NEW YORK STATE OF OPPORTUNITY. | Office for the Aging

DRAFT

2019-2023 New York State Plan on Aging

www.aging.ny.gov

A Message from the Director

Dear Colleagues:

The Older Americans Act (OAA), which set up the infrastructure for what is today's network of aging services professionals, was signed into law by President Lyndon B. Johnson on July 14, 1965. It established the Administration on Aging within the Department of Health, Education and Welfare, and called for the creation of State Units on Aging.

The OAA authorized grants to states for community planning and services programs, as well as for research, demonstration, and training projects in the field of aging. Later amendments to the Act added grants to Area Agencies on Aging for local needs identification, planning, and funding of services, including but not limited to nutrition programs in the community as well as for those who are homebound; programs that serve Native American elders; services targeted at low-income minority elders; health promotion and disease prevention activities; in-home services for frail elders, and those services that protect the rights of older people such as the Long Term Care Ombudsman Program.

At the signing of the Older Americans Act, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and to their aunts. And no longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

The OAA and other federal policies have expanded since the OAA signing to address issues such as age discrimination (1967), create the Foster Grandparents and RSVP programs (1969), creating the national nutrition program (1972), creating the Title V SCSEP workforce program (1973), authorizing protective services for adults, homemaker services, transportation, adult day care and information and referral services (1974), established the Long Term Care Ombudsman Program (1978), established the family caregiver support program (2000), authorized the establishment of Aging and Disability Resource Centers and provided a greater focus on civic engagement, volunteerism, prevention, health and wellness and mental illness (2006), and expands the delivery of evidence-based programs such as fall prevention and chronic disease self-management programs (2016).

The role of the aging network has grown substantially and is being recognized as key network to address social determinants of health, health disparities and as an important partner in health care and long term care reform. The aging network is a trusted community resource that is an important part of the three critical components of successful aging: the absence or avoidance of disease and the risk factors associated with disease; the maintenance of physical and cognitive function; and active engagement with life.

The ***2019-2023 New York State Four Year Plan on Aging*** is designed to guide service delivery and policy development throughout the state. It will form the basis for restructuring policies and serve as a benchmark to measure effectiveness and efficacy. While NYSOFA has been charged with the development of this plan, the office has sought broad community input from the Area Agencies on Aging, consumers, service providers, and educators, among others. I am pleased to present the New York State Plan on Aging for the period October 1, 2019–September 30, 2023. I am proud to be a part of a network dedicated to serving older adults and welcome your continued involvement as we work together to respond to challenges and opportunities in the years ahead.

Greg Olsen, Acting Director

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Verification of Intent

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

_____ DATE: _____

Andrew M. Cuomo, Governor, State of New York

Verification of Intent

The State of New York, Office for the Aging, hereby submits the New York State Plan on Aging for the period October 1, 2019 to September 30, 2023 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.

_____ DATE: _____

Greg Olsen, Acting Director, New York State of the Aging

New York State Office for the Aging

The New York State Office for the Aging (NYSOFA), established in 1965 by Article 19-J of the Executive Law (now, New York State Elder Law, Article II, Title 1), is New York's designated state unit on aging as required by the federal Older Americans Act (OAA). NYSOFA is the lead agency for promoting, coordinating, and administering in the delivery of federal, state, and local programs and services for older New Yorkers age 60 and over and their caregivers.

It is the mission of the New York State Office for the Aging to help older New Yorkers 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 that support and empower older New Yorkers and their families, in partnership with the network of public and private organizations that serve them.

NYSOFA's role in the delivery and administration of services is continuing to evolve and expand, due to the recognition that the service delivery infrastructure and federal partnership requirements enable NYSOFA to connect systems to improve the lives of older New Yorkers. In addition, under Governor Cuomo's leadership, the state's Prevention Agenda, Health Across All Policies Approach, and Age-Friendly designation further coