforts truly reflect the expressed needs, preferences, and expectations of its members.

Naturally Occurring Retirement Community Supportive Service Program

In 1994, New York State determined that there is an increasing need for support services for older people residing in certain communities that have high concentrations of people aging in place. Through the provision of support services residents would be able to maintain their independence, improve their quality of life and avoid unnecessary hospital and nursing-home stays. Over time, many people who moved into their homes or apartments when they were young have grown older and now need help to remain in their residences. Such areas with high numbers of older people are called “naturally occurring retirement communities.”

New York State developed two Naturally Occurring Retirement Community (NORC) programs. The Naturally Occurring Retirement Community Supportive Service Program (NORC-SSP) provides services to older people living in a building complex. The Neighborhood NORC (NNORC) provides similar services to older persons living in residential areas consisting of single family homes and low rise apartment buildings. Currently there are 19 NORC-SSP programs and 17 NNORC programs across New York State receiving a total of more than $4 million dollars.

Community partnerships are a required and essential element to the success of a NORC or NNORC. NORC and NNORC programs are operated by not-for-profit organizations specializing in housing, health or human services and other core partners typically include a health care provider(s), housing partner, as well as the senior residents. Programs offer

supportive services, such as case assistance, case management and healthcare assistance as well as other services that can include counseling, transportation, homecare and socialization activities. Services provided in a NORC or NNORC should not duplicate existing services, but should fill gaps in existing services and help coordinate existing services effectively and efficiently. Programs are expected to empower resident participation and involvement in program planning, implementation, oversight and evaluation so that services can be customized to meet the unique needs and preferences of the seniors in the community.

The Low-Income Home Energy Assistance Program

An increasing number of older adults depend on energy assistance to help pay their heating bills. The Low-Income Home Energy Assistance Program (LIHEAP) is a federally funded program that assists low-income eligible households in meeting their home energy costs. In New York State, the program is administered by Local Social Services Districts (LSSD). Local Area Agencies on Aging contract with LSSD offices to be alternate certifiers in the processing of HEAP applications for people 60 years of age and older. In New York, 48 of the 59 AAAs contract to be an alternate certifier.

Weatherization Referral and Packaging Program

The Weatherization Referral and Packaging Program (WRAP) is administered in 56 Area Agencies on Aging. Local WRAP liaisons work to identify low-income, energy-vulnerable older adult households through extensive outreach, targeted publicity, and networking among other energy and aging services providers in the community. The WRAP liaisons assist seniors by arranging for an energy audit of their homes to determine if weatherization repairs are needed, such as insulating windows and doors, and making repairs to heating systems. Energy conservation efforts may include: replacing or adding insulation; replacing windows; fixing a furnace; and replacing or adding a storm door.

Nutrition Services

Nutrition Program for the Elderly

The Nutrition Program for the Elderly (NPE) is authorized by the federal Older Americans Act of 1965, as amended in 2006. Since its inception, the program has operated statewide through 59 AAAs, including two Indian Tribal Organizations (ITOs). Services are provided directly or through sub-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. Since 1984, New York State's Supplemental Nutrition Assistance Program (SNAP) provides funding primarily for home-delivered meals to frail older persons who are unable to prepare meals for themselves, but it also supports nutrition counseling, nutrition 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.

The purposes of the program are: "to reduce hunger and food insecurity; to promote socialization of older individuals; and to promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior." (Source: 2006 Reauthorization of OAA)

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, nutrition education, nutrition 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 sites to deliver health-promotion and disease-prevention services, thereby allowing them to integrate such services 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 programs 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) is authorized under 7CFR Part 249 USDA Food and Nutrition Services. While it became a permanent federal program in Fiscal Year 2007, it 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, New York State Department of Health (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 DOH Commodity Supplemental Food Program (CSFP). The 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 for the program. Coupon booklet production costs are covered by a small amount of SNAP funds from each AAA's annual allocation. The purpose of the program

is to increase the consumption of fresh fruits and vegetables, provide nutrition education, and support local farmers (a major component of New York State's economy).

Governor's Council on Food Policy (NYS CFP) created by Executive Order in 2007 is composed of twenty-one members appointed by the Governor. Members represent the public, private and consumer sectors and the New York State Office for the Aging is a permanent member of the Council. NYS CFP develops and makes recommendations to the Governor on State regulations, legislation and budget proposals in the area of food policy to ensure a coordinated and comprehensive interagency approach to state food policy issues. The four key issue areas identified by the NYS CFP are:

- Maximize participation in, and support for, food and nutrition assistance programs;
- Strengthen the connection between local food products and consumers;
- Support safe, efficient and profitable food production and retail food infrastructure; and
- Foster a culture of healthy and local eating for all New York State residents.

Disease Prevention and Health Promotion Services

Preventive Health Services

Since the introduction and increased promotion of Medicare preventive and screening benefits, the New York State Office for the Aging has worked to increase consumer awareness and use of these benefits among New Yorkers. These benefits include a 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. Collectively these benefits provide an opportunity to help older adults to stay healthy. An annual wellness exam is a new benefit this year and will require physicians and other health providers to develop a preventive plan for Medicare beneficiaries to help them to stay healthy in the years ahead. Starting January 1, 2011 many of the preventative and health screening benefits will no longer have co-payments or deductibles, thereby removing a financial barrier to older adults to stay healthy. 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.

In 2010, NYSOFA teamed-up with the American Cancer Society (ACS) and worked with Cayuga and Erie Counties to have older adults registered on the ACS website. Once registered, people get reminders of when it's time for them to be screened for various cancers based on their age, gender, family history and known risk factors. This pilot project resulted in more than 500 people registering at this site in a six month period. With the help of the State University of New York, NYSOFA staff and Master level School of Public Health student interns routinely reviewed Centers for Medicare and Medicaid Service's paid claims data and Behavioral Risk Factor Surveillance System self-reported survey data to provide county-specific, population profiles on the use of preventive and health screening benefits such as flu and pneumococcal vaccinations and colorectal screening.

Medication Management

Medication Management activities are those that assist older persons to adequately manage the medications they are taking and avoid medication misuse and/or abuse. OAA Title III-D requires a portion of the funds under this Title to be used by the Aging Network for any of the following Medication Management activities:

- The creation and/or distribution of consumer information about Medication Management provided to individuals or at group settings such as senior centers, nutrition sites, social adult day care programs and health fairs.
- The provision and distribution of helpful devices such as: daily use pill boxes; immunization record charts; refrigerator reminders and magnets; medication use calendars; etc.
- The production and/or distribution of brochures and other educational materials dealing with drug interaction.
- Seminars concerning Medication Management conducted by Registered Dieticians, Pharmacists, Nurses or other qualified professionals.
- Assistance to older persons with information about and/or the registration for insurance programs about prescription drugs such as New York State's Elderly Pharmaceutical Insurance Coverage Program (EPIC).

Supporting Caregivers

National Family Caregiver Support Program

New York State ranks third in the nation with more than 2.2 million caregivers (family, friends, and neighbors). AARP estimates that the value of this unpaid care, if purchased at the market rate, would be about $25 billion per year. The voluntary care provided by caregivers also saves billions of Medicaid dollars annually. Informal caregivers are an invaluable resource for their loved ones and play a primary role in helping them to remain independent and avoid more intensive, higher levels of care. However, caregiving often comes at a price; it is challenging work, creating physical, emotional, and/or financial strains on the caregiver. An increasing body of evidence indicates that caregiving can take a major toll on the physical and mental health of the caregiver, and even on their mortality. In addition, caregivers who experience undue stress and burden are more likely to give up their daily caregiving responsibilities and place their loved ones in institutions, a more costly option to both the older person and scarce public resources.

The New York Elder Caregiver Support Program (funded under Title III, Part E of the Older Americans Act) assists 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. Because of the assistance they receive, these older persons with chronic illnesses or disabilities are able to continue living independently in the community. Some local programs also assist grandparents and other older relative caregivers of children and promote the retention of the children in a nurturing family environment instead of placement in foster care. New York's Area Agencies on Aging provide a multifaceted system of support services for informal caregivers of older people, as well as for grandparents and other older relatives caring for children.

New York State Family Caregiver Council

Established in 2007 with the New York State Office for the Aging as the lead State Agency, the New York State Family Caregiver Council (FCC) includes caregivers across the age and care spectrum, community advocates, academic experts in caregiving issues, and New York State government agencies. The FCC's mission is to provide guidance, advice, and recommendations that will enable the State to develop policies and programs that support caregiving by reducing barriers and enhancing support for individuals who provide care for friends, family or community members of all ages and all levels of ability.

Respite Services

Respite services, an important component of the home and community-based long-term care service delivery system, 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. With the aging of the baby boomers, there will be an increasing number of older people due to the size of this cohort. As the boomers age, there is an increased likelihood that they will need support in everyday living tasks. As a result, the demands placed on informal caregivers will continue and likely will increase.

Informal caregivers play a critical role in the long-term care system; in fact, the system cannot function without them. Respite services temporarily relieve caregivers of their caregiving responsibilities by providing a short-term break, allowing the caregiver to devote time to address other needs. Respite services include home care (e.g., personal care levels I & II, 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 often results 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. In State Fiscal Year (SFY) 2011-12, there are 10 community-based respite programs that are included in the State Budget, for which the New York State Office for the Aging has administrative responsibility. 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.

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 support, 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 and therapeutic activities 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 unique cost-effective package of services that provides person-centered interventions which promote slowing the progression of the illness. SADS prevents or delays 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 in a safe environment.

New York State's Area Agencies on Aging provide social adult day services through a variety of State and federal funding programs, including Older Americans Act Title III-B and III-E funds, and the State-funded Community Services for the Elderly program and Expanded In-home Services for the Elderly Program. In addition, the New York State Office for the Aging directly funds 17 SADS programs under a State-funded program (Section 215 of the New York Elder Law).

Activities for Health, Independence and Longevity

Civic Engagement and Volunteerism

Over the past two decades there has been a growing body of research that demonstrates volunteering provides individual health benefits in addition to social benefits. This research has established a strong relationship between volunteering and health and wellness: 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.

Retired and Senior Volunteer Program

The New York State Office for the Aging's 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 elderly persons in the areas of home visiting, escort, transportation and home-delivered meals as well as cross-generational efforts in tutoring and mentoring children. These volunteers play a key role in supporting the network of 59 Area Agencies on Aging in New York.

Foster Grandparent Program

The New York State Office for the Aging's Foster Grandparent Program (FGP) supplements 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 serve a minimum of 15 hours per week, providing support to special needs children aged birth to 21 years in a wide variety of community sites. 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. 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.

Older American Community Service Employment Program

The aging of New York's population will substantially affect certain occupations and industries in New York and future workforce needs may go unmet unless mature workers are retained and retrained. The Older American Community Service Employment Program (OACSEP), Title V of the Older Americans Act is a community service and work-based training program for older workers. It was authorized by Congress in Title V of the Older Americans Act of 1965 to provide subsidized, part-time, community-service work-based training for low-income persons aged 55 or older who have poor employment prospects. The purpose of the program is to place these individuals into unsubsidized employment.

Vulnerable Elder Rights Protection Activities

New York State Long Term Care Ombudsman Program

The New York State Long Term Care Ombudsman Program has been in existence since 1972. It is funded with federal and State dollars. The Older Americans Act 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. Each State organizes and operates the program in the way that best serves the needs of its residents. In New York, the program is administratively housed within the State Office for the Aging and advocacy services are provided through a network of local ombudsman programs hosted by county based Area Agencies on Aging and non-profit organizations. Each local ombudsman program has a paid coordinator who recruits, trains and supervises a corps of trained volunteers that provide a regular presence in nursing homes and adult care facilities.

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 of care and 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.

Nationally, states including New York are rebalancing their long-term care systems to both contain the rising Medicaid costs associated with institutional care and to provide a wider range of home and community-based services to allow older adults and persons with disabilities to remain living independently in their own homes and communities for as long as possible. Current program priorities include: increasing consumer access to effective and timely advocacy services through improved volunteer recruitment, retention and training activities; empowering more residents and their families to resolve concerns without outside intervention when appropriate; and, improving systemic advocacy efforts to address facility-wide or statewide issues and problems experienced by residents.

SMP (Senior Medicare Patrol Program)

The U.S. Office of Inspector General estimates that Medicare and Medicaid lose tens of billions of dollars each year due to errors, fraud, waste, and abuse. Both the multiple systems for disbursing funds and the magnitude of health-care expenditures increase the probability of errors and create opportunities for fraud and abuse. In 2006 alone, Medicare lost approximately $10.8 billion to improper Medicare payments.

The SMP Program was designed to reduce Medicare/Medicaid errors, fraud, and abuse by coordinating federal, State, local, and private resources. The SMP uses educational and outreach efforts to increase awareness and encourage reporting by beneficiaries and others of suspected Medicare/Medicaid errors, fraud, and abuse. New York was one of the first five states funded by

the Administration on Aging (AoA) in 1995 to participate in SMP. The New York State Office for the Aging generates public awareness about SMP, and NYSOFA collaborates with other State Agencies that are involved in health financing and certification with legal entities authorized to prosecute health-care fraud and abuse, and with the provider community to recoup funds to the Medicare and Medicaid System. In 2010 NYSOFA received an SMP Expansion Grant to advance New York State's established and growing Medicare and Medicaid fraud and abuse abatement program. This grant will enable NYSOFA to increase collaboration and program integration within the state and local community networks and in particular in three Medicare fraud "hot spots" - Albany County, Monroe County, and New York City.

The SMP Program has established alliances with the NYS Department of Health, NYS Office of Children and Family Services, NYS Attorney General's Office, NYS Division of Criminal Justice, NYS Office of the Comptroller, NYS Office of the Medicaid Inspector General, NYS Department of Insurance, and the Regional Center Medicare Services contractor and carriers. Partnerships provide an efficient, global way to ensure a unified voice for policy improvements in the state's health care system, including solutions for health care system problems.

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. Because it often is hidden and 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.

In 1995, New York State legislation established 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.

ADMINISTRATION ON AGING DISCRETIONARY GRANTS

Enhancing Older Americans Act Core Services

Lifespan Respite Grant Program

The Lifespan Respite Care Act of 2006 defines Lifespan Respite Care Programs as "coordinated systems of accessible, community-based respite care services for family caregivers of children or adults with special needs." New York is one of twelve states awarded a Lifespan Respite grant in September, 2010 to develop and enhance coordinated, accessible, community-based respite

care programs to family caregivers of children or adults of all ages with special needs. The ultimate goal of these activities is the reduction of family caregiver strain.

As the grantee, the New York State Office for the Aging is working in collaboration with the Statewide Caregiving and Respite Coalition of New York (SCRCNY) to form a New York Lifespan Respite Program Core Team to meet the project's goal and objectives. New York will implement a lifespan respite program that builds and strengthens SCRCNY and coordinates existing respite services across all sectors. A respite inventory and data base will be developed and linked with the NY Connects statewide resource directory, as well as caregiver, volunteer, and professional training materials, and media materials.

Evidence Based Disease and Disability Prevention Grant Program

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. To help people remain in the community and improve their quality of life, for the past six years the New York State Office for the Aging, the New York State Department of Health and the State University of New York at Albany's Center for Excellence on Aging and Community Wellness have worked to make available self-management programs. These organizations work with six regional partners to expand the Chronic Disease Self-Management Program (CDSMP). NYSOFA received funding for the initial demonstration beginning in 2006 through the federal Administration on Aging. In April 2010, AoA awarded NYSOFA a two-year grant as part of the American Recovery and Reinvestment Act of 2009 to implement the "Communities Putting Prevention to Work Chronic Disease Self-Management Program."

These funds have allowed NYSOFA to expand delivery of the CDSMP, an evidence-based health promotion program developed by Stanford University. The CDSMP is a six-week program consisting of two and one-half hour sessions each week, which trains participants with one or more chronic diseases or their caregivers to better manage conditions associated with high blood pressure, arthritis, diabetes, chronic obstructive pulmonary disease and other chronic diseases. Program topics include physical activity, nutrition, medication management and improving communication with health care providers. Evaluation findings demonstrate reduced fatigue, increased quality of life, and decreased number of physician visits and hospitalizations of participants.

Aging and Disability Resource Center Grant Programs

According to 2004 data published in the New England Journal of Medicine, 15 percent of Medicare beneficiaries are readmitted within the first 30 days of discharge and 30 percent are readmitted within the first 90 days. During the course of an illness an older adult may receive care in multiple settings, which can lead to confusion due to a lack of information and poorly implemented discharge plans. Significant service gaps exist for a specific population of frail, isolated, health challenged older adults that include an overall lack of health literacy, patient education, appropriate follow up, and communication among health care providers.

In 2009, NYSOFA received a three year federal grant from the Administration on Aging to expand its NY Connects Program. Albany and Tompkins Counties were selected as pilot sites to implement the goals and objectives of this grant, a key component of which is the development of a Care Transitions Program to facilitate smooth and effective transitions from hospital to home.

To support person-centered discharge planning during transitions from one care setting to another, NYSOFA established the Community Supports Navigator (CSN) program to operate through NY Connects in both Albany and Tompkins Counties. The CSN model was derived from the Coleman's evidence-based Care Transitions Intervention (CTI) model. The CTI applies screening criteria to identify patients who are most at-risk for readmission after hospital discharge (i.e. diagnosis, age, etc.). Once enrolled, a Care Transition Coach follows a proven protocol that promotes the person's capacity to "self-manage" throughout the first 30 days at home – the most vulnerable time for readmission. The CSN program differs from Dr. Coleman's model in that highly trained volunteers are used to provide additional support with non-medical tasks (e.g., attending to follow-up appointments and physician visits, improving the patient's health literacy, assisting with access to services) for an additional 60 days. This program aims to further empower individuals to navigate their health and long-term care support options, resulting in improved health outcomes and reductions in preventable re-hospitalizations.

In addition to developing care transition supports, Albany and Tompkins counties are developing standardized protocols for the provision of Long-Term Care Options Counseling (Options Counseling). Options Counseling is a specialized form of counseling that is built upon the provision of comprehensive Information and Assistance. It supports consumers of every age needing long-term care and their caregivers in making the right decisions based on their unique circumstances, needs, preferences and cost. Individuals may need options counseling to help resolve their immediate concerns as well as plan for their future needs. Options Counseling allows the individual to understand the impacts of their choices and decisions before they are carried out.

This ADRC grant provides an opportunity to standardize Long-Term Care Options Counseling (Options Counseling) protocols across New York State and provides training and tools to the NY Connects' Information and Assistance Specialists. Albany and Tompkins NY Connects programs are formalizing Options Counseling referral protocols with hospital discharge planners, which will serve as a resource to avoid preventable re-hospitalizations.

Evidence Based Care Transitions Model: Care Transitions Intervention℠

In 2010, NYSOFA received an additional grant from AoA to enhance the existing care transitions program (NY Connects Community Supports Navigator) in Albany County. The program enhances the CSN program by linking a Care Transitions nurse through Northeast Health with the volunteer CSN to empower older adults to manage and adhere to their care plan, thereby fostering an understanding and self-maintenance of their needs. The CSN will serve a population of older adults diagnosed with a chronic disease who are currently in the hospital or have recently been discharged, as well as their caregivers. The reduction in preventable re-hospitalizations will result in lower health care costs, improved quality of care, increased patient

satisfaction, support for caregivers, and skills for future self advocacy. Through a rigorous evaluation component of this program, NYSOFA will demonstrate the value of using trained volunteers to support transitions for older adults from hospital to home; work with hospitals to identify consumers in need of added support and determine who is best served through this model; and work with partners to develop a plan for broader statewide replication and sustainability of the program.

Cost Share for Title III-B In-Home Services

Under the Nursing Home Diversion Modernization program and the Community Living Program, the New York State Office for the Aging has been exploring the feasibility of cost-sharing with Older American Act funds. Based on a consensus of local partners and equity considerations, the State determined it was necessary to implement cost-sharing for federal funds under these two grant programs. Thus New York State requested and received a waiver to permit the 10 AAAs partnering with NYSOFA on these grants to implement cost-sharing in their counties. Currently, New York does not cost-share with OAA funds in any other counties but does have a policy for cost-sharing under State-funded EISEP and CSE for EISEP-like services. NYSOFA is considering allowing cost-sharing for caregiver services under Title III-E and permissible services including personal care, chore, home modifications and transportation under Title III-B as well.

CONSUMER CHOICE AND CONTROL

Consumer Directed In-Home Services

Community Living Grant Program

The New York State Office for the Aging received a 2009 Community Living Program (CLP) grant to enhance the functions of NY Connects: *Choices for Long Term Care*. This grant allows NYSOFA to build upon the Consumer Directed (CD) service model created through the Nursing Home Diversion and Modernization Program (NHDM). The NHDM program was coordinated between NYSOFA and three implementing counties. It was designed to reach individuals at high risk of nursing home placement and spending down all their income and assets to the Medicaid level. The goal of the program was to help those individuals maintain their independence and remain in their communities by offering CD models of care. Additionally, there was a Veterans Directed component to the NHDM program that is being carried through to the CLP. The description and future plans of this program are provided in the section titled, Veterans Directed Home and Community-Based Services Program.

The CLP is funded through a two year AoA grant and it is affording NYSOFA the opportunity to expand the CD service model into seven additional counties. The CLP is being implemented with input from the three mentoring NHDM programs. Each of the three mentor counties successfully embedded consumer direction within their Agency and they continue to provide CD services. A majority of the CLP funds are utilized for planning and program development,

ensuring AAAs' ability to provide CD care within their existing budgets and, therefore, allowing for replication.

Veterans Directed Home and Community-Based Services Program

The Veterans Directed Home and Community-Based Services (VDHCBS) Program is a federally funded, locally administered program that strives to keep veterans of all ages who are at-risk of nursing home placement in their homes by giving them more control over the services and goods they receive. VDHCBS is a partnership between the Veterans Health Administration (VHA) and the Aging Services Network; VHA is responsible for providing the funding for this program and referring eligible veterans to the Aging Services Network. The Aging Services Network is responsible for helping these veterans develop care plans that meet their needs and for the delivery of services. Under this program, qualified veterans can hire whomever they choose to provide personal care services, as long as the person is not legally or financially responsible for the veteran. These veterans can also receive other home and community-based services through the Aging Services Network that are not available through the VHA. Payment flows from the local Veterans Administration Medical Center to the AAA. Provider Agreements (i.e., contracts) are in place between these two entities to operate the program.

The VDHCBS Program is taking place initially in the ten pilot counties that are developing consumer-directed service models under the Administration on Aging's 2008 Nursing Home Diversion Modernization and 2009 Community Living Program Grants. The ten participating counties are: Albany; Broome; Cayuga; Dutchess; Oneida; Onondaga; Orange; Otsego; Tompkins; and Washington. The participating Veterans Administration Medical Centers are: Albany Veterans Administration Medical Center; Syracuse Veterans Administration Medical Center; and the Veterans Administration Lower Hudson Valley Healthcare System. Based on the success of the first ten counties, the NYSOFA will explore the possibility of statewide replication and partnering with all Veterans Administration Medical Centers.

EFFECTIVE AND RESPONSIVE MANAGEMENT

Information Driven Programs/Initiatives/Services

Data Quality, Collection, and Analysis

Reliable data about customers served, services provided, and expenditures are essential in a well-managed, cost-effective network of services for older adults. Quality data assist network personnel and funders in evaluating the effectiveness of existing services and making appropriate decisions about pursuing new projects. Equally important, information about customer needs and preferences enables service providers to tailor programs and care plans to meet the unique requirements of the customers. NYSOFA's Data Quality, Collection, and Analysis initiative is directed primarily to two audiences: NYSOFA staff, particularly Agency leadership and Aging Services Representatives; and Area Agency on Aging staff - particularly directors and staff involved in collecting and reporting data. The initiative has three aims: to shift data collection from an aggregate to a customer-specific basis; to encourage and enable local AAAs and State-

level decision-makers to use the data to make informed decisions about Aging Network programs and services; and to provide sound data for informed advocacy.

County Data Book: Selected Characteristics

The County Data Book: Selected Characteristics (2008), published in September of 2009, has been prepared for use by local Area Agencies on Aging (AAAs), the NY Connects Aging and Disability Resource Center Program and the public for planning, advocacy, and other activities. It provides information that has been requested repeatedly over time about selected demographic characteristics (including projections), Aging Network programs and services, and NY Connects program information for 2008. The Data Book provides state level information and county specific information for each county in New York (except for New York City, which includes the five boroughs in one data set). These data have been compiled from: selected United States Census 2000 and American Community Survey; Woods and Poole Economics., Inc. data including demographic projections; NY Connects program data; and Consolidated Area Agency Reporting System reports which concern units of service and unduplicated counts of clients.

The data include projections through the year 2030 for the overall population and for selected age groups. These anticipated changes in population can illustrate important trends that require specific attention and planning. In addition, these data are developed statewide, so the opportunity exists to compare and contrast local areas with the entire state. As the population of the state continues to age, relevant and accurate data become essential to the planning and management of aging programs as well as for advocacy processes.

Performance Outcomes Measurements Project

Over the past several years there has been a growing interest within the Aging Network in assessing program performance, especially program outcomes. Since 2000, the New York State Office for the Aging, in response to the rising importance of outcome assessment, has been participating in the Administration on Aging's national Performance Outcomes Measurements Project (POMP) to develop outcome measures that can assess the value and effectiveness of Aging Network programs and services. From 2000 to 2009, AoA has awarded NYSOFA the Standard POMP grant and the Advanced POMP grant to collect timely, accurate, and comparable outcome data to demonstrate the efficiency and effectiveness of Aging Network programs and assist AoA in meeting the accountability provisions of the Government Performance Results Act and the Office of Management and Budget's program assessment requirements.

Since 2008, NYSOFA has received the Performance Outcome Measurements Project–Next Generation Grant to develop and plan for Next Generation: POMP and to develop the "POMP TO GO" generic toolkit. The toolkit intends to assist the Aging Network and other interested parties in conducting outcome assessments and using the information collected for program improvement and budget justification. The project also includes developmental work on predictive modeling of nursing home placement using existing POMP survey data, participation in the development of longitudinal surveys to compliment the cross-sectional information of existing POMP surveys and validating the nursing home predictor model that is currently being developed and to enhance its utility at the national level through replication and inclusion of community context variables (nursing home bed supply, community characteristics).

NYSOFA took a collaborative approach to implementing the POMP –Next Generation grants in New York State, integrating the resources and skills of each collaborative partner to develop outcome measures and to collect, analyze, and report data on the impact of local aging services. NYSOFA's collaborative partners include: the Finger Lakes Geriatric Education Center (a university-based research center) and several local Area Agencies on Aging.

Equal Opportunity, Diversity Management

Over the last decade, the minority population aged 60 and older in New York State grew by 43 percent, compared to eight percent for the non-minority population. Between 2010 and 2020 the minority population will increase by 51 percent. The New York State Office for the Aging's revised targeting policy and targeting efforts for 2011-2015 will focus on strengthening the statewide Network's capacity to serve the diverse populations of New York State. During 2010, NYSOFA has begun to increase system capabilities by developing and providing training to staff and providers to improve cultural competence in service delivery and the ability to work with diverse populations.

NYSOFA's former Targeting Services unit has been renamed Equal Opportunity and Diversity Management (EODM) to reflect a broader focus on increasing the cultural competence of New York State's Aging Network providers. In compliance with OAA's requirements to serve older individuals with greatest social and economic need, NYSOFA's present targeting policy (which is in the process of being updated and revised) recognizes the following target populations: (1) minority (classified by the Office of Management & Budget), (2) low income (at or below 150 percent of poverty), (3) frail (one or more functional activity of daily living deficit), (4) vulnerable (limited English-language skills, rural residence, older persons with disabilities, and older persons who are institutionalized).

In New York, AAAs must strive to serve members of target populations in substantially higher percentages than their representation in the general population of the AAAs' planning and service areas (PSAs). For example if a PSA has 10,000 older people, of whom 500 belong to a particular target group, that target group represents 5 percent of the general older population. If 1,000 older persons are to be served within the PSA, successful targeting would ensure that, at minimum, 50 members of the target group are included among service recipients (5 percent x 1000). This criterion is used to monitor progress in meeting county-level targeting goals.

Targeting is required under the OAA and also defined in New York State regulation 9 NYCRR sec. 6651.2(i) (1) as a range of activities at system, program and client levels which are designed to increase service delivery to an identified population. During the 2010-2016 period, NYSOFA will retain a focus on the above groups but will also increase targeting emphasis on Native Americans, lesbian, gay, bisexual or transgendered and frail/persons with disabilities particularly blind, deaf, visually and/or hearing impaired older adults. In addition to the targeting requirements in federal and State-funded programs, NYSOFA is committed to insure that all aging programs and practices are in compliance with Civil and Human Rights legislation, including the New York State Human Rights Law, Title VII of the Civil Rights Act and the Americans with Disabilities Act.

Community Affairs and Public Participation

In order to improve communications with the public and connect New York State residents with the New York State Office for the Aging and the Aging Network more directly, NYSOFA established the Community Affairs and Public Participation Group (CAPP) within the Executive Division. The function of the staff assigned to CAPP is to provide a responsive means to: develop clear and well-defined Agency message strategies and provide coordinated and regular communication between NYSOFA and the Agency's constituencies, including consumers; providers; advocacy groups; trade associations; the media; etc. The CAPP supports and coordinates its efforts with the other operating divisions within NYSOFA and coordinates the Agency's relationship with the Executive Chamber's Communications staff. Major responsibilities of CAPP include:

- Communicating with constituency/advocacy groups.
- Creating strategies to address issues and working collaboratively with policy staff within NYSOFA.
- Providing coordination and support to Agency staff working with local Area Agency on Aging advisory committees and provide support to NYSOFA's primary advisory committee, the Governor's Advisory Committee.
- Coordinating information sessions to inform the public about issues of concern to NYSOFA's constituencies.
- Developing relations with state and local media outlets to insure that interests of the elderly are presented and represented in media outlets throughout the state.
- Developing multiple vehicles to ensure the public understands and is aware of the services and programs administered/provided by the state's network of Area Agencies on Aging and affiliated providers.

Intergovernmental Collaboration

The New York State Office for the Aging advocates for older adults and their caregivers at every level of government and throughout local communities in New York State. NYSOFA also has a responsibility to ensure that the Governor's office, the legislature, other State agencies, local governments, advocacy groups, and other stakeholders are aware of the issues that the Agency is working on and effectively communicates. To accomplish that, NYSOFA has formalized relationships with other State agencies to address cross-agency issues that will help older adults be served in program areas that traditionally are not under the direct purview of the Agency, such as mental health, alcohol and substance abuse, developmental disabilities, hearing impairments, etc.

The Agency's business model is enabled through its collaboration with other State and local partners, consumers, stakeholders and other concerned citizens in the community. That collaboration is evidenced throughout the summary of accomplishments written below. The Agency continues to be actively engaged in all interagency collaborations established by the New York State Most Integrated Setting Coordinating Council which includes interagency work groups that address housing, transportation and employment. The following are just a sample of additional State level interagency collaborations, often with strong stakeholder engagement, that the NYSOFA is an active partner in: The New York State Developmental Disabilities Planning

Council; The Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind or Hard of Hearing; Alzheimer's Disease Coordinating Council; Geriatric Mental Health and Substance Abuse Council; Council on Food Policy and the New York State Smart Growth Cabinet. The Agency's active participation at the table, often as chair or co-chair of those interagency collaborations, works to ensure the success of the interagency planning and policy development process for all stakeholders. Information detailing the interagency collaborations that NYSOFA is a partner in, is included in the Attachments Section of this State Plan document.

Emergency Preparedness

The New York State Office for the Aging collaborates with several 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 on Aging at the federal level, New York State Emergency Management Organization (SEMO) and the New York State Department of Health at the State level, and Area Agencies on Aging at the local level. The involvement of various levels of government is necessary in order to adequately prepare for, prevent, and respond to emergencies and declared disasters, including floods, fires, ice storms, flu epidemics, or acts of terrorism. In addition, NYSOFA cooperates with the Office of Homeland Security to help assure that all levels of government, voluntary organizations, and the private sector identify areas of vulnerability which can be addressed and mitigated.

At the State level, NYSOFA coordinates with SEMO by participating in several task force initiatives, and NYSOFA also is a member of the State Emergency Operations Center in times of activation. SEMO operates a 24 hour alert and warning point in its State Emergency Coordination Center to provide support to local, State, and federal governments in reporting and responding to incidents. NYSOFA assists SEMO in disseminating public health and safety protection information to senior citizens and their families affected by emergencies and declared disasters. NYSOFA also coordinates efforts for emergency planning with the New York State Department of Health, who is leading New York State's response to Pandemic Influenza. At the local level, in times of emergency, NYSOFA coordinates and supports the relief efforts provided by the local Area Agencies on Aging, which play a critical role in identifying and serving the elderly who are most vulnerable.

GOALS, OBJECTIVES, STRATEGIES, and EXPECTED OUTCOMES

NEW YORK STATE PLAN ON AGING - GOAL 1

Empower older New Yorkers, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and long-term care options.

Access Services

Transportation

Objectives:

1.1 Stimulate transportation coordination through the issuance of requests for proposals for Federal Transit Administration funding supported by Section 5316 of the Job Access or Reverse Commute Program and Section 5317 of the New Freedom Initiative through collaboration with New York State Department of Transportation (DOT) and other State agencies.

1.2 Establish a Mobility Manager/Health and Human Service Transportation Coordinator within additional counties in New York State to implement the use of mobility management strategies to improve the availability and accessibility of transportation services.

1.3 Develop Community Call Centers that coordinate scheduling by bringing together disparate call taker/transportation functions under one mobility management scenario.

1.4 Identify collaboration and useful practices between 211 services and 511 services to improve resources dedicated to navigating consumers to timely and accurate mobility options and information services for transportation.

1.5 Strengthen the capacity of AAAs to collaborate with other agencies in their planning and service area to enhance coordination and sharing of available Section 5310 resources.

1.6 Provide informational and educational presentations through the AAAs to help older drivers, their families, and other members of the community to successfully identify and address potentially unsafe and at-risk driving situations.

1.7 Replicate the NYSOFA's Older Driver Assistance Network Model in additional counties in New York State.

1.8 Stimulate the design and implementation of innovative transportation models that promote community-building and volunteerism and that are not solely reliant on public funding.

Strategies:

- Collaborate with DOT and other State agencies to stimulate transportation coordination through the issuance of requests for proposals for Federal Transit Administration funding supported by Section 5316 of the Job Access/Reverse Commute Program and Section 5317 of the New Freedom Initiative.
- Collaborate with DOT and other State agencies to establish a Mobility Manager/Health and Human Service Transportation Coordinator in counties in New York State to implement the use of mobility management strategies to improve the availability and accessibility of transportation services.
- Collaborate with DOT and other State agencies to develop Community Call Centers that coordinate scheduling by bringing together disparate call taker functions under one-mobility management scenario.

- Collaborate with DOT and other State agencies to identify collaboration and useful practices between 211 services and 511 services to improve resources dedicated to navigating consumers to timely and accurate mobility options and information services for transportation.
- Provide technical assistance to Area Agencies on Aging to strengthen their capacity to collaborate with other agencies in their planning and service area to enhance coordination and sharing of available resources.
- Assist AAAs and their local community service providers to access National Highway Traffic Safety Administration grant funding to support the provision of informational and educational presentations to help older drivers, caregivers and other members of the community to successfully identify and address potentially unsafe and at-risk situations.
- Provide technical assistance to AAAs to enable the replication of NYSOFA's older driver assistance network model in additional counties in New York State. NYSOFA's older driver assistance network model includes representatives from the following State/local agencies and organizations: AARP; Albany County Department for the Aging; Albany County Department of Public Works, Traffic Safety Education Program; American Automobile Association, Hudson Valley; American Automobile Association, Northway; Alzheimer's Association of Northeastern NY; Capital District Transportation Authority; Capital District Transportation Committee; Colonie Senior Service Centers Inc.; Governor's Traffic Safety Committee; New York State Department of Health, Bureau of Injury Prevention; New York State Department of Motor Vehicles; New York State Department of Transportation; Rensselaer County Department for the Aging; Schenectady County Senior and Long Term Care Services; Senior and Special Needs Driving, LLC; and Sunnyview Rehabilitation Hospital.
- Advocate that the federal mileage deduction for volunteer drivers be increased from the current .14 to the rate allowed for business (.505).
- Assist in the development and testing of other transportation models that promote community-building and volunteerism and that are not reliant on public funding.

Objective	Expected Outcome	Target Date
1.1	Transportation coordination will be increased through the issuance of Requests for Proposals for Federal Transit Administration funding supported by Section 5316 of the Job Access/Reverse Commute Program and Section 5317 of the New Freedom Initiative through collaboration with DOT and other State agencies.	2013
1.2	The number of counties with Mobility Manager/Health and Human Service Transportation Coordinators positions needed to enable coordinated Public Transit Human Service Transportation Plans and operations will be increased by two counties.	2013
1.3	The number of Community Call Centers that coordinate scheduling by bringing together disparate call taker functions under one-mobility management scenario will be increased by two counties.	2013
1.4	Collaboration and useful practices between 211 services and 511 services to improve resources dedicated to navigating consumers to timely and accurate mobility options and information services for	2012

	transportation will be identified.	
1.5	Collaborations among aging organizations and other stakeholder that apply for 5310 grants will be increased.	2013
1.6	The provision of informational and educational presentations through the AAAs to help older drivers, caregivers, and other members of the community to successfully identify and address potentially unsafe and at-risk driving situations will be increased.	2012
1.7	NYSOFA's older driver assistance network model will be replicated in two additional counties in New York State.	2013
1.8	Several new innovative transportation models that promote community-building and volunteerism and that are not solely reliant on public funding will be designed and implemented.	2015

Information & Assistance

Objectives:

1.9 Implement fully functional Aging and Disability Resource Centers (ADRC-NY Connects in New York State) statewide.

1.10 Enhance existing NY Connects program operations and partnerships.

1.11 Advance long-term care planning and systems reform at the State and local level.

1.12 Work with partners at the local Department of Social Services to develop a process for streamlining Medicare Savings Program applications at the County level.

1.13 Develop a referral system for low income applicants directly to the Health Insurance Information and Counseling Program (HIICAP).

1.14 Continue to decrease the number of older New Yorkers eligible, but not receiving Low Income Subsidy (LIS) and Medicare Savings Programs (MSP) benefits.

1.15 Provide ongoing education and technical assistance to the 59 local HIICAP Programs so that they may continue to provide objective one-on-one counseling to Medicare beneficiaries and their caregivers.

1.16 Provide outreach and education to those identified by the Social Security Administration who reside in rural, non-English speaking communities.

1.17 Provide outreach and education to the AAAs regarding the needs of the LGBT older adult community and those older adults living with HIV/AIDS and their caregivers and share good practices in service delivery.

1.18 Provide timely and thorough response and assistance to constituent inquiries received through the New York State Office for the Aging's Help Line.

1.19 Provide non-English translation services to the standard operations of the Help Line.

1.20 Conduct regional listening sessions throughout New York State on the current and future role of senior centers to develop a comprehensive senior center policy and program agenda.

1.21 Increase the capacity for the long-term care ombudsman program to provide information and assistance to residents of facilities through increased volunteer recruitment.

1.22 Work with AARP, state agencies and other community partners to increase food stamp use among older adults.

Strategies:

- Expand NY Connects programs to the few counties that are currently not participating.

- Provide State directed contract management, and training and technical assistance to sustain local NY Connects operations.
- Assist Local Long-Term Care Councils to develop and annually report recommendations to the NY Connects state Long-Term Care Advisory Council.
- Train the NY Connects Programs to understand the Low Income Subsidy and Medicare Savings Programs to better help them assist their clients with applications and information about these programs.
- Train local Medicare Improvements for Patients and Providers Act (MIPPA) counselors to understand the application process, the budgeting methodology, eligibility standards and other issues in order to efficiently assist low-income New Yorkers with the program applications.
- Update and enhance the HIICAP Web-Site.
- Expand the number of programs, services, and type of information available to consumers through NYSOFA's computerized Help Line system.
- Analyze information obtained through inquiries to NYSOFA's Help Line and from NY Connects referral type data and local reform efforts to determine trends occurring in communities and statewide, in order to better understand the needs of aging constituents and the need for development of materials and services to address those needs.
- Collect good practices from LGBT and HIV/AIDS provider specialists to share with the aging network to better serve these older adults.
- Conduct regional information sessions regarding challenges and opportunities for senior centers to help inform NYSOFA regarding statewide senior center agenda.
- Track changes in the Affordable Care Act, Medicare and Medicaid and other state policies in order to provide accurate information to the public.
- Utilize internal resources to target recruitment of volunteers for HIICAP and LTCOP starting with those areas with high needs.

Objective	Expected Outcome	Target Date
1.9	Two additional NY Connects programs will be fully functional in the state.	2013
1.10	There will be five percent annual increases in the number of individuals contacting their local NY Connects program based on 2010-2011 levels.	2013
1.10	NY Connects as a referral source will be embedded in the discharge planning process in sixty-five percent of community hospitals. Currently there are no hospitals that have NY Connects embedded in the discharge planning process as a referral source.	2015
1.10	NY Connects teleconferences/webinars will take place quarterly, or as needed. County on-site technical support will happen annually, within the 4 years of the plan. Contract management will be provided on an as needed basis and at a minimum quarterly.	On-Going
1.11	100 percent of the NY Connects Long Term Care Councils will have developed and forwarded an annual report to the State Long Term Care Advisory Council.	2015
1.12	In order to better assist low income clients, formal working relationships will be developed between the local Department of	On-Going

	Social Services and the local Area Agency on Aging pertaining to the submission, determination and recertification of Medicare Savings Program applications.	
1.15	The total number of trained HIICAP counselors will increase by ten percent	2014
1.17	All AAAs will be provided good practices for targeting and serving the LGBT older adult population.	2013
1.19	Non-English translation services will be available through the statewide Help Line.	2012
1.20	A senior center program and policy agenda will be developed by NYSOFA for NYS.	2013
1.21	There will be an increase in HIICAP and LTCOP volunteers in targeted areas.	2012
1.22	Food stamp use among older adults will increase.	On-going

Case Management

Objective:

1.23 Provide technical assistance to the Area Agencies on Aging to support the continued provision of OAA Title III-B, Expanded In-home Services for the Elderly Program (EISEP) and Community Services for the Elderly (CSE) Program funded case management services for older adults and their caregivers.

1.24 Explore cost-sharing for Title III-B financed case management services.

Strategies:

- Develop and issue appropriate Technical Assistance Memorandums, Informational Memorandums and Program Instructions to the Aging Network.
- Assess training needs and deliver the necessary interventions to support the needs identified by the Aging Network.
- Develop a cost-sharing policy for OAA Title III programs.
- Offer mental health training to case managers to help them identify mental health problems among older adults and know where and how to refer for mental health services.
- Ensure that the assessment of training needs includes the ability to identify behavioral health conditions and appropriately and effectively link to mental health care.
- Increase collaboration with the Alzheimer's Association to better understand what an Alzheimer diagnosis means to the lives of those with the disease and their care partners.
- Explore the possibility of arranging comprehensive geriatric case management training across the state.

Objective	Expected Outcome	Target Date
1.23	Area Agencies on Aging will have the information and support needed to effectively and efficiently manage and deliver case management to ensure case coordination and access services.	On-Going
1.24	Test cost-sharing in 5 counties.	2014

NEW YORK STATE PLAN ON AGING - 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

In-Home Contact and Support

Objectives:

2.1 Expand the availability of non-medical home care services as a cost-effective alternative to more intensive and costly forms of care.

2.2 Enhance the ability of informal caregivers to care for older persons in a home environment.

2.3 Improve the planning, accessibility and management of home care services at the community and client levels.

2.4 Increase the capacity of the Aging Network to more effectively target its' resources to older people most in need.

2.5 Expand the provision of ancillary services provided by Area Agencies on Aging (AAA) as a strategy to address the needs of individuals in a flexible manner that is sensitive to individual needs and preferences.

2.6 Implement consumer direction in Expanded In-home Services for the Elderly Program (EISEP) to promote independence, individual choice and decision-making.

2.7 Offer home safety training to case managers to reduce incidence of falls and injuries related to falls.

Strategies:

- Issue one or more guidance documents to describe the changes that have been made to the regulations for ancillary services and how these changes can be used to address the needs and preferences of those served by EISEP.
- Use distance learning mechanisms (e.g., conference calls, teleconferences, and webinars) to reinforce and supplement guidance documents and to support activities on the local level to expand ancillary services.
- Issue one or more guidance documents to describe and expand upon the regulations that have been added to permit consumer directed in-home services under EISEP.
- Develop and disseminate a set of questions and answers to support EISEP-funded consumer-directed in-home services.
- Use distance learning mechanisms (e.g., conference calls, teleconferences, and webinars) to reinforce and supplement guidance documents and to support activities on the local level to implement consumer-directed in-home services.
- Review the ability to use health care costs as a deduction for determining cost share for the EISEP program.
- Explore ways to increase the use of assistive technologies as a means to support individuals and reduce the reliance on costly professional personnel.
- Consider the implementation of regular or periodic conference calls to support program expansion relative to ancillary services and/or consumer-direction.
- Collaborate with the New York State Department of Health bureau managing the Consumer Directed Personal Assistance Program through periodic meetings to provide program updates, share experiences and learning and to address problems and concerns.

- Conduct/arrange for training and provide technical assistance as needed to support AAAs in serving the culturally diverse populations in their communities utilizing the Community Services for the Elderly Program (CSE).
- Partner with occupational therapist association for training on fall and injury prevention and home safety interventions.

Objective	Expected Outcome	Target Date
2.5	Ancillary services being provided other than Personal Emergency Response System will be increased.	2012
2.5	At least 20 percent of the AAAs will fund at least one ancillary service that falls under in-home contact and support. Currently only one local area agency on aging currently funds an ancillary service that falls under in-home contact and support.	2013
2.6	At least five AAAs not participating in the Community Living Program will have implemented consumer directed in-home services.	2013
2.6	At least 33 percent of the AAAs will include consumer-directed in-home services as a service delivery model they offer in EISEP.	2015
2.7	Home safety training will be offered to case managers.	2013

Supporting Aging in Place

Objectives

2.8 Develop a Community Evaluation Tool for use by New York's communities.

2.9 Test the Livable New York Academy in select locations.

2.10 Provide community access to the Livable New York Academy training.

2.11 Assure compliance with NORC statute so that all NORC Programs meet population requirements based on the 2010 Census.

2.12 Increase Naturally Occurring Retirement Community (NORC) resident participation in program planning, implementation and evaluation in a minimum of 50 percent of the programs promoting a sense of empowerment and community among seniors.

2.13 Conduct Home Energy Assistance Program/Weatherization Referral and Packaging cluster meetings for AAAs in each region of the state.

Strategies:

- In 2011, state funding will be used to develop a Community Evaluation Tool for use by New York's communities that will comprise: (1) a survey instrument, which will address the initiative's focus areas and which will be available as a means for communities to measure all residents' perceptions of their community's livability; and (2) a survey implementation process, with defined steps that advance the initiative's principles. A community's evaluation findings will provide a basis for planning and implementing projects and activities that will improve their level of livability (quality of life).
- In 2012, funding will be sought to make a three-year, three-step Academy process of community-based training and technical assistance available to communities, which will help communities: (1) understand the Livable New York approach to planning and project-implementation, (2) implement a community evaluation of residents' perceptions

of their community's livability, and (3) prioritize actions and implement projects and activities in response to the evaluation's findings.

- New York State Office for the Aging (NYSOFA) staff will assess the population status of NORC Programs by conducting a survey of all programs with 2010 census data, analyzing the information and making recommendations for addressing deficiencies.
- NYSOFA staff will write program standards to be implemented by the NORC programs.
- NYSOFA staff will develop a monitoring tool used to evaluate compliance with NORC program standards, analyze the information, and provide programs with feedback and an opportunity to submit a corrective action plan for approval, if warranted.
- NYSOFA staff will provide technical assistance and training to programs emphasizing and building strategies and skills to empowering NORC residents to play an active role in the NORC.
- NYSOFA staff will make a recommendation of changes that may be needed to the NORC legislation that reflect the evolution of the NORC program as well as NYSOFA's goals and priorities.

Objective	Expected Outcome	Target Date
2.8	A community evaluation tool will be developed.	2012
2.9 **2.10**	At least one community will test the three step Livable New York Academy.	2012
2.10	Livable NY Academy resources will be made available to communities throughout state via website.	2013
2.11	All NYSOFA funded NORC programs will be in compliance with statutory population criterion based on the 2010 Census.	2012
2.12	A minimum of 50 percent of the NORC programs will demonstrate an increase in senior resident participation in program planning, implementation and evaluation based on the number of seniors currently participating in the program, thereby providing vital services that are a direct result of senior involvement.	2014
2.13	Home Energy Assistance Program/Weatherization Referral and Packaging cluster meetings for AAAs will occur in all regions of the state.	2013

Nutrition Services

Nutrition Program for the Elderly

Objectives:

2.14 Maintain the provision of healthy, balanced congregate and home delivered meals.

2.15 Maintain the provision of nutrition counseling, nutrition education and health promotion service.

2.16 Increase the number of Area Agencies on Aging that operate evidence-based nutrition and disease prevention programs by 3 each program year over FY2010 baseline level.

Strategies:

- Implement 2010 Dietary Guidelines statewide by FY2012.

- Annually monitor compliance with nutrient requirements and dietary guidelines for meals served.
- Annually monitor compliance of State requirement concerning the use of a registered dietitian in each local nutrition program.
- Support the continued use of registered dietitians to perform nutrition screening, assessments and prevention.
- Monitor service data against projected levels of service quarterly and determine reasons for any variances.
- 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.
- Continue to serve on the Governor's Council on Food Policy to represent the issues, needs and concerns of older adults, caregivers and local nutrition programs, such as food safety, access to and availability of food (especially locally grown), and food insecurity.
- Annually monitor compliance of State requirement concerning the use of a registered dietitian in each local nutrition program.
- Support the continued use of registered dietitians to perform or oversee the planning and provision of annual nutrition education plans and the provision of nutrition counseling to participants especially those with high nutrition risk scores.
- Monitor service data against projected levels of service quarterly and determine reasons for any variances.
- 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.
- Use existing annual planning process to identify local programs planning to implement evidence-based programs and use the process to follow local program development activities in those areas using evidence-based programs already.
- Continue existing collaborations with various public and private partners including advocacy groups concerning health promotion disease prevention.

Objective	Expected Outcome	Target Date
2.14	Participant dietary intake levels based on serving size for all food groups will meet or exceed the national indicators.	On-Going

2.15	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
2.15	Wider availability of physical fitness activities for older adults.	On-Going
2.15	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
2.15	Increase by five percent the use of Medicare preventative and health screening benefits. (Source: CMS published claims data)	On-Going
2.16	Reduced risk or threat of acute and chronic diseases, such as diabetes and heart disease through the wider availability of evidence-based nutrition and disease prevention programs. (Source: Previous published research indicates the 70 percent or more of health is related to lifestyle choices)	On-Going
2.16	Lower rates of hospitalizations amongst participants of evidence-based interventions. (Source: Previous Peer-reviewed research)	On-Going
2.16	Higher quality of life reported by participants of evidenced-based interventions. (Source: Pre and post tests of CDSMP Participants)	On-Going

Supporting Caregivers

National Family Caregiver Support Program

Objectives:

2.17 Train and educate caregiver coordinators to expand their capacity and promote their professional development, and thereby enhance their ability to support informal caregivers who are caring for family members, friends and neighbors.

2.18 Provide easy access to up-to-date, relevant and useful information to caregivers and professionals through New York State Office for the Aging's (NYSOFA) caregiving web site.

2.19 Coordinate outreach to help caregivers self-identify themselves to access support if they want it.

2.20 Strengthen coordination with the State Caregiver and Respite Coalition of NYS and the NYS Family Caregiver Council.

Strategies:

- Hold monthly conference calls with the caregiver coordinators for training purposes, as well as problem-solving.
- Maintain the NYSOFA caregiving web pages as a resource for consumers and professionals, keeping it up to date, as well as improving and expanding it and linking it to other relevant sites including the NY Connects statewide resource directory.
- Maintain the page on the New York State Area Agencies on Aging Resources and Information Network (AAARIN) web site to support caregiver program coordinators in their administration and operation of the program.

Objective	Expected Outcome	Target Date
2.17	With increasing knowledge, caregiver coordinators, Area Agencies on Aging (AAAs) staff and sub-contracted agency personnel will be able to support caregivers so their care receivers can remain in the community.	On-Going
2.18	Caregivers and professionals who use the NYSOFA Caregiving Web Pages will find the information and additional linkages helpful as they assume their caregiving roles and responsibilities.	On-Going

Respite Services

Objectives:

2.21 Provide programming to ensure that informal caregivers will benefit from utilizing respite services.

2.22 Develop a coordinated system of accessible, community-based respite services for people of all ages and across all needs and conduct a statewide inventory of respite services and integrate services into the NY Connects statewide long-term care database (according to the Lifespan Respite Care Program work plan); thereby improving access to respite services for caregivers.

2.23 Increase the number of residential facilities that offer emergency, overnight and weekend respite services.

2.24 Increase, through collaboration with other state agencies and stakeholders, additional respite options.

Strategies:

- Administer the ten New York State-funded respite programs, 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**.**
- Implement the work plan activities (specified in the Administration on Aging's LifeSpan Respite Act approved application) that includes strengthening the infrastructure of the Statewide Caregiving and Respite Coalition of New York to become a fully functioning statewide caregiving and respite coalition; contacting partners from State agencies and local long-term care councils to engage them in identifying respite that is provided through all sources, and involving community volunteer or faith-based groups in their locality.

Objective	Expected Outcome	Target Date
2.21	Informal caregivers will self-report that they personally benefited from utilizing respite care services for their loved ones based on POMP information including in-home care, adult day services and overnight respite. (See State Plan Attachment E)	2013
2.22	Access to respite services for informal caregivers will be improved with a statewide coordinated respite system.	2013

2.22	Access to respite services for informal caregivers will be improved with a statewide electronic data base of respite services.	2013
2.23	There will be an increase in the residential facilities that offer respite services.	2013
2.24	Additional respite options will be created.	2013

Social Adult Day Services

Objectives:

2.25 Assess Social Adult Day Services **(**SADS) programs directly funded by the New York State Office for the Aging (NYSOFA) for compliance with the state regulations; thereby assuring that quality services are being provided to functionally impaired participants and their caregivers.

2.26 Through utilization of monitoring tools, Area Agencies on Aging **(**AAAs) that fund SADS determine compliance with program requirements and regulations; thereby assuring that quality services are being provided to functionally impaired participants and their caregivers.

2.27 Develop new models of SADS such as the enriched social adult day services model.

Strategies:

- Through an annual application process, quarterly reporting and on-site visits; state funded SADS programs have opportunities to demonstrate compliance with requirements and to receive technical assistance as needed.
- Review AAAs' SADS monitoring tools during the next four years to assure that program requirements are specifically monitored by AAA staff and technical assistance will be provided as needed.
- Work with DOH, the NY Connects long-term care councils and other stakeholders to develop and test the enriched SADS model.
- Explore the possibility of offering programs at different times of the day and night.

Expected Outcomes

Objective	Expected Outcome	Target Date
2.25	Functionally impaired participants who attend NYSOFA SADS programs will remain living in the community and not be institutionalized for an average of 18 months or longer.	2013
2.25	Caregivers who access adult day services in NYSOFA SADS programs will be able to care for their loved one at home and not institutionalize them for an average of 18 months or longer.	2013
2.26	Functionally impaired participants who attend AAAs' SADS programs will remain living in the community and not be institutionalized for an average of 18 months or longer.	2013
2.26	Caregivers who access adult day services in AAAs' SADS programs will be able to care for their loved one at home and not institutionalize them for an average of 18 months or longer.	2013
2.27	Explore opportunities to create innovative models of SADS.	Ongoing

New York State Family Caregiver Council

Objectives:

2.28 Work with the NYSOFA and the core team for the Lifespan Respite Program to develop a statewide, cross-age, cross-disability caregiving and respite network. The core team includes NYSOFA, SCRCNY and Monroe County Office for the Aging (MCOFA).

2.29 Educate the public about the unique needs, including housing, of grandparent caregivers who provide stability for children and keep them out of the formal foster care system.

2.30 Reach out to the business community and involve employers in finding creative solutions to allow caregivers to remain a productive part of the work force.

2.31 Work with SCRCNY to promote the theme, *You Care for Them, We Care For You* that was developed by the Family Caregiver Council in 2008.

2.32 Continue to raise awareness about caregiver issues and focus on those concerns of young caregivers through the Family Caregiver Council (FCC).

2.33 Identify training and technical assistance opportunities to provide materials that may be used in schools to reach out to young caregivers.

Strategies:

- Develop materials to be included on the Caregiver section of the New York State Office for the Aging (NYSOFA) web site.
- Reach out to the State Education Department to identify strategies to reach young caregivers in school settings.

Objective	Expected Outcome	Target Date
2.28	A statewide, cross-age, cross-disability caregiving and respite network is built and supported to serve all caregivers in New York State.	2012
2.30	Presentations to local businesses and local Chambers of Commerce will be made to educate employers about the value of family caregivers.	2013
2.31	Enhanced recognition about and for caregivers of all ages, and the importance of providing respite care.	2013
2.32	Young caregivers will have ready access to information about their situation to support them in their caregiving role.	On-Going
2.33	Contacts through the New York State Education Department will be established to develop a stronger network of support for young caregivers.	2013

Enhancing Older Americans Act Core Services

Lifespan Respite Grant Program

Objectives:

2.34 Develop a coordinated system of accessible, community-based respite services for people of all ages/across all needs.

2.35 Conduct a statewide inventory of respite services and include that information in the statewide New York Connects database.
2.36 Identify and facilitate the development of Respite Services for underserved populations.
2.37 Identify current programs that train informal caregivers and provide a methodology to link caregivers to programs.
2.38 Determine best practices and establish linkages to recruitment and training of volunteers.
2.39 Raise public awareness about caregiving and value of Respite Care.
2.40 Develop a strategic approach to ensure sustainability of Lifespan Respite Services delivery and management.

Strategies:

- Work with the New York Lifespan Respite advisory group to include representation of all key stakeholder groups for design, establishment, and implementation activities of the Lifespan Respite Program.
- Establish sub-groups of the New York Lifespan Respite advisory group as needed to focus and work on specific tasks (e.g., inventory, program design, training, web design and other technology, media and marketing, etc.).
- Build and strengthen the infrastructure of Statewide Caregiving and Respite Coalition of New York (SCRCNY) to become ready for all components of a fully functioning statewide caregiving and respite coalition.
- Review current membership of the SCRCNY and conduct outreach to expand membership.
- Establish and use formal communication channels in SCRCNY to reach out to members and the general public (e.g., web site, newsletter, or e-mail blasts).
- Conduct inventory with the New York Lifespan Respite core team and advisory group and determine best methods to integrate information into the New York Connects data base. Work with State agencies to identify additional respite programs and the criteria for eligibility to integrate into New York Connects database.
- Develop steps to work with advisory sub-group and stakeholders to identify services to meet needs of underserved populations and use of existing services to meet those needs.
- Develop steps to work with advisory sub-group and stakeholders to identify services to meet needs of underserved populations and use of existing services to meet those needs.
- Develop steps to review current methods to recruit and train volunteers for respite services provision.
- Determine best message strategy to communicate with both the public and caregivers and continue to develop the message.

Objective	Expected Outcome	Target Date
2.34	The NYCRC, with guidance and direction from NYSOFA, will become a recognized, statewide, cross-age, cross-disability network.	2013
2.35	An inventory of all respite services will be conducted by the Lifespan Respite Program Core Team and Advisory Group to build a comprehensive, statewide respite database. The respite database will be part of or will be merged into the existing NY Connects resource directory.	2012

2.36	The NYCRC Advisory Group will assist in identifying the types of services that would meet the needs of underserved and diverse populations and determine if existing services might be used or modified to meet those needs. Additionally, best practices for underserved populations will be identified through local LTCCs, and will be disseminated through NYCRC.	2012
2.37	Existing caregiver training and education programs will be identified and included in the SCRCNY Web site for use across the state.	2012
2.38	The NYCRC will gather and review 'good' recruitment and training practices and establish linkages to recruitment and training of respite volunteers.	2013
2.39	The NYCRC will use a 'marketing' message such as the one developed by the New York State Family Caregiver Council, "You Care for them, We Care for you," to enhance recognition about and for caregivers of all ages, and the importance of providing respite care.	2013
2.40	State agencies and other stakeholders will be convened to identify strategies to increase respite care funding and removal of regulatory/policy barriers.	2013

Community Supports Navigator Grant Program

Objectives:

2.41 Increase availability of the Community Transitions Initiative (CTI) model to consumers and caregivers by expanding the targeted populations and develop a CTI-Plus model that combines CTI with the Community Supports Navigator Grant Program.

2.42 Increase capacity through provision of additional training in the CTI model.

2.43 Sustain the CTI-Plus program by working with providers and payors to identify ongoing reimbursement.

2.44 Conduct an evaluation involving consumers and caregivers to support sustainability and replication.

2.45 Work with Department of Health and other stakeholders to apply for federal Affordable Care Act Care Transitions grants to reduce preventable hospital readmissions for targeted Medicare beneficiaries.

Strategies:

- Formalize eligibility guidelines and complete administrative and staffing preparations to serve additional CTI patients.
- NYSOFA and State University of New York at Albany Center for Excellence in Aging Services and Community Wellness will provide a formal and comprehensive training to volunteers to ground them in their roles and responsibilities.
- Initiate discussions with local insurance companies and hospitals to sustain and expand care transitions programs.
- Collect data on a quarterly basis to assess the program's effectiveness at achieving its goals and objectives.

Objective	Expected Outcome	Target Date
2.41	Staffing preparations will be complete and the CTI will be available to additional eligible target populations.	2012
2.42	Volunteers providing the CTI will be trained and grounded in their roles and responsibilities.	2013
2.43	NYSOFA and local partners will create additional opportunities for cross system community building to leverage CTI sustainability and replication to other counties.	2013
2.44	The care transitions programs will reduce the rate of hospital readmissions among at-risk patients in Albany and Tompkins Counties by 50 percent.	2013

Community Living Grant Program

Objectives:

2.46 The New York State Office for the Aging **(**NYSOFA) will make regulatory changes to accommodate expansion of the Community Living Program (CLP).

2.47 Produce a Process Evaluation to outline the steps involved in developing a Consumer-Directed (CD) program to be used by Area Agency on Aging (AAA) Directors.

2.48 Produce evidence-based data on the program's ability to reduce nursing home placement and Medicaid spend-down.

Strategies:

- Adopt proposed regulation changes to Expanded In-home Services for the Elderly (EISEP) and expand cost-share of Older Americans Act (OAA) funds throughout the state.
- Complete a user manual based on interviews with Nursing Home Diversion and Modernization (NHDM) and CLP managers, as well as, through a formal process analysis.
- Track enrollees of the NHDM program and the CLP and produce a formal program evaluation.

Objective	Expected Outcome	Target Date
2.46	With new regulations, CLP counties will be able to continue to provide CD services. Furthermore, counties not currently involved in the CLP grant will be able to offer CD services.	2014
2.47	All New York counties will have a complete resource guide outlining the most efficient way to develop a CD program.	2013
2.48	Local programs and State decision makers will recognize the implications of the CD programming and will be able to incorporate the main concepts of CLP into efforts concerning long-term care plan restructuring.	2014

Veterans Directed Home and Community-based Services Program

Objectives:

2.49 Finalize Program Guidelines/Policy Manual and veteran materials for the program.

2.50 Develop and implement the Veterans-Directed Home and Community-Based Services (VDHCBS) Program in seven additional counties, for a total of ten operational counties.

2.51 Examine VDHCBS data for Oneida, Onondaga, and Broome Counties to determine the effectiveness of the program and to make improvements to the program.

Strategies:

- Review materials produced by other states participating in the VDHCBS Program.
- Work with the three Veterans Administration (VA) Medical Centers and VA Central Office to finalize Program Guidelines and veteran outreach materials for the VDHCBS Program in New York State.
- Support efforts of the VA Medical Centers to obtain approval from the VA Public Relations Office to disseminate the materials.
- Facilitate discussions and contract negotiations between the Area Agencies on Aging that are participating in the VDHCBS Program, and their partnering VA Medical Centers through face-to-face meetings and conference calls.
- Obtain and analyze data on the veterans participating in the program from the three counties.

Objective	Expected Outcome	Target Date
2.49	New York State will have established Program Guidelines and consumer materials that will guide the program in the participating counties and ensure consistently high quality care for veterans.	2012
2.50	VDHCBS is expected to be operational with fully executed Provider Agreements in four additional counties.	2012
2.50	VDHCBS will be fully operational in all ten counties.	2013
2.51	NYSOFA will be able to report to Veterans Hospital Administration and the Administration on Aging on the effectiveness and success of the VDHCBS Program.	2014
2.51	NYSOFA will be able to present the findings from the VDHCBS Program at the "Aging Concerns Unite Us" Conference.	2012

Cost-Share for Title III Services

Objective:

2.52 Establish New York State Office for the Aging (NYSOFA) cost-sharing policy for Older Americans Act (OAA) Title III Services.

2.53 Test cost-sharing in counties.

Strategies:

- Determine the feasibility of cost-sharing for those services that are permissible under the OAA programs.

- Review other states' experiences with cost-sharing Title III Services
- Review cost sharing for OAA services under Title III based on the collective experience in both the Nursing Home Diversion and Modernization Grant Program and Community Living Program demonstrations and, based on outcomes, will consider whether or not cost-share provisions would be extended statewide.
- Seek input from the Area Agencies on Aging (AAAs) and respective advisory councils.

Objective	Expected Outcome	Target Date
2.52	NYSOFA will determine the feasibility of a cost-share policy for Title III funded services.	2013
2.53	Seek input from area agencies on aging (AAA) and respective advisory councils regarding cost sharing for OAA funded programs. A group will be organized (NYSOFA, AAAs and relevant stakeholders) to better understand the pros and cons of cost sharing. Policies and procedures will be developed around cost sharing that can be tested by counties that self-select. Cost-sharing will be tested in at least 5 counties	2014

NEW YORK STATE PLAN ON AGING - GOAL 3

Empower older New Yorkers to stay active and healthy through Older Americans Act Services and the new prevention benefits under Medicare.

Disease Prevention and Health Promotion Services

Preventive Health Services

Objective:

3.1 Increase the use of all Medicare preventive and health screening benefits, focusing especially 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. The overall goal is to prevent and to reduce morbidity and mortality rates, and improve the quality of life of older adults, while at the same time reduce the use of health resources.

3.2 Develop a coordinated outreach plan with the Department of Health to increase use of prevention and wellness benefits.

Strategies:

- Work with Centers for Medicare Services (CMS), Health and Human Services (HHS), and the Administration on Aging (AoA) to identify opportunities to increase the use of Medicare preventive benefits for New York State's older adults.
- Work with New York State health care system including the New York State Department of Health, the Medical Society of the State of New York, Community Health Association of New York State, Health Association of New York State, American Cancer Society,

American Heart Association and other organizations to best use Medicare preventive benefits especially the annual wellness exam.

- Increase the number of older adults who receive reminders for Medicare preventive and health screening benefits.
- Explore the possibility of providing annual training sessions on available service and support resources, including programs to screen for the prevention of depression, coordination of community mental health services, and referral to psychiatric and psychological services.
- Review and analyze data and information on early cancer diagnoses, the use by people age 65 and older of cancer screening and of other prevention benefits and CMS fiscal claims data and provide county-specific information to Area Agencies on Aging (AAAs) and other organizations to assist them in their public health work with older adults.
- Publicize via accurate, up-to-date information Medicare preventive and health screening benefits available through New York State's 59 AAAs, NY Connects, congregate meal sites, local Health Insurance Information and Counseling Assistance Programs and through other venues as noted above to increase consumer awareness.
- Based on resources available, develop targeted small scale media events to increase the use of Medicare benefits.

Objective	Expected Outcome	Target Date
3.1	Increase by five percent the use of Medicare preventive and health screening benefits. (Source: CMS published claims data)	On-Going
3.2	A plan will be developed to provide a unified outreach message for prevention, health screenings and wellness.	2012

Evidence-Based Disease and Disability Prevention Grant Program

Objectives:

3.3 Implement the Chronic Disease Self-Management Program (CDSMP) in each of the six regions of New York State.

3.4 Monitor progress in each region with support from the University at Albany's Center for Excellence in Aging & Community Wellness, Quality and Technical Assistance Center (QTAC).

3.5 Work with each regional collaborative to develop a business plan for grant implementation and CDSMP sustainability beyond the grant period.

3.6 Work with the Department of Health to identify collaborations and resources to expand CDSMP statewide through the aging network.

Strategies:

- Through Regional Collaborative staff, train Master Trainers and Peer Leaders in conducting workshops at multiple sites in the region.
- Through QTAC, request information from participating regions for each completed workshop and track data through the National Council on Aging (NCOA) Evidence-Based Healthy Aging Program database.

- Work with QTAC to assist each region in developing a business plan by giving feedback to regions based on progress updates and providing each region with quarterly goals for participants and completers.

Objective	Expected Outcome	Target Date
3.3	Increase to 10,000 the number of older New Yorkers who participate in the CDSMP. (Baseline: 2,900 as of July 2011)	On-Going
3.5	Each region will have a plan for sustainability developed by April 2011, and revised if necessary by April 2012.	2012
3.5	QTAC will provide final reports to NYSOFA, AoA and each regional collaborative.	2012
3.5	Each region will have a business plan developed and in place.	2011
3.6	CDSMP will be expanded through the aging network	2013

Activities for Health Independence and Longevity

Civic Engagement, Volunteerism

Objectives:

3.7 Enhance the rates of older adults participating in volunteer service.

3.8 Encourage communities to engage in comprehensive planning efforts designed to meet the needs of an aging population and create livable communities.

3.9 Reduce the rate of social isolation among older adults.

3.10 Increase community organizations use of the state volunteer website newyorkersvolunteer.org to match volunteers with meaningful volunteer experiences.

3.11 Develop positive outreach messages on aging including the economic, intellectual and social value of older adults to counter the stereotype that aging is a drain on public resources. Positive message will include data showing the significance of older adults to the economy and the community's economic activity.

Strategies:

- Increase interagency collaborations.
- Encourage local communities to engage in comprehensive local planning efforts to prepare for the challenges and opportunities of an aging population.
- Prepare statistics about the social and economic contributions of older adults to their communities.
- Conduct trainings and provide technical assistance and information about best practices regarding civic engagement activities.
- Increase awareness by the Workforce Investment Board's One-Stop Centers of the unique needs and challenges confronting older workers.

Objective	Expected Outcome	Target Date
3.7	There will be a five percent statewide increase in the number of older New Yorkers who volunteer based on SFY 2010-2011 levels.	2013 and on-going

3.8	Communities will engage in thoughtful and deliberative process to plan for the challenges and opportunities that will be presented by an aging population.	On-Going
3.9	There will be a reduction in isolation among older adults through efforts to increase volunteerism and assisting communities in thoughtful community planning. .	On-Going
3.10	There will be an increase in the number of volunteer postings on www.newyorkersvolunteer.org	On-Going
3.11	A positive message on aging will be developed.	2012

Retired Senior Volunteer Program

Objectives:

3.12 Increase awareness of and participation in the Retired Senior Volunteer Program (RSVP) program.

3.13 Increase the cultural diversity of programs, both with respect to the recruitment of volunteers and their placement.

Strategies:

- Monitor prior and current year volunteer and service levels and utilize internal resources as well as external partnerships to increase RSVP volunteers.
- Provide additional guidance to programs to encourage new and/or innovative methods of recruitment and outreach for the program**.**
- Provide guidance to programs concerning recruitment methods targeted to individuals of diverse cultural backgrounds and provide technical assistance as needed**.**

Objective	Expected Outcome	Target Date
3.12	There will be an increase in the number of volunteers recruited by a minimum of five percent from State Fiscal Year 2010-11 levels.	2013
3.13	Increase the number of volunteers from culturally diverse back-grounds at least five percent from State Fiscal Year 2010-11 levels.	2013

Foster Grandparent Program

Objectives:

3.14 Increase awareness and participation in the Foster Grandparent Program.

3.15 Increase the diversity of programs, both with respect to the recruitment of volunteers and their placement.

Strategies:

- Monitor prior and current year volunteer and service levels and utilize internal resources as well as external partnerships to increase Foster Grandparent volunteers.
- Provide additional guidance to programs to encourage new and/or innovative methods of recruitment and outreach for the program.

- 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
3.14	The number of new volunteers recruited will be increased by a minimum of five percent from State Fiscal Year 2010-11 levels.	2013
3.15	The number of new volunteers from culturally diverse backgrounds will be increased by at least five percent from State Fiscal Year 2011-12 levels.	2014
3.15	The participation by schools and other facilities serving children/families of diverse backgrounds and underserved individuals will increase by a minimum of five percent from 2011-12 levels.	2014

Older American Community Service Employment Program (Title V)

Objectives:

3.16 Enhance employment opportunities for older New Yorkers and the promotion of older workers as a solution for businesses seeking a trained, qualified, and reliable workforce.

3.17 Utilize a service approach that can respond quickly and effectively to the changing needs of business.

3.18 Encourage the placement of Title V workers in aging services programs that are seeing a reduction in volunteer hours due to fuel costs.

Strategies:

- Continue to hold regional trainings throughout the state for local Older American Community Service Employment Program (OACSEP) coordinators.
- Coordinate and host an annual Equitable Distribution meeting with the eight national contractors also operating in New York State.
- Encourage the State to utilize Older Americans Act funded Title V workers to fill existing employment gaps.
- Expand slots by eliminating unnecessary unemployment insurance payments. Encourage participation of Title V Programs in the Make Work Pay initiative (an employment training program funded by a CMS Medicaid Infrastructure Development Grant that is designed to increase New York's capacity to support individuals with all ranges of disabilities with a desire to work – including older workers who desire to remain in the workforce) that is being headed up by the Office of Mental Health (OMH).

Objective	Expected Outcome	Target Date
3.16	Employment opportunities for older New Yorkers and the promotion of older workers as a solution for businesses seeking a trained, qualified, and reliable workforce will be increased.	On-Going
3.17	The New York State Office of Mental Health and the New York State Department of Labor will link Title V workers to the Make Work Pay web-based system leading to a five percent increase in the number of Title V workers being placed in unsubsidized employment.	2012

NEW YORK STATE PLAN ON AGING - GOAL 4

Ensure the rights of older New Yorkers and prevent their abuse, neglect and exploitation.

Legal Services

Legal Assistance Program

Objectives:

4.1 Identify the legal issues most frequently encountered by older adults, particularly among those individuals with the greatest economic or social needs who might otherwise be unable to obtain necessary legal assistance.

4.2 Increase awareness of and understanding by Area Agencies on Aging (AAAs), providers of legal assistance, older New Yorkers, their families, and their caregivers of the fiduciary responsibilities of a guardian or an attorney-in-fact with respect to managing the older person's property and of legal steps that can be taken to avoid or prevent abuse, neglect and financial exploitation.

4.3 Encourage local efforts for elder rights coordination among AAAs, providers of legal assistance, Long Term Care Ombudsman coordinators and local ombudsmen to provide timely legal assistance to such individuals.

Strategies:

- Develop partnerships to conduct a Statewide Survey of Older New Yorkers, AAAs, and Legal Assistance Providers to determine legal needs.
- Establish a workgroup to: review current program standards; develop best practices for outreach, access to legal services, monitoring, reporting, and program assessment; and develop a uniform reporting format.
- Determine if the AAAs need assistance in efforts to develop partnerships to encourage developing pro bono programs to supplement AAA legal services providers with expertise by attorneys from the private sector.
- Collaborate with legal providers and other elder rights advocacy programs for the development and dissemination of education pieces and education activities to increase awareness of and understanding by older New Yorkers, their families, and their caregivers of the legal issues they encounter including fiduciary relationships, advanced directives, insurance, and long-term care for prevention and early detection of a problem that would jeopardize the independence and dignity of the older adult.

- Facilitate discussion among the AAAs, Long Term Care Ombudsman Coordinators and Legal Assistance Providers for the creation and implementation of local referral procedures for older adults in need of legal assistance residing in institutional settings.
- Coordinate activities with other agencies to address fraud, exploitation, and abuse of older New Yorkers. State agencies will include New York State's Office of Children and Family Services (in which Protective Services for Adults {PSA}is located), State Police, Department of Criminal Justice Services, District Attorneys Association, State Department of Law, and Consumer Protection Board.
- Encourage and support events which provide access to various workshops on legal issues of concern and interest to elders, their families, and their caregivers.
- Encourage referral by the AAA to the Legal Assistance Providers to appeal denials of the Low Income Subsidy (LIS) and Medicare Savings Programs (MSP) benefits.
- Encourage the formation of local multi-disciplinary Elder Abuse Prevention Councils by providing examples of successful models and best practices throughout the state.

Objective	Expected Outcome	Target Date
4.1	New York will improve its position to be better able to identify the need and direct limited legal services resources toward their most efficient use.	On-Going
4.2	New York will improve its position and achieve a better understanding of obligations under the law pertaining to managing the older person's property and of legal steps that can be taken to avoid or prevent abuse, neglect and financial exploitation.	On-Going
4.3	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.	2015

New York State Long-Term Care Ombudsman Program

Objectives:

4.4 Improve local ombudsman program's capacity and skills to provide effective individual and systems advocacy.

4.5 Improve consumer access to ombudsman and other advocacy services including legal assistance.

4.6 Increase the number of LTCOP volunteers to provide coverage for all facilities under their jurisdiction.

Strategies:

- Revise the Long Term Care Ombudsman Program's (LTCOP) training manual/methodology to improve consistency and complaint investigation/resolution skills.
- Promote the convening of local stakeholders groups focused on identifying and addressing risk factors associated with abuse, neglect and exploitation.
- Provide technical assistance to help local programs improve volunteer recruitment and retention, including recruitment of volunteers from culturally diverse backgrounds.

- Establish regular coordination with other Elder Rights programs to promote cross training and develop referral protocols.
- Collaborate with other organizations to develop and implement training to help ombudsmen promote and enhance the development of resident councils in adult homes.
- Coordinate with MFP grantees and the state Survey and Certification agency to ensure nursing home residents receive information about options for returning to the community.
- Improve coordination with agencies and programs involved in nursing home diversion and transition efforts, including Money Follows the Person and the new nursing home MDS 3.0 Section Q requirements.
- Recalibrate training curriculum and delivery to enhance ombudsman investigation and advocacy skills and improve coordination with other Elder Rights programs and initiatives that provide legal services, elder abuse prevention and public benefits counseling.

Objective	Expected Outcome	Target Date
4.4	The percentage of nursing homes and adult care facilities that receive routine visits from a local ombudsman will increase to at least 90 percent and 75 percent respectively.	2015
4.5	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.	2015
4.6	The number of volunteers will increase.	On-Going

SMP (formerly, Senior Medicare Patrol Program)

Objectives:

4.7 Recruit and train volunteers to educate older New Yorkers and the general public on how to identify and report error, fraud, and abuse and expand SMP to a broader statewide initiative.

4.8 Produce more mini-regional Medicare fraud summits modeled after the Brooklyn New York Summit in one or more areas in New York State.

4.9 Produce greater awareness among all Medicare beneficiaries about health care fraud and abuse and how people can best protect themselves.

Strategies:

- SMP grantees recruit and train volunteers to conduct anti-fraud education and prevention in senior-oriented community events.
- Grantees collaborate with community organizations serving disabled, homebound, non-English-speaking, and hard-to-reach populations to ensure that the SMP message reaches vulnerable, socially isolated populations.
- Grantees incorporate the SMP message into their own organizations' programs and their partner organizations' programs.
- Encourage county partnerships to play a critical role in fighting health-care fraud and abuse.
- Print and distribute a supply of educational material for local programs to use for outreach.

- Expand the SMP Consortium to include representation from State and federal agencies that share interest in fighting against health care fraud and abuse, for example Attorney General's Office, Office of Medicaid Inspector General, Consumer Protection Board.
- Train local HIICAP/SMP programs on establishing and maintaining their volunteer programs.
- Assist local programs with developing action plans to recruit, train and retain volunteers.
- Focus on educating targeted populations that have vulnerability to health care fraud.

Objective	Expected Outcome	Target Date
4.7	The number of SMP-only volunteers will be increased from 15 to 50 in New York State.	On-Going
4.7	The number of Medicare beneficiaries that recognize two or more ways to protect themselves from Medicare fraud and abuse will be increased through trainings.	On-Going
4.8	At least one mini regional Medicare fraud summit will take place in high fraud areas.	2014
4.9	Outreach to non-English speaking, hard-to-reach populations to protect, detect and to report health care errors, abuse and fraud will be increased.	On-Going
4.9	The number of telephone calls to the SMP hotline on suspected fraud and abuse, and an increase in Medicare funds recovered will be increased.	On-Going

Elder Abuse Education and Outreach Program

Objectives:

4.10 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.

4.11 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.

4.12 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.
- Update the 25 year old Memorandum of Understanding (MOU) between the New York State Office for the Aging (NYSOFA) and the Office of Children and Family Services (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.

Objective	Expected Outcome	Target Date
4.10	Services and activities, including the conducting of public awareness presentations, training of professionals and non-professionals working	On-Going

	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.	
4.10	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
4.11	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 Public Service Area (PSA) and aging services.	2013
4.12	A new/revised local MOU will be produced between PSA and aging funded services that cover information in key areas necessary for good coordination and referrals between local Area Agencies on Aging and Departments of Social Services.	2013

NEW YORK STATE PLAN ON AGING - GOAL 5

Refine current management and operational practices to achieve greater efficiency and an effective management structure throughout the Aging Network in New York State.

Information Driven Programs/Initiatives/Services

Data Quality, Collection, and Analysis

Objectives:

5.1 Provide Area Agencies on Aging (AAAs) with data verification reports that allow them to confirm reported data and assist them with making corrections to their client data.

5.2 Identify data needed locally to improve performance and guide the tailoring of services to the unique needs of older adults and their caregivers.

Strategies

- Continue and enhance support for user-group activities. Provide technical assistance to group meetings on: (1) strengthening data-collection practices by provider organizations and AAA direct-service staff; and, (2) reviewing data by provider organizations and AAA personnel to assure reliability.
- Work with vendors to encourage the development and/or enhancement of tools that support routine program operations (for example, using customer information and mapping technologies to create efficient routing of vehicles that transport older adults to medical appointments).
- Reinforce the shift from aggregate data systems to customer-based systems through training and technical assistance activities.

Objective	Expected Outcome	Target Date
5.1 **5.2**	Data will be available to improve performance and guide the tailoring of services to the unique needs of older adults and their caregivers.	On-Going

County Data Book: Selected Characteristics

Objective:

5.3 Maintain the highest standards of quality and usability and base knowledge of the attainment of those standards through the interaction with various customers.

Strategies:

- Review of ongoing data-requests to determine customer needs.
- Review of policies and directives (internal and external) requiring support data.
- Provide additional data as new resources become available.

Objective	Expected Outcome	Target Date
5.3	Timely and accurate demographic data, depicting population trends and characteristics will be available at the county level and accurately portray the older adult population and their caregivers.	On-Going

Performance Outcomes Measurements Project

Objectives:

5.4 Demonstrate New York's Aging Network is providing high quality services by implementing POMP consumer satisfaction tools in at least half of the counties.

5.5 Demonstrate the value of New York's Aging Network Services by showing the number of select home and community-based services recipients with severe disabilities (3+Activities of Daily Living (ADL) limitations) equal to or greater than one third of the client population.

5.6 Include targeted POMP questions in the AAA required Annual Implementation Plan.

5.7 Provide POMP tools to all counties and encourage their use.

Strategies:

- Assist Area Agencies on Aging (AAAs) and service providers in adopting "POMP TO GO" toolkit to collect consumer satisfaction data to demonstrate the quality of New York's Aging Network.
- Provide AAAs and service providers training on how to use "POMP TO GO" toolkit to collect consumer satisfaction outcome data.
- Assist the Administration on Aging (AoA) in conducting longitudinal surveys to compliment the cross-sectional information of existing POMP surveys and validate the nursing home predictor model.
- Assist AAAs in adopting "POMP TO GO" toolkit to collect client data on their ADL/IADL limitations.
- Provide AAAs training on how to use "POMP TO GO" toolkit to collect data.
- Assist AoA in conducting longitudinal surveys to monitoring the changes in clients' functional abilities over time.

Objective	Expected Outcome	Target Date
5.4	Consumer satisfaction data will be collected by at least 50 percent of the AAAs.	2013
5.5	Longitudinal survey instruments will be developed and tested.	2012
5.5	Pertinent functional ability data on select home and community-based services recipients will be collected by at least 80 percent of the AAAs.	2013
5.7	POMP TO GO toolkits will be disseminated to non-POMP AAAs and service providers.	On-Going

Equal Opportunity, Diversity Management

Objectives:

5.6 Identify and coordinate implementation of methods for providing improved linguistic accessibility for major New York State language groups in service delivery.

5.7 Conduct at least two regional and /or statewide Area Agencies on Aging (AAAs) and provider trainings, including Webinars, on Cultural Competence and Targeting issues per year during the 2011-2015 Plan cycle.

Strategies:

- Explore cost effective telephone language line services that can be utilized by NYSOFA and providers in areas where bilingual staff may be difficult to recruit and retain. Efforts to implement these services where necessary will be continued over the next 2011-2015 Plan cycle.
- Re-issue NYSOFA's targeting policy in 2011and provide mandated statewide targeting training for all 59 AAAs in New York State. The training will include the fundamentals of targeting requirements.
- Continue to provide cultural competency and best practices training as well as ongoing efforts to provide direct training for AAAs as feasible. A grant has been obtained by NYSOFA to provide staff training in Technical Skills in Outreach and Assessments of Culturally Competent Services to Diverse Populations. This training will be designed to build staff capacity to provide technical assistance to AAAs in identifying diverse community linkages and areas where cultural competence in services to targeted groups can be improved.
- Expand requests to the AAAs for information and planning on regional efforts to improve targeting outcomes. Based on the information collected, NYSOFA will expand technical assistance to providers in meeting their targeting goals and improving service delivery to target populations.

Objective	Expected Outcome	Target Date
5.6	AAAs will have access to cost effective telephone language line services for interpretation services in areas where recruitment and retention of bilingual staff is difficult to attain and/or bilingual services are needed only sporadically.	2012

5.7	AAAs and other Network providers will increase knowledge, skills and abilities in designing and delivering culturally competent services to targeted populations.	On-Going

Community Affairs and Public Participation

Objective:

5.8 Advance the priorities of the New York State Office for the Aging (NYSOFA) and the Aging Network.

Strategies:

- Identify and develop informational/educational products that highlight NYSOFA and Area Agency on Aging (AAA) programs and services.
- Identify and develop systems within NYSOFA to provide a coordinated message to educate the public about the Aging Network programs and services.

Objective	Expected Outcome	Target Date
5.8	The Community Affairs and Public Participation Unit (CAPP) will continue to develop a range of products, using multiple types of formats, aimed at informing constituencies, providing technical assistance to Area Agencies on Aging, aimed at advancing the priorities of NYSOFA and the Aging Network.	On-Going

Intergovernmental Collaboration

Objective:

5.9 Forge viable relationships with other State and local agencies, to enhance the New York State Office for the Aging's (NYSOFA) capacity to address cross agency issues that will help older adults be served in program areas that traditionally are not under the direct purview of the Agency.

Strategy:

- Formalize relationships with other State agency partners to address cross-agency issues.

Objective	Expected Outcome	Target Date
5.9	The Agency collaborations will assist in meeting NYSOFA stated outcomes in four year plan.	On-Going

Emergency Preparedness

Objectives:

5.10 Maintain a structure at the New York State Office for the Aging (NYSOFA) for managing involvement in state and local emergency preparedness and recovery activities.

5.11 Inclusion of older adults and county Area Agencies on Aging (AAAs) in the development of all local emergency plans.

5.12 Provision of training through the State Emergency Management Office (SEMO) on-line training.

Strategies:

- Coordination of activities within NYSOFA through a disaster preparedness team coordinated by the Division of Community Services.
- Provision of updates on disasters to affected counties and collection of status reports from the AAAs in these areas.
- Partnerships with SEMO, the Disaster Preparedness Commission, and Area Agencies on Aging.
- Continue assisting SEMO and the Office of Homeland Security with recovery operations, as requested.
- Continue participating on SEMO standing and ad hoc committees.
- Work with SEMO and other State agencies to help develop state and local plans for assisting special-needs populations.
- Continue to work with AAAs in emergency preparedness and relief/recovery efforts.
- Continue to assure that the Nutrition Program for the Elderly provides frozen and/or shelf-stable meals that may be used in emergency situations.

Objective	Expected Outcome	Target Date
5.10 **5.11**	Inclusion of the needs of older persons and their families in special-needs population plans for emergencies will be ensured.	On-Going
5.10 **5.12**	Timely support will be available and viable for AAAs during local and regional emergencies.	On-Going

APPENDICES

Appendix A

STATE PLAN ASSURANCES, REQUIRED ACTIVITIES AND INFORMATION REQUIREMENTS
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging

will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-
(A) services associated with access to services (transportation, health services **(**including mental health services**)**, outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);
(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and
(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--
(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long Term Care Ombudsman, a State Long Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with

social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in

anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;
(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;
(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*
(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.
(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

INFORMATION REQUIREMENTS

Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))
The term "in-home services" includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

Section 305(a)(2)(E)
provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

Section 306(a)(17)
Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

Section 307(a)
(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

Section (307(a)(3)
The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate*

funding formula, and a demonstration of the allocation of funds to each planning and service area)
(B) with respect to services for older individuals residing in rural areas:
(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

Section 307(a)(8)) (Include in plan if applicable)
(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.
(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

Section 307(a)(10)
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

Section 307(a)(21)
The plan shall:
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III)*, if applicable, and specify the ways in which the State agency intends to implement the activities .

Section 307(a)(28)
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

Section 307(a)(29)
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Section 307(a)(30)
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

Section 705(a)(7)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through (6) of this section are listed below)*
In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;
(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;
(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;
(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;
(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);
(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

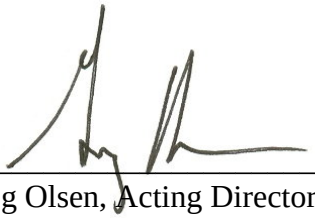
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order.



June 27, 2011

Greg Olsen, Acting Director

APPENDICES

Appendix B

INTRASTATE (IFF) FUNDING FORMULA

Please Note – The Intrastate Funding Formula for the 2011-2015 State Plan is unchanged from the previously approved formula.

APPENDICES

Appendix 1

Financial Plan

Projected Financial Plan

for Federal Fiscal Year 2011
Projected New York State Operating Budget

Resources To Be Used for State Agency Activities

	Title III	Title III Match	Other	Total
Title III	$3,977,737			$3,977,737
Title III Long-Term Care Ombudsman Program	1,299,000			1,299,000
Other Older Americans Act Funds			1,910,715	1,910,715
Other Federal Funds			830,930	830,930
State Funds		1,470,246	288,754	1,759,000
Total	$5,276,737	$1,470,246	$3,030,399	$9,777,382

Note:
New York State pays fringe benefits for personal service costs out of a central fund consisting of 100% state funding. This equals approximately $2,140,000 for Title III funded personal services and $956,000 for other OAA-funded personal services. These fringe benefit costs are not reflected in the above schedule.

Projected New York State Program Allocations
By Planning and Service Area for FY 2011

Planning and Service Area	Title III Funds	Other OAA Funds	Non-Title III Funds	Total Funds Awarded
ALBANY	$1,018,341	$874,764	$2,385,688	$4,278,793
ALLEGANY	193,340	136,315	523,682	853,337
BROOME	809,566	354,974	1,300,838	2,465,378
CATTARAUGUS	299,128	170,067	627,527	1,096,722
CAYUGA	308,324	140,355	611,624	1,060,303
CHAUTAUQUA	572,684	231,797	998,883	1,803,364
CHEMUNG	366,052	118,807	678,535	1,163,394
CHENANGO	210,417	123,007	535,852	869,276
CLINTON	268,107	283,110	597,590	1,148,807
COLUMBIA	255,240	117,120	570,116	942,476
CORTLAND	188,707	179,772	540,183	908,662
DELAWARE	235,243	115,732	538,991	889,966
DUTCHESS	822,480	244,273	1,327,302	2,394,055
ERIE	3,849,067	1,158,349	5,603,912	10,611,328
ESSEX	175,584	264,864	522,403	962,851
FRANKLIN	196,391	261,329	530,495	988,215
FULTON	234,238	146,750	564,126	945,114
GENESEE	206,888	163,247	560,838	930,973
GREENE	208,763	122,104	532,933	863,800
HAMILTON	0	4,551	270,699	275,250
HERKIMER	294,877	114,868	590,782	1,000,527
JEFFERSON	341,791	162,366	641,316	1,145,473
LEWIS	171,953	122,478	453,185	747,616
LIVINGSTON	182,848	100,653	467,738	751,239
MADISON	223,455	160,495	653,996	1,037,946
MONROE	2,373,199	555,122	4,024,492	6,952,813
MONTGOMERY	241,944	100,064	545,814	887,822
NASSAU	4,520,372	600,155	7,269,912	12,390,439
NIAGARA	837,796	249,096	1,369,496	2,456,388
ONEIDA	972,705	408,021	1,701,899	3,082,625
ONONDAGA	1,567,556	433,768	2,632,788	4,634,112
ONTARIO	320,465	148,069	646,605	1,115,139
ORANGE	919,924	275,148	1,600,059	2,795,131
ORLEANS	171,953	83,929	515,311	771,193
OSWEGO	383,591	227,495	685,792	1,296,878
OTSEGO	236,899	164,402	540,730	942,031
PUTNAM	229,587	107,044	575,296	911,927
RENSSELAER	497,483	187,983	991,820	1,677,286
ROCKLAND	858,078	200,074	1,386,133	2,444,285
ST. LAWRENCE	409,471	193,868	705,259	1,308,598
SARATOGA	545,013	224,097	957,431	1,726,541
SCHENECTADY	567,334	174,379	978,629	1,720,342
SCHOHARIE	171,755	100,922	452,362	725,039
SCHUYLER	171,953	87,081	454,036	713,070
SENECA	171,634	90,351	453,827	715,812
STEUBEN	379,763	165,743	723,521	1,269,027
SUFFOLK	4,040,331	731,555	6,196,690	10,968,576
SULLIVAN	312,383	136,685	607,697	1,056,765
TIOGA	176,722	113,898	461,467	752,087
TOMPKINS	223,545	289,570	565,810	1,078,925
ULSTER	617,145	164,936	1,073,435	1,855,516
WARREN	346,567	233,983	548,641	1,129,191
WASHINGTON	215,604	166,436	537,637	919,677
WAYNE	301,873	138,700	611,807	1,052,380
WESTCHESTER	3,205,338	817,956	4,841,597	8,864,891
WYOMING	171,953	132,412	454,780	759,145
YATES	171,755	116,073	449,435	737,263
NYC	34,788,952	15,297,347	44,228,808	94,315,107
SEN. NATION	155,254	42,987	346,360	544,601
ST. REGIS	155,254	42,234	1,036,391	1,233,879
TOTAL	$73,064,635	$29,073,733	$113,801,001	$215,939,369

ATTACHMENTS

SECTION A

INTERGOVERNMENTAL COLLABORATION

Governor's Smart Growth Cabinet

The Governor's Smart Growth Cabinet, comprised of various state agencies including the New York State Office for the Aging, is committed to working with localities to use smart, sensible planning to create livable communities for younger as well as older adults, protect our natural resources and promote economic growth. These efforts can provide enhanced State access to technical assistance programs and greater interagency communication at all levels of government, will help local civic leaders and other stakeholder prepare for the challenges and opportunities of an aging population. Strengthening the relationship between State government and its diverse collection of municipalities will be key to advancing approaches that can be useful in helping achieve this goal. Because complex growth and development issues transcend community boundaries, inter-municipal cooperation and the fostering of partnerships with businesses, academia, community and community organizations will improve delivery of State and local services that can help older people to live independently.

Smart Growth can reduce reliance on automobile travel. Compact development reduces the distance traveled between daily destinations - homes, workplaces, restaurants, stores and parks. Mixed-use communities arrange these destinations together, which further reduces the length and number of car trips. And the combination of density and mixed-use creates a built environment that is more conducive to walking, ride-sharing and mass transit – which all help enhance the health and well-being of older adults.

At its core, Smart Growth is smart, sustainable land use planning. And local land use planning has a profound impact on communities, the state and the entire planet. Researchers have found that community design can determine the level of physical and social activity in a community, which affects both physical and mental health of older adults and persons of all ages. Through the collaborative work of the Smart Growth Cabinet, municipal planning is no longer just a technical matter; it’s a tool for economic and environmental sustainability.

Geriatric Mental Health and Chemical Dependence Council

As the population of older adults grows by 50 percent in New York State over the next quarter century, so too will the number of older adults with mental disorders from 540,000 to 780,000. Approximately 20 percent of this age cohort have diagnosable mental and/or substance abuse disorders. The prevalence of these disorders increases with age. More than half of older adults by the age of 85 have mental disorders, mostly dementia but, also frequently, co-occurring with mental disorders such as anxiety, depression, and psychoses however, less than half of older adults get mental health care. Of those who get treatment, more than half go to primary care physicians, who provide minimally adequate care less than 13 percent of the time. Because older adults often are not comfortable seeking services in places that are labeled mental health

treatment sites, aging service programs, where older adults have trusting relationships with staff, offer important opportunities to identify mental health conditions and coordinate care. Mental health services offered by the aging service system could include mental health promotion and prevention; outreach and education; identification and engagement; screening, assessment, and on-site treatment or connection with mental health providers.

To confront the growing need for geriatric mental health services and planning, New York State formed The Interagency Geriatric Mental Health and Chemical Dependence Planning Council (the Council), which was established pursuant to the Geriatric Mental Health Act of New York. The Council, which is chaired by the Directors of the State Office for the Aging and the Division of Veterans Affairs and the Commissioners of the Office of Mental Health and the Office of Alcohol and Substance Abuse Services, is charged with developing recommendations regarding geriatric mental health needs and reporting annually to the Governor and the Legislature. The Act also established a geriatric mental health service demonstration program with initial funding of $2 million per year for five years. A total of nine programs were funded throughout New York State. Six awards were for physical health-mental health integration programs and three awards were for community gatekeeper projects.

Most Integrated Setting Coordinating Council

On June 22, 1999, the United States Supreme Court held in *Olmstead v. L.C.* that pursuant to the Americans with Disability Act (ADA), unjustified institutional isolation is properly regarded as discrimination based on disability. The Court further ruled that institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life.

In response to the Olmstead ruling New York State enacted Chapter 551 of the Laws of 2002, creating the Most Integrated Setting Coordinating Council (MISCC). The Most Integrated Setting Coordinating Council is comprised of the following State agencies: New York State Department of Health; New York State Office for People With Developmental Disabilities; New York State Office of Mental Health; New York State Office of Alcoholism and Substance Abuse Services; New York State Education Department; New York State Office for the Aging; New York State Office of Children and Family Services; New York State Department of Transportation; New York State Division of Housing and Community Renewal; and the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities. The New York State Developmental Disabilities Planning Council and the New York State Department of Labor are ex-officio members of the Council. The Council also includes nine advocates: three each of consumers, providers, and individuals involved in providing services to seniors. New York State's Most Integrated Setting Coordinating Council is responsible for developing and implementing a comprehensive State Plan guided by the principles set forth under the federal Olmstead decision to empower individuals with disabilities of all ages to live more independently within the community.

New York State Developmental Disabilities Planning Council

The New York State Developmental Disabilities Planning Council works under the direction of the Governor of the State of New York. The New York State Developmental Disabilities

Planning Council is funded through the federal Developmental Disabilities Assistance and Bill of Rights Act and is currently celebrating its 40th year serving New Yorkers with developmental disabilities and their families. The Council is comprised of thirty-four members in the following categories: people with developmental disabilities; parents; guardians or relatives of people with developmental disabilities and State agencies that represent the health and long-term care service delivery system. The New York State Office for the Aging is an active member of the Council and works on behalf of older individuals with developmental disabilities and their families. The New York State Developmental Disabilities Planning Council has an Executive Committee and four standing committees: Adult Issues, Children's' Issues, Systems Coordination and Community Education as well as a Consumer Caucus group.

The New York State Developmental Disabilities Planning Council is responsible for developing new ways to improve the delivery of supports and services to all New Yorkers with developmental disabilities and their families. The Council focuses on increasing the opportunities for consumers to become more involved in the community, secure education, employment and housing. The New York State Developmental Disabilities Planning Council affects positive systems change through grant programs that fund such activities as: demonstration programs; training for all families and staff; outreach to un-served/underserved populations; support to communities; interagency collaboration and coordination; and systems design and redesign. To a large extent the New York State Developmental Disabilities Planning Council programs are developed in direct response to the concerns and ideas voiced by consumers, families, service providers, policy makers and other professionals. The contributions of the New York State Developmental Disabilities Planning Council play a key role in maintaining New York's exceptional level of quality service to individuals of all ages with developmental disabilities. The Council works to ensure that all New Yorkers with developmental disabilities are given the greatest possible opportunity to become valued, participating members of their community.

The Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind or Hard of Hearing

Funding was provided in the 2008-09 State Budget to establish an Interagency Coordinating Council for Services to Persons Who are Deaf, Deaf-Blind or Hard of Hearing under the administrative lead of the New York State Commission on Quality of Care & Advocacy for Persons with Disabilities. The Council includes seven State Agency heads and/or their designees from the following agencies: the New York State Commission on Quality of Care & Advocacy for Persons with Disabilities (Chair): New York State Public Service Commission, New York State Office of Children and Family Services, New York State Office for the Aging, New York State Department of Education; New York State Department of Health; and New York State Department of Labor. In addition to the State Agency representatives, the Council includes eight consumer representatives appointed by the Governor and the State Legislature. The establishment of a Council that includes persons who are deaf, deaf-blind or hard of hearing has done much to ensure that services for this population are responsive to the special needs of these groups.

Services for deaf, deaf-blind or hard of hearing persons are administered by many agencies of State government. Funding is allocated by those State agencies to numerous local service providers. Through interagency collaboration the Council is working to assess the needs of the deaf, deaf-blind and hard of hearing communities and to affect a more efficient matching of service needs to State resources.

Alzheimer's Coordinating Council of New York

An estimated five million Americans have Alzheimer's Disease. This number has doubled since 1980, and is expected to be as high as 13.4 million by 2050. Current estimates using the formula of the Alzheimer's Association and Census data are that just over 450,000 people in New York State have this disease. The Alzheimer's Advisory Council was established in 2007 to facilitate interagency planning and policy, review specific Agency initiatives for their impact on services related to the care of persons with dementia and their families, and provide a continuing forum for concerns and discussion related to the formulation of a comprehensive State policy relating to Alzheimer's Disease and services for persons with incurable dementia. The New York State Department of Health (DOH) serves as the lead Agency for Council activities because of its primary regulatory responsibilities for the health care network, and the Council is co-chaired by the New York State Office for the Aging (NYSOFA).

ATTACHMENTS

SECTION B

NEW YORK STATE OFFICE FOR THE AGING
SUMMARY OF ACCOMPLISHMENTS/STATUS
PROGRAMS/INITIATIVES/SERVICES
2007-2011 STATE PLAN PERIOD

Senior Citizens' Help Line and Constituency Services

- The New York State Office for the Aging's (NYSOFA) Help Line provided 12,340 instances of assistance and referral in 2010.
- The Constituency Liaison responded to approximately 100-125 e-mails and approximately 10-15 formal written correspondences during each month in 2010.

New York Connects: *Choices for Long-term Care*, Aging Disability Resource Center

- NY Connects has served approximately one half million New York State residents and receives approximately 37,000 contacts related to long-term care support options per quarter.

Health Insurance Information, Counseling, and Assistance Program (HIICAP)

- The Health Insurance Information, Counseling, and Assistance Program served over 130,000 clients a year in 2010, recruited and trained approximately 500 local volunteer counselors and maintained over 400 local counseling sites throughout the state.
- The Program was ranked #2 nationwide based on the National Council on Aging's reporting under the Medicare Improvements for Patients and Providers Act with assisting Medicare beneficiaries with low-income subsidy applications.

Medicare Improvements for Patients and Providers Act (MIPPA)

- Due to Medicare Improvements for Patients and Providers Act outreach and application assistance, estimates of the number of Medicare beneficiaries potentially eligible for the Low-Income Subsidy program declined by 17 percent from 2009 to 2010.

Transportation

- Through on-going technical assistance NYSOFA strengthened the capacity of Area Agencies on Aging to collaborate with other agencies in their planning and service area to enhance coordination of available Section 5310 resources.
- NYSOFA assisted AAAs and their local community service providers to access grant funding to support the provision of outreach, assistance and informational and educational presentations to help older drivers, their families, and other members of the community to successfully identify and address potentially unsafe and at-risk situations.
- NYSOFA's Older Driver and Pedestrian Safety Project replicated the older driver assistance network model in additional counties in New York State and raised community awareness about interventions available to help older drivers to drive safely longer as

well as support older individuals who are no longer able to drive without risk to themselves and/or others.

- NYSOFA provided hundreds of outreach, assistance and informational and educational presentations through the AAAs to help older drivers, their families, and other members of the community to successfully identify and address potentially unsafe and at-risk situations. Thousands older drivers and caregivers throughout the state have received driver improvement and safety interventions from NYSOFA's Older Driver and Pedestrian Safety Project.

Expanded In-Home Services for the Elderly Program (EISEP)

- State regulations governing the Expanded In-Home Services for the Elderly Program were revised to increase local flexibility and better meet the needs and preferences of clients. This included: allowing for consumer direction within the EISEP program, expanding the array of goods and services that can be funded under ancillary services and expanding the amount of funds that could be spent on these services; decreasing the minimum amount that AAAs must spend on in-home services; and increasing the maximum housing adjustment that can be used for cost-share calculations.

Veterans Directed Home and Community-based Services Program

- NYSOFA worked closely with the Veterans Integrated Services Network Upstate New York and the Syracuse Veterans Administration Medical Center to structure a consumer-directed program that embodies national program requirements, including developing a Provider Agreement, working through legal and programmatic issues, setting rates for services, developing trainings, establishing quality indicators, and setting up a billing and payment system.

Social Adult Day Services

- NYSOFA has on its website an area dedicated to Social Adult Day Services (SADS). It explains the two types of adult day services in New York State (social and medical) and provides supportive materials for those interested in starting a social model adult day program, including how to start a Social Adult Day Services program, funding options, New York State regulations, and other resources.
- Instituted quarterly reporting for the directly funded SADS programs. This will result in an annual report that will have demographic information about participants and caregivers, and that describe the functional levels of participants.

Community Supports Navigator Program

- Developed a program utilizing highly trained volunteers to work with discharge planners to reduce preventable hospital readmissions.
- Developed eligibility and referral criteria and a training curriculum to clarify roles and responsibilities and increase knowledge of available services for Consumer Navigators.
- Initiated volunteer recruitment process and obtained volunteers through the Medical Reserve Corp and local colleges/universities.
- Developed a formal evaluation plan for the project which outlines data collection processes and outcome measures.

Community Living Grant Program (CLP)

- Developed a program model that targets older adults at imminent risk of Medicaid spend-down and nursing home placement and provides non-medical long-term care services and supports through a consumer-directed model using Older Americans Act service dollars.
- An Operations Manual was completed to provide resources for developing programs. This manual lists program guidelines and requirements.
- NYSOFA contracted with State University of New York at Albany's Center for Excellence in Aging and Community Wellness (CEACW) to conduct evaluation activities. Their evaluation of CLP demonstrated success in meeting the major goals related to nursing home diversion and Medicaid spend down. Evaluation showed that the program served a very fragile older adult population at imminent risk of nursing home placement. Of all recipients in the evaluation study, over an eight-month period, five individuals (4.5%) entered other Medicaid programs but remained in the community and 86 percent were diverted from costly nursing facility care.

Community Empowerment Initiative

- In the fall of 2009, NYSOFA provided training to Community Empowerment conference attendees and grantees on the topic of Community Organizing & Coalition Building.
  In the summer of 2010 NYSOFA convened a second conference on Empowering Communities for Successful Aging in Albany and Batavia, New York.
- Enhancements have been made to NYSOFA's website to include community empowerment pages that highlight regional happenings, how to volunteer and best practices, including a community empowerment organizing toolkit.

Nutrition Services: Nutrition Program for the Elderly (including New York State's Supplemental Nutrition Assistance Program) and Senior Farmers Market Nutrition Program

- Led the nation in the provision of healthy, balanced meals statewide that followed dietary guidelines (22,911,792 meals to 187,094 individuals; 10,504,925 congregate meals to 128,902 individuals; 12,406,867 home-delivered meals to 58,192 eligible individuals). All AAAs are responsive to participant needs by providing special diets (low sodium, low fat), choice, variety and meals that are culturally appropriate.
- Led the nation in the provision of nutrition counseling statewide (13,235 units of nutrition counseling to improve nutritional status and for chronic-disease management statewide.) One ITO ranked 10th statewide in the provision of nutrition counseling.
- Provided nutrition education and counseling to more than 81,204 individuals statewide (unduplicated count); 72,212 individuals received nutrition education – sessions on healthy eating, nutrition and chronic disease management, food safety and physical activity, and 8,992 individuals received nutrition counseling.
- Successfully identified and served participants at high nutritional risk. Congregate meals were provided to 23,439 individuals at risk; home-delivered meals to 17,600 individuals at risk, and nutrition counseling to 3,951 individuals at risk (44 percent of all individuals receiving nutrition counseling).
- American Recovery and Reinvestment Act (ARRA) Stimulus funding allowed area agencies on aging to increase the number of meals provided and to reduce or eliminate waiting lists for home delivered meals.
- Provided healthy meals in a safe manner. Completed four program years with no recorded outbreaks of food-borne illness in 1,000 sites statewide.

- Successfully completed annual regional food safety training in collaboration with the food sanitation division of New York State Department of Health.
- Area Agencies on Aging have expanded the preventive health and physical activity services they offer and are actively integrating them into nutrition programs. Sixty percent of area agencies statewide offer physical fitness programs.
- All AAAs provide medication management services to participants in their service area.
- More than one-third of area agencies on aging offer evidence-based nutrition and disease prevention programs. In the FY2010 there was a 31 percent increase in the number of area agencies offering such programs statewide. In addition, area agencies provide a wide range of health screenings, influenza and vaccine clinics, and preventive health information.
- Promoted the consumption of fresh fruits and vegetables through the New York State Farmer's Market Nutrition Program which has been extremely successful and is very popular with participants. Statewide eighty percent ($1.35 million dollars) of the 83,400 distributed coupon booklets were redeemed by eligible participants.

New York Elder Caregiver Support Program and Caregiver Resource Centers

- In 2009 and 2010, NYSOFA conducted 18 conference calls with the caregiver coordinators for training that provided access to expert speakers. A wide range of topics were discussed including results of caregiver related surveys conducted, health promotion and disease prevention programs and benefits, specific caregiver programs available in different communities in New York State, suicide/suicide prevention programs and services, program reporting, kinship care and the older driver.
- In 2009 and 2010, NYSOFA held 8 regional training conferences for the caregiver coordinators. Topics covered included care transitions, end-of-life issues, strengthening the relationship with NY Connects, home safety, emergency preparedness and elder mistreatment.

Family Caregiver Council

The Family Caregiver Council (FCC) undertook multiple efforts to gather data and information about caregiving and has successfully undertaken the following initiatives, events, and activities since it was established:

- Sponsored nine Town Hall meetings to solicit input and hear directly from caregivers and providers across New York.
- The FCC took an active role in assisting the Finger Lakes Geriatric Education Center in developing a survey designed to identify gaps and capture perspectives from each community's stakeholders (providers and consumers) about caregiver services. The FCC reviewed those findings, along with findings from a NYSOFA sponsored survey to help determine caregiver satisfaction with current services.
- Released the 2009 FCC Report, Supporting and Strengthening Caregivers in New York State (2009), which is available on the NYSOFA web site.
- Published FCC recommendations and two companion reports that portrayed caregivers and care receivers in the Title III-E program provided a service gaps analysis, and community assessment of existing caregiving programs in counties across the state.
- Raised awareness about caregiving through the release of surveys, recommendations, updated web-based resources and the production of a brochure on Resources for Caregivers in New York State, produced in English and Spanish.

- Strengthened the Statewide Caregiving and Respite Coalition of New York and provided a framework for developing the coalition statewide.
- Received a grant from the Administration on Aging in 2010 under the Lifespan Respite Program to coordinate existing respite services and strengthen the Statewide Caregiving and Respite Coalition of New York.
- Established a FCC work group to research issues and develop action steps regarding young caregivers.
- Established a FCC work group with the Department of Health to determine how to better assist caregivers whose loved ones have been placed in a residential facility.
- Participated in activities with the Alzheimer's Disease Coordinating Council.

Livable New York Initiative

Two major products completed under this initiative in 2009 and 2010 have been publicized and posted on NYSOFA's Web site as technical assistance resources for all community residents, professionals, officials, providers, community leaders, and other stakeholders:

- An 86-member statewide Advisory Workgroup (state and local governments, businesses, non-profits, professional disciplines, retired persons, individuals with disabilities, community leaders, faith community) convened and developed recommendations, which are meant to advance the initiative's goals by overcoming barriers/challenges communities often encounter when implementing activities and projects related to the initiative's focus areas. Posted the Livable New York Advisory Workgroup Report on NYSOFA's web site.
- A Resource Manual, which consists of 118 short articles written by 62 experts and which are devoted to the initiative's focus areas, was developed as an education, planning, and development resource for all community members. Each article provides a description of a model or strategy; benefits of the model/strategy for older adults, persons with disabilities, caregivers, and the community; operating examples of the model/strategy; relevant laws; and extensive links to written and Web resources for more in-depth information. Posted the Livable New York Resource Manual on NYSOFA's web site.

Home Energy Assistance Program

- In the program year 2009-2010, AAAs certified 76,645 people aged 60 and over for HEAP benefits and referred 3,785 elderly for emergency HEAP benefits.

Weatherization Referral and Packaging Program

- The WRAP program leveraged $2,768,643 in 2009-10 resulting in hundreds of homes occupied by older adults throughout New York State being weatherized and thereby reducing energy consumption and costs.

Civic Engagement and Volunteerism

- In 2008, NYSOFA took the lead in applying for the National Governors Association (NGA) Center for Best Practices - Policy Academy on Civic Engagement: Engaging Seniors in Volunteering and Employment. As a result of NYSOFA's involvement in this effort, strategies were developed to enhance the skills, knowledge and talents of older adults by improving meaningful volunteer activities that can help address many community problems.

Retired and Senior Volunteer Program (RSVP)

- In 2010, 26,885 RSVP volunteers served at more than 3,600 stations throughout New York State.

Foster Grandparent Program (FGP)

- In 2010, the Foster Grandparents Program served 6,860 children.

Preventive Health Services (Senior Health Check-Up)

- The Senior Health Check-Up, a summary list of Medicare preventive and health screening benefits for Medicare beneficiaries, was promoted at several large state-wide events such as the State Fair, New York State Office for the Aging Senior Citizens' Day, Martin Luther King Day and the Black and Hispanic Caucus. NYSOFA has also developed radio ads that are designed to encourage and remind people to use their benefits, get screened and stay healthy that have been aired in the following regions: Western New York and in the Capital District and Mid-Hudson Valley Regions.
- Teamed-up with the American Cancer Society (ACS) and worked with Cayuga and Erie Counties to get older adults registered on ACS website to get reminders of when it's time for them to get screened for various cancers based on their age, gender, family history and some known risk factors. This pilot project resulted in more than 500 people registering at this site during a six month time period.
- Developed and supported the airing of targeted radio ads in the Western New York and Capital District regions to increase the use of Medicare preventive benefits. A review of data and information showed that older New Yorkers in Western New York were screened for colorectal cancer at a later stage compared to older adults in other regions of New York State. The Capital District was used to promote the use of all Medicare benefits but especially vaccinations and cancer screening.
- NYSOFA with the help of the State University of New York, Master level School of Public Health interns routinely reviewed Centers for Medicare and Medicaid Services (CMS) claims data and the Behavioral Risk Factor Surveillance System (BRFSS) population survey data to provide county, population profiles on actual and reported use of Medicare preventive benefits for services such as flu and pneumococcal vaccinations and colorectal screening.

Evidence-Based Disease and Disability Prevention Grant Program

- Six regionally based collaboratives were established in Albany, Broome, Genesee, New York City, Suffolk and Westchester Counties to implement Evidence Based Disease and Disability Prevention Grant Programs in each region.
- As of January 2011, 132 workshops were held through the third quarter of the grant.
- As of April 2011, more than 1,300 people participated in Evidence Based Disease and Disability Prevention Grant Programs and more than 1,100 people completed the Program (participants who completed at least four out of six workshop sessions) in concert with the six regional collaboratives.

Elder Abuse Education and Outreach Program

During SFY 2009-2010, the following services and activities that are designed to address the various forms of elder abuse were provided:

- 154 public awareness presentations to 3,670 people in the Finger Lakes Region (11 counties) and 17 public awareness presentations to 357 people in other parts of New York State on elder abuse, scams, and frauds to senior groups, civic groups, and fraternal orders.
- 1,772 professionals and non-professionals who work with, or are in regular contact with older people, were trained at 87 different events to better recognize abuse in domestic settings and to facilitate intervention.
- Direct intervention was provided in 320 new cases and 55 ongoing cases of elder abuse, including scam and fraud cases.
- Intensive case management geriatric addiction services were provided to 146 clients, including 91 new clients and 55 ongoing clients.
- Financial management services were provided to 597 clients, including 491 clients who received daily financial management, 81 clients who received a limited power of attorney and 25 clients who received a guardianship.

<u>During this period of time, the following was accomplished by the New York State Coalition on Elder Abuse:</u>

- 11 bulletins were disseminated to over 1,000 professionals highlighting collaborative initiatives; trainings, conferences and resources; best practices; special events and changes in laws and proposed legislation.
- Supporting documents were developed for the change in the law governing power of attorney, including a reference document comparing the old and new law and a summary of changes.

Data Quality, Collection, and Analysis

In 2010:

- In 2008 and 2010 NYSOFA partnered with the New York State Office of Children and Family Services (OCFS), the University at Albany's Professional Development Program (PDP) and the two primary vendors for client based software used by the AAAs to develop on-line videos which provided training in using the two software packages.
- In conjunction with staff from the software vendor, NYSOFA conducted technical assistance workshops with the AAAs serving the metropolitan areas surrounding New York City to assist them in utilizing various software and product enhancements. NYSOFA also worked with staff from one of the two software vendors serving New York to organize user group meetings at four locations across the State.
- NYSOFA created a system for the collection of ARRA funded congregate and home delivered meals. This system was done in two parts. First the client based data files were modified to allow meals funded with ARRA dollars to be reported. Second a web based data entry screen was created which allowed AAAs to report persons served, meals provided, expenditures as well as additional program information on the affect of the program.

Performance Outcomes Measurements Project

- Produced a core set of performance measurement surveys to assess, through a consumer perspective, service quality and outcomes of critical OAA services.
- Produced the Nursing Home Risk Factors and the Effects of Service Receipt.

Equal Opportunity and Diversity Management

- NYSOFA's Targeting Performance Measurement Report for 2008-2009 indicates that New York State met Statewide Targeting Performance Measures for: Low Income; Low Income Minority; Frail/Disabled; Live Alone; and Minority (combined as a whole).
- NYSOFA distributed the Administration on Aging's newly released (in 2010) "Toolkit for Serving Diverse Communities" to staff and AAAs. Additionally, NYSOFA partnered with AoA staff to provide a Webinar on *Serving Diverse Communities* based in large part on the AoA Toolkit to 195 NYSOFA staff, AAAs and other Aging Network providers participating in the training. Additionally, NYSOFA provided basic Targeting/Cultural Competence training to NYSOFA staff, LTCOP Coordinators, and new AAA Directors in 2010.
- NYSOFA revised the requirements within the 4 Year Implementation Plan (2011-2015) to include expanded instructions and requests for information regarding how AAAs will obtain input from targeted groups and use this information in planning and meeting the needs of underserved populations, including older individuals with limited English Proficiency (LEP). NYSOFA Standard Assurances under this Plan require providers, both AAA and subcontractors, to the maximum extent feasible, to provide services to targeted groups and meet specific objectives as reflected in the Plan.

Most Integrated Setting Coordinating Council (MISCC)

- NYSOFA contributed to the Annual Implementation Plan for the Most Integrated Setting Coordinating Council which identifies individual State agency goals and objectives related to assisting individuals with disabilities to live in the most integrated setting.

New York State Developmental Disabilities Planning Council

- The Office for Persons with Developmental Disabilities worked collaboratively with NYSOFA to produce an "Aging in Community Training Initiative" for use by and dissemination through the aging and developmental disabilities networks statewide. This initiative is funded by the New York State Developmental Disabilities Planning Council.
- Provided information and support to the Council concerning issues related to developmental disabilities and aging.

Interagency Coordinating Council for Services to Persons who are Deaf, Deaf-Blind or Hard of Hearing

- NYSOFA contributed to the Council's statewide evaluation of the needs of the deaf, deaf-blind and hard of hearing communities, including technology and collected information on the incidence of deafness, deaf-blindness and other hearing loss throughout the state.
- The Council completed a comprehensive, interagency strategic planning process that focused on the delivery of services such as medical, housing, transportation, technology supports, personal care, family supports, and day programs to individuals who are the deaf, deaf-blind or hard of hearing.
- The Council produced and submitted two reports to the Governor and State Legislature containing advisement on policy and recommendations for legislative initiatives effecting deaf, deaf-blind and hard of hearing individuals.

- NYSOFA provided information and support to the Council concerning issues related to aging and hearing loss.

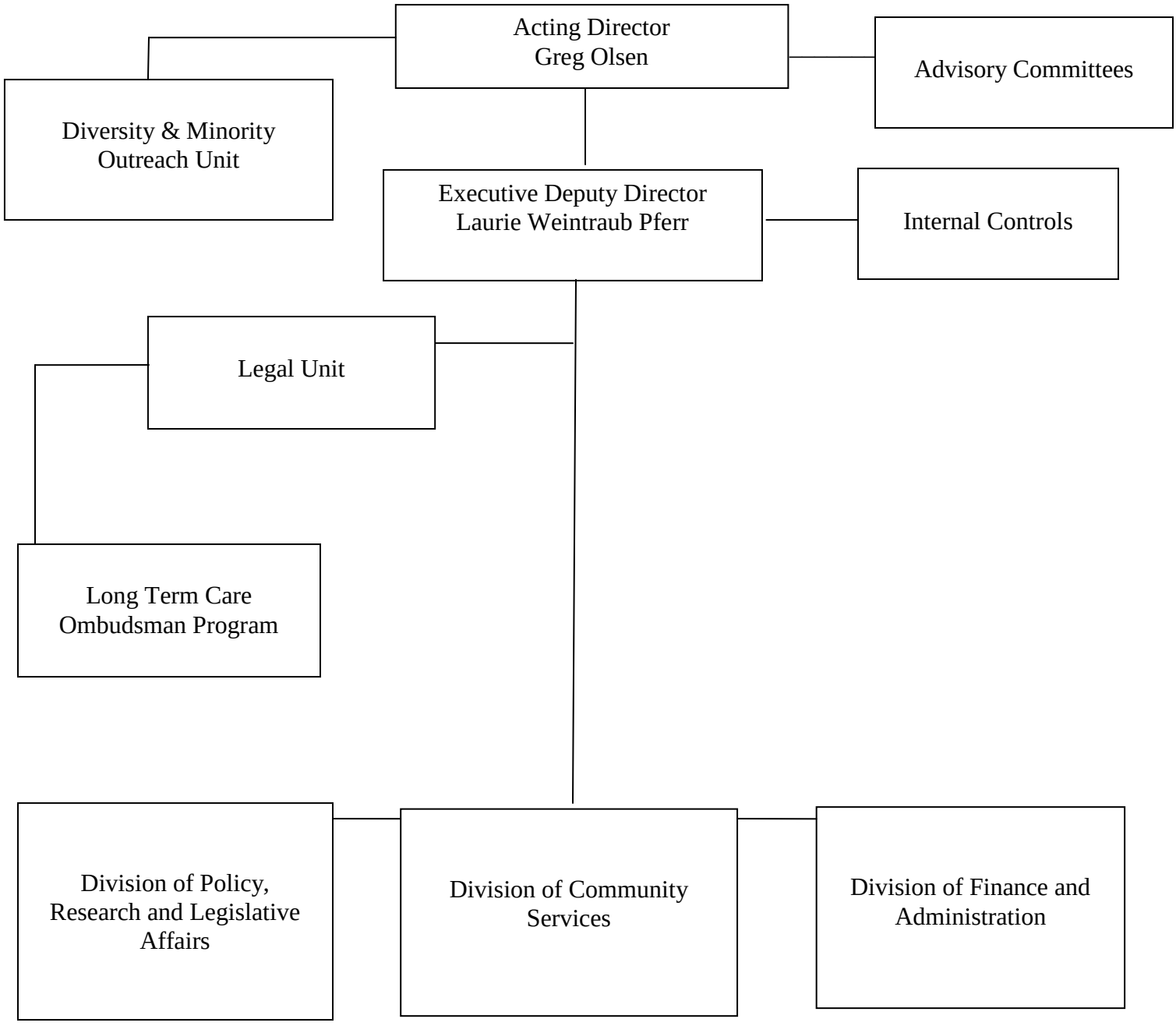
Emergency Preparedness

- The New York State Office for the Aging (NYSOFA) developed an internal protocol for responding to disasters and established an internal email group and monthly meetings to assure ongoing communication.
- Provided staff support at the State Emergency Management Office's (SEMO), State Emergency Coordination Center to help respond to recovery needs in affected sites, and participating in disaster training drills.
- Served as a conduit for information to and from local and state agencies during disaster preparedness and recovery operations in order to assist affected senior citizens and their families.
- Served on standing and ad hoc committees and workgroups established by SEMO.
- Provided AAAs and aging network organizations with training, information, and materials to assist them in with disaster-preparedness planning.

ATTACHMENTS

SECTION C

NEW YORK STATE OFFICE FOR THE AGING
ORGANIZATIONAL CHART



ATTACHMENTS

SECTION D

LIST OF NEW YORK STATE AREA AGENCIES ON AGING

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Kimberley Toot, Director
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Broome County Office for the Aging
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Binghamton, NY 13902-1766

Cattaraugus County Dept. of the Aging
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Cayuga County Office for the Aging
Nancy Siefka, Director
160 Genesee Street
Auburn, NY 13021-3483

Chautauqua County Office for the Aging
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Chemung County Dept. of Aging and Long Term Care
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Elmira, NY 14902-0588

Chenango County Area Agency on Aging
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Norwich, NY 13815-1794

Clinton County Office for the Aging
Crystal L. Carter, Director
135 Margaret Street, Suite 105
Plattsburgh, NY 12901-2966

Columbia County Office for the Aging
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325 Columbia Street
Hudson, NY 12534-1905

Cortland County Area Agency on Aging
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Cortland, NY 13045-2746

Delaware County Office for the Aging
Thomas Briggs, Director
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Delhi, NY 13753-1066

Dutchess County Division of Aging Services
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Erie County Department of Senior Services
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LIST OF NEW YORK STATE AREA AGENCIES ON AGING (Continued)

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Madison County Office for the Aging
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Montgomery County Office for the Aging
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Nassau County Dept of Senior Citizen Affairs
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60 Charles Lindbergh Blvd., Suite #260
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New York City Department for the Aging
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LIST OF NEW YORK STATE AREA AGENCIES ON AGING (Continued)

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Lisa D. Alford, Commissioner
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Syracuse, NY 13202

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Orleans County Office for the Aging
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Otsego County Office for the Aging
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LIST OF NEW YORK STATE AREA AGENCIES ON AGING (Continued)

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Seneca Nation of Indians Office for the Aging
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Tioga Opportunities Inc.
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LIST OF NEW YORK STATE AREA AGENCIES ON AGING (Continued)

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ATTACHMENTS

SECTION E

NEW YORK STATE CAREGIVER SURVEY

Executive Summary

The Caregiver Support Programs Participants Survey was funded by the federal Administration on Aging (AoA), as part of the Performance Outcomes Measures Project (POMP) under AoA Grant# 90AM3103 to test a statewide survey methodology and to assess the outcomes of caregiver support programs administered through the aging services system in New York State. For more than two decades, the New York State Office for the Aging (NYSOFA) has developed and implemented an array of services that support and assist informal caregivers in caring for their loved ones aged 60 and older who are frail, chronically ill or in need of assistance with daily tasks. The types of caregiver support services provided through NYSOFA and local Area Agencies on Aging (AAAs) include: information and assistance, individual counseling, support groups, training, respite, and supplemental services to complement the care provided by the caregiver.

Little information has been collected to date to provide a profile of caregivers served by NYSOFA/AAA caregiver support programs and to quantify the impact of programs and services on caregivers and care recipients. In 2008, NYSOFA undertook a statewide survey to: (1) gather detailed information that describes the caregiver population who receive services from NYSOFA /AAA caregiver programs and services, (2) demonstrate the impacts of NYSOFA or AAA support programs and services on caregivers, and (3) help inform program administrators, service providers, and policy makers so that they may improve programs and services. Detailed information was collected about the demographic characteristics, functional status, health conditions, caregiving experience, and the impact of NYSOFA/AAA caregiver support programs that caregivers utilized. The *Sustaining Informal Caregivers: New York State Caregiver Support Programs Participants Survey Report of Findings on the Aging Services Network* details the survey findings, which underscore the importance of caregivers and the impact and value of NYSOFA/AAA caregiver support programs and services.

Survey: Objectives and Methodology

The survey was conducted by mail from mid-May to mid-June, 2008. A sample of 1,109 caregivers was randomly selected from a stratified random sample of 30 of New York's 59 AAAs using caregiver support program participant lists to draw the sample population of caregivers who received caregiver support services. Of the 1,109 caregivers included in the sample, 607 responded to the survey, representing a response rate of 55 percent.

Selected Survey Results

Caregiver Characteristics

The typical caregiver in the New York aging services system is a 64-year-old female, who has either a high school, or some college education, and spends more than 40 hours a week providing care to her mother. The majority (66 percent) of caregivers are married and close to one fifth of them reported that their household income is below $20,000.

Care Receiver Characteristics

In New York's aging services network caregiver support programs, individuals receiving care from caregivers are more likely to be female (64 percent) and a majority (85 percent) of them are aged 75 or older. Many of them have significant health needs, with 94 percent of the caregivers reporting that their care receivers had at least one health problem. The most prevalent health condition of care receivers was Alzheimer's Disease or other dementia; 75 percent reported this condition. Care receivers also have many functional limitations. A majority (85 percent) of them have one or more impairments in taking a bath or shower, walking, dressing, getting in or out of a bed or chair, getting around inside the home, using the toilet, and eating. More than three-quarters (79 percent) of care receivers have three or more activities of daily living limitations as reported by the caregivers.

Relationship between Caregivers and Care Receivers

The person most likely to be providing care to a dependent older adult is a daughter (48 percent), followed by a wife (23 percent), a husband (10 percent), a son (10 percent), other relatives (5 percent), a brother or a sister (2 percent), friends or neighbors (2 percent), and domestic partners (1 percent). A significant number (54 percent) of the caregivers live with their care receivers. The majority of caregivers are primary caregivers; 75 percent provided all or nearly all care to the care receiver. The duration of caregiving ranged from less than a year to over 20 years, with an average of 6.2 years.

Amount and Types of Care Provided to the Care Receiver

Caregivers participating in New York caregiver support programs are providing significant amounts of care – higher than the amounts reported by caregivers in national studies. The difference between this study and what is reported in national studies is likely because caregivers in this survey are exclusively caregivers of older adults, and most of those older adults have include caregivers providing care across the age spectrum and all levels of disability. Caregivers served in New York caregiver support programs report spending an average of 62.6 hours a week providing care, which is considerably higher than the national average of 21 hours estimated in a 2008 AARP report. The care and assistance that caregivers provided ranged from around the clock care or supervision, to assisting in specific tasks, such as: transportation (96 percent), financial management (91percent), arranging for care or services (86 percent), housekeeping (86 percent), arranging for home repair (82 percent), helping with medical needs (79 percent), performing home repair (77 percent), personal care (68 percent), and paying for services (68 percent). Caregivers participating in New York caregiver support programs tend to have a heavy care load: 36 percent reported that their care receivers cannot be left alone at home, and 42 percent reported that their care receivers can only be left alone for short periods of time or need to be checked on in person several times a day.

Caregiving Rewards and Burdens

Caregiving can be stressful, but it also has positive benefits and rewards. Many survey respondents reported positive emotional rewards. For example, caregivers reported that at least sometimes they feel they are helping the care receiver (99 percent), have a sense of satisfaction (92 percent), are helping a family member (90 percent), have a sense of accomplishment (90 percent), feel appreciated (87 percent), and have a sense of companionship (67 percent). Caregivers also reported some negative consequences to caregiving, including financial, emotional, and physical strain for caregivers. The burdens indicated by caregivers include: causing emotional strain (90 percent), not having enough time for self (86 percent), causing physical stress (77 percent), having conflicts with social life (74 percent), affecting health (74 percent), not having enough time for family (72 percent), interference with work (59 percent), and financial burden (53 percent).

Services Utilization and Satisfaction

The top three sources of information about caregiver support programs in the aging services network are: family or friends (22 percent), the state or local office for the aging (19 percent), and a case manager or a social worker (14 percent). The top three caregiver support services that caregivers received are: information and assistance (72 percent), respite care (47 percent), and caregiver counseling, training, or education (43 percent). Caregiver support services were rated as excellent, very good, or good by 87 percent of survey respondents. The top three home and community-based services that care receivers received are: information about services (44 percent), home care (40 percent), and case management (31 percent). Care receiver support services were rated as excellent, very good, or good by 91percent of survey respondents.

Benefits of Caregiver and Care Receiver Services

Caregivers reported that the services they received assisted them in providing care for care receivers in many ways. Seventy-three percent stated the services resulted in benefits to care receivers, 59 percent suggested that the services enabled them to provide care longer, and 56 percent stated that the services helped them be more confident about caregiving. Fifty-two percent reported that their care receivers would not be able to continue to live in the same home if NYSOFA/AAA services had not been provided. These caregivers suggested that potential outcomes for care receivers without the needed services might include: living in a nursing home, living in an assisted living facility, moving in with the caregiver, moving in with another member of the family or a friend, entering into a hospital or a rehab center, or having around-the-clock help.

Additional Help and Information That Would Be Valuable to Caregivers

While the majority of caregivers gave high ratings on the quality of services they received and are likely to recommend the services to a friend, they also indicated that they would like to have additional help. The top three areas identified by survey respondents that would help support them in their caregiving role are: tax credits or tax breaks (71 percent), respite care (63 percent), and help with financial assistance to pay for services (61 percent). In terms of additional or new kinds of information that would be valuable to caregivers, the top three types of information identified by caregivers responding to the survey are: help in working with formal agencies (88 percent), information about changes in laws (87 percent), and a centralized caregiver helpline (85 percent). When asked how services could be improved, the top three areas identified by survey

respondents are: increasing the amount of current services they received (79 percent), providing services in a less complicated manner (e.g., less bureaucracy and less paper work) (78 percent), providing services in a more timely manner, including starting services sooner, providing services when needed, and shorter waiting period (73 percent).

Discussion and Implications

The Significance of Informal Caregivers and Caregiving Consequences

The survey shows that caregivers using NYSOFA/AAA services and programs provide substantial care to vulnerable older adults with significant needs. Caregivers served by NYSOFA/AAA services and programs are a particularly vulnerable group. Over two-thirds of the caregivers said they have been providing care for three years or longer and almost one quarter of them are aged 75 or older. Caregivers bear immense burdens resulting from the intensive care needed by many care receivers. The top three caregiving burdens reported by caregivers were emotional strain, lack of time for oneself, and physical stress. According to previous caregiving research literature, such caregiving burdens and stresses are linked to serious health consequences, including increased risk of drug dependency, mental health problems, heart disease, high blood pressure, poorer immune function, lower perceived health status, and higher mortality rate. Because of the potential physical and emotional stress from caregiving responsibilities and the increasing numbers of informal caregivers, the stress of caregiving is now considered to be a public health concern.

Economic Value of Informal Caregiving

The value of the labor contributed by the caregivers served by NYSOFA/AAA services and programs is substantial even though the actual value of such uncompensated care is difficult to estimate. Applying the methodology used in AARP's 2008 Report, the total economic value of informal care provided by all caregivers served by NYSOFA/AAA caregiver support programs would be about $16 million a week and close to $832 million per year if the work of these caregivers had to be replaced by paid home care workers.

Impacts of NYSOFA/AAA Caregiver and Care Receiver Support Services and Programs

Because of potential physical and mental health consequences, informal caregivers of dependent older adults are in need of formal services and supports to alleviate their burden and stress. Previous literature shows that caregiver support programs and services can enable caregivers in getting information on how to obtain home and community-based services to supplement the care provided, accessing temporary relief from their care load, and obtaining training and education on how to care for the special needs of their loved ones. These documented research findings show that caregiver and care receiver support services enable caregivers to continue providing care for their loved ones and help care receivers to stay at home, preventing them from entering into nursing homes or assisted living facilities. It is demonstrated by the findings of this survey that investment in NYSOFA/AAA services and programs not only help caregivers and their loved ones, but also eases the burden on our health and long term care systems.

Conclusion

For the first time, results from the NYSOFA Statewide Caregiver Support Programs Participants Survey provide detailed information that describes the caregiver population who receive services

from NYSOFA/AAA caregiver programs. The reported findings expand understanding about the importance of informal caregivers in caring for dependent older adults and the value of caregiver support services in New York. The survey results show that caregiver support services and community resources help caregivers to provide care longer, and may also help delay or prevent nursing home placement of dependent elders. Survey responses provide a robust estimate of the unpaid value of the labor contributed by the caregivers served by NYSOFA/AAA services and programs. The total economic value of informal care provided by caregivers served by NYSOFA/AAA caregiver support programs is estimated to be close to $832 million per year if the work of these caregivers had to be replaced by paid home care workers. The survey results also inform New York State and local decision makers about the strengths and effectiveness of the current service delivery system in order to identify areas for improvement, and ways to support caregivers address the consequences of stressful aspects of the caregiving experience. The survey is successful in providing a rich array of information about NYSOFA/AAA programs and services that support caregivers. Future research topics to be considered include: learning more about caregivers of diverse populations including, non-English speaking, racial and ethnic minority groups, disabled individuals under the age of 60, and gay and lesbian caregivers. Studies on grandparents and other kin members caring for grandchildren and relatives also should be considered.

Additional Information

To read or download the complete report visit NYSOFA's web site at
http://www.aging.ny.gov/Caregiving/Reports/index.cfm

Related Reports

New York State Family Caregiver Council. (2009). *Supporting and Strengthening Caregivers in New York State: New York State Family Caregiver Council Report.* New York State Office for the Aging: Albany, NY.

Caprio, T., Katz, P, Karuza, J, and Rehse, D. (2009). *New York State Caregiver Services Survey: **NY Connects** Local Long Term Care Councils' Assessment of Community Caregiver Support Services.* Report to the New York State Family Caregiver Council. Finger Lakes Geriatric Education Center of Upstate New York: University of Rochester Medical Center, Rochester, NY

ATTACHMENTS

SECTION F

PUBLIC COMMENT SUMMARY

Opportunities for Public Comment on the New York State Plan on Aging

An important step in the process of developing the State Plan on Aging is insuring that interested individuals and constituents throughout the state are provided an opportunity to review and provide comments on the draft State Plan before it is finalized and submitted to the Administration on Aging. To enable that, the New York State Office for the Aging provided multiple opportunities for the public to provide written and/or verbal comments on the draft State Plan.

A draft of the New York State Plan on Aging was posted on the New York State Office for the Aging's public web site for review and comment. A public notice inviting comment on the draft State Plan was sent out electronically to all interested parties prior to the posting. Additionally, a Media Advisory Notice was sent to all media outlets statewide to notify interested individuals and constituents of the posting of the draft State Plan on the New York State Office for the Aging's public web site and to invite review and comment. The Governor's Advisory Committee on Aging was also engaged to provide review and comment on the draft State Plan. An electronic mailbox was provided on the web site to facilitate the submission of written comments from the public on the draft State Plan. The New York State Office for the Aging also invited individuals to provide written comments in hard copy and provided a mailing address for doing so on the agency's public web site.

In addition, the New York State Office for the Aging convened Public Hearings to review and discuss the draft State Plan in Rochester, Albany and Nassau Counties. Participants at the Public Hearings were invited to present comments on the draft State Plan in writing and/or verbally.

Transportation

- **Objective 1.2** - I strongly support Objective 1.2 that establishes a Mobility Manager in each county. I would encourage NYSOFA to broaden this to also assist in developing regional mobility alliances that recognize the travel patterns between counties.
- **Objective 1.2 -** Establishing a Mobility Manager/Health and Human Service Transportation Coordinator is a wonderful idea.
- **Objective 1.3 -** I agree and support the idea of Developing Community Call Centers that coordinate scheduling.
- **Objective 1.3** - I recommend that the strategy that entails "bringing together disparate call taker/transportation dispatch functions under one mobility-management scenario" be modified to remove the "dispatch" functions from that scenario. Dispatch is a function of individual providers and in urban areas it would be unrealistic and too intrusive to have a single dispatch provider.

- **Objective 1.5** – I support and applaud Objective 1.5 that calls for the sharing of available 5310 resources.
- **Objective 1.7 -** We encourage the expansion of NYSOFA's Older Driver Assistance Program which helps seniors stay safe on the road and independent in their communities.
- **Objective 1.8** - In terms of Objective 1.8 that promotes volunteerism, I would encourage NYSOFA to advocate that the federal mileage deduction for volunteer drivers be increased from the current $ .14 to the rate allowed for business ($ .505). This would provide a greater incentive and equity to this deduction and would value the work of volunteers in providing cost effective services.
- **Objective 1.8 -** In terms of transportation, having flexible and affordable options for people that go beyond normal 'taxi' service is imperative if we want to keep older adults at home, independent and engaged in the community.

Information & Assistance

- **Objective 1.9 -** The State Plan on Aging lists as Objective 1.9 for information and assistance "Implement fully functional Aging and Disability Resource Centers (ADRCs) statewide." As the State moves forward to capture federal dollars to implement Aging and Disability Resource Centers, a "no wrong door" model should be implemented instead of a "single point of entry" approach.
- **Objective 1.10 -** Ensure that NY Connects programs are providing information, assistance and referral to mental health programs and services through Objective 1.10.
- **Objective 1.10** - In objective 1.10, which states, "enhance existing NY Connects program operations and partnerships," the Plan should specifically identify the requirement for NY Connects to contract with ILCs who have access to a wide breadth of long-term services and supports resources for individuals of all ages.
- **Objective 1.11 -** Ensure that there is mental health representation on all long-term care councils through Objective 1.11.

Case Management

- **Objective 1.23 –** Strategy for Objective 1.23 should ensure that the assessment of training needs includes the ability to identify behavioral health conditions and appropriately and effectively link to mental health care.
- **Objective 1.23 –** Strategy for Objective 1.23 should offer mental health training to case managers to help them identify mental health problems among older adults and know where and how to refer for mental health services.
- **Objective 1.24** - There is concern that cost share clients may drastically reduce contact with case managers in an effort to hold down their costs. This would impact the quality of service provided by the case management team. Suggest a flat rate assessment fee rather than a cost share for every reported unit of service, and existing clients exempted from this requirement.
- **Objective 1.24** - While cost sharing is intended to increase revenue and expand services, it comes at a cost in both case management responsibilities and administrative activities. I am concerned that any increase in revenue would be subsumed by the cost of determining and collecting the cost share.

[Please Note: Suggested Strategies Related to Plan Section Above]

- **Suggested Strategy -** Increase collaboration with the Alzheimer's Association to better understand what an Alzheimer's diagnosis means to the lives of those with the disease and their care partners as well as what medical resources and other services are available to them.
- **Suggested Strategy -** Comprehensive geriatric case management training across the state would certainly be helpful in raising the bar for quality services and providing consistency.

Legal Assistance Program

- **Objective 4.2 -** There is an increasing need for guardianship, financial management, and legal services for poor and vulnerable adults. As a provider of these services with over 30 years experience, we encourage community leaders, legislators and organizations to publicize the benefits of written, well thought-out and communicated Advance Directives such as Living Wills, Powers of Attorney, Health Care Proxies and MOLST forms.
- **Objective 4.3 -** Additional Strategy for Objective 4.3 - Encourage referral by the AAA to the Legal Assistance Providers to appeal denials of the Low Income Subsidy (LIS) and Medicare Savings Programs (MSP) benefits.
- **Objective 4.3 -** Additional Strategy for Objective 4.3 - Encourage the formation of local multi-disciplinary Elder Abuse Prevention Councils by providing examples of successful models and best practices throughout the state.

In-Home Contact and Support Services

- **Objective 2.1** - Objective 2.1 specifically mentions the expansion of "non-medical home care services as a cost-effective alternative to more intensive and costly forms of care." One way to mitigate costly forms of care is to increase the use of assistive technologies. Nowhere in the Plan is there a mention of durable medical equipment or assistive technologies as a means to support individuals and reduce the reliance on costly professional personnel.
- **Objective 2.1 -** When cost sharing for case management is implemented (2014), the number of cost sharing participants may be reduced. This will lower program income and make it difficult to expand the availability of non-medical home care services.
- **Objective 2.5 -** The expansion of the Ancillary Service option for EISEP is very welcomed and we look forward to utilizing it in creative ways in our community.
  [Please Note: Suggested Strategy Related to Plan Section Above]
- **Suggested Strategy -** I would recommend that NYSOFA review the ability to use health care costs as a deduction for determining cost share for the EISEP program. The financial burden of health care services is complicated further by the fact that many of NY'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, and are more costly to provide and where availability of specialized services is less likely.

Supporting Aging in Place

- **Objective 2.8 -** Expand the "Livable New York" and "Livable New York Academy" initiatives including developing a Community Evaluation Tool to survey New York Communities as a basis for planning and implementing age-friendly projects.
  [Please Note: Suggested Strategies Related to Plan Section Above]

- **Suggested Strategy -** Assist the housing provider with the development and implementation of a congregate meal program and/or homebound meal program at the federally-assisted rental housing and Low Income Housing Tax Credit rental housing properties.
- **Suggested Strategy -** A "housing with services" section in the plan would help residents of subsidized housing age in place and provide efficiencies and cost savings in service delivery within congregate housing settings.
- **Suggested Strategy -** Assist the housing provider with initiating and implementing wellness and prevention programs for older individuals in federally-assisted rental housing and Low Income Housing Tax Credit rental housing properties.
- **Suggested Strategy -** Incentivize the use of monitoring technologies in housing and HCBS programs as a means to enhance care coordination and redirect care to outpatient settings.
- **Suggested Strategy -** Develop an Interagency Council of Senior Housing with Supportive Services of state agencies and service providers that would address the need for more coordinated and rational state policy on housing with services models.
- **Suggested Strategy -** The WRAP is a beneficial program that should provide an allowance for basic roof repairs. This minor adjustment to WRAP funding protocol would assist in creating more accessible housing for the aging/disabled population.
- **Suggested Strategy -** NYSOFA's Livable New York Initiative should incorporate addressing mental health and substance abuse problems among older adults so as to help communities better plan for the behavioral health needs of older residents.
- **Suggested Strategy -** Each county in New York has access to an independent living center and many of them specialize in accessibility and preparedness. An outreach to these agencies would provide OFA an opportunity to create an informative public outreach that could educate folks on the basics of accessibility.

Disease Prevention and Health Promotion Services

- **Objective 3.2 -** I recommend that the NYSOFA work closely with the Department of Health to bridge the gaps in service between community-based services and the Health Department to reduce the duplication of effort and support people where they need services.

  [Please Note: Suggested Strategies Related to Plan Section Above]
- **Suggested Strategy -** Provide for annual training sessions on available service and support resources, including programs to screen for the prevention of depression, coordination of community mental health services, and referral to psychiatric and psychological services; training on mental health screening for older adults for service coordinators, if applicable.
- **Suggested Strategy -** Prioritize health equity efforts on LGBT elders and other marginalized groups of older New Yorkers and focus on the economic disparities of LGBT elders and other NYSOFA target communities, in order to prioritize health services and prevention programs within the LGBT communities.

Supporting Caregivers

- **Objective 2.18 -** Ensure that access to up-to-date, relevant and useful information to caregivers and professionals as stated on Objective 2.18 includes mental health resources and supports.

- **Objective 2.19 -** AAAs should take advantage of the ILC expertise in identifying, training, and managing direct care workers, particularly in the area of outreach noted in Objective 2.19.
- **Objective 2.28 -** We need to broaden the Objective 2.28 to include respite for any grandparent regardless of age or disability.
  [Please Note: Suggested Strategies Related to Plan Section Above]
- **Suggested Strategy -** Make the 10% for kinship caregivers mandatory rather than possibly.
- **Suggested Strategy -** Where possible, the State Plan for Aging should account for the unique family structures and collective experiences of LGBT older adults and various racial and ethnic communities by recognizing partners, families of choice, spouses and biological families as caregivers.

Social Adult Day Services

- **Objective 2.27 -** Develop new models of adult day services such as the enhanced social adult day services model and/or revise regulations to include the capacity to provide medication administration.
  [Please Note: Suggested Strategy Related to Plan Section Above]
- **Suggested Strategy -** Consider offering programs at different times of the day and night. Overnight SADS have been offered in other parts of the country with great success both for the person with dementia as well as their primary caregivers.

Older American Community Service Employment Program

- **Objective 3.18** - The mission of the SCSEP is to help participants reach unsubsidized employment. This Objective centers on serving the sites needs and does not help foster transitioning of our participants to the private sector.
  [Please Note: Suggested Strategy Related to Plan Section Above]
- **Suggested Strategy -** The Older American Community Service Employment Program and the Senior Corps provide opportunities that should be expanded based on a higher income threshold.

Civic Engagement and Volunteerism

[Please Note: Suggested Strategies Related to Plan Section Above]

- **Suggested Strategy -** Human Service agencies would benefit from training and support for volunteer administration.
- **Suggested Strategy -** Communities need to find innovative ways to honor and support volunteers – for example – if a person is a 'certified transportation volunteer' then perhaps they have access to cheaper gas or discounted car washes and oil changes.

Vulnerable Elder Rights Protection Activities

- **Objective 4.4 -** Ensure that the recalibrated training curriculum to enhance ombudsman investigation and advocacy skills and improve coordination includes identification of mental health issues and appropriate coordination with mental health services.
- **Objective 4.5 -** Additional Strategy for Objective 4.5 - Encourage Ombudsman programs to contact their local Legal Assistance providers to obtain training on legal issues for the ombudsman volunteers.

- **Objective 4.10 -** Additional Strategy for Objective 4.10 - Require PSA workers to obtain yearly elder abuse prevention training and serve on any Elder Abuse Prevention Council and the NYS Coalition on Elder Abuse.
- **Objective 4.11 -** Additional Strategy for Objective 4.11 - Seek support at the local level for updating the 25 year old MOU between NYSOFA and OCFS. Many counties work closely with PSA and have MOU's or policies and procedures in place to maximize staffing and resources to better serve vulnerable at-risk seniors.
  [Please Note: Suggested Strategy Related to Plan Section Above]
- **Suggested Strategy -** Focus the efforts of NYSOFA's Elder Abuse Education and Outreach Program on vulnerable constituencies, such as older LGBT adults. Due in large part to high rates of social isolation and fear of discrimination, many LGBT older adults are at a high risk for elder abuse, neglect and various forms of exploitation.

Community Living Grant Program

- **Objective 2.47** - Several of the new CLP counties have used the Onondaga County NHDG manual as a template to create their CLP manuals. To save time and meet the 2013 outcome date, suggest the Onondaga County version be updated and expanded rather than create a new manual.

Veterans Directed Home and Community-based Services Program

- **Objective 2.51 -** The finalized service payment structure (fee for service or Bundled with Rainy Day fund) has not been determined in original three counties. This may be cause for recent hold up of VA payment for VD-HCBSP services. Problem should be resolved before new VD-HCBSP programs initiated.

Cost Share for Title III Services

- **Objective 2.52** - While cost sharing is intended to increase revenue and expand services, it comes at a cost in both case management responsibilities and administrative activities. I am concerned that any increase in revenue would be subsumed by the cost of determining and collecting the cost share.

Information Driven Programs/Initiatives/Services

[Please Note: Suggested Strategies Related to Plan Section Above]

- **Suggested Strategy -** Where appropriate, NYSOFA should require that data collection efforts, reporting requirements and assessments include LGBT older adults, in order to ensure that aging services are reaching these populations.
- **Suggested Strategy -** As you move forward with your plans we encourage you to gather data and input through online questionnaires such as survey monkey, or to offer video conferences and online trainings and meetings.
- **Suggested Strategy -** Develop research on the cost effectiveness of providing affordable housing and supportive services, especially as it contrasts to placements at higher levels of care.
- **Suggested Strategy -** Whether a unit of service is counted in aggregate or is client specific, the measurement is still output. Output data informs government how much

of a specific service is provided and informs the public as to the cost of providing each service. However, output data does not provide information on the impact of the service, whether the service led to any quality of life improvements, and whether the service had any preventive effect. Outcome measures need to be incorporated into Data Quality, Collection and Analysis to yield results that show the achievement of goals and for effective advocacy.

Equal Opportunity, Diversity Management

- **Objective 5.6 -** Additional Strategy for Objective 5.6 - Local districts are unique in diverse populations and many are experiencing in-migration of older adults from many countries. The Diversity Officer at the area AAA will be well informed on local migration patterns, needs and trends. The Diversity Officer will also be available to NYSOFA to coordinate training at the local and regional level.
- **Objective 5.6 -** We recommend that special attention focus on traditionally underserved populations, who are the rapidly growing cohort in the baby boom generation. We know that older New Yorkers who are racial and ethnic minorities are often the most impoverished and in need of services that are linguistically and culturally appropriate.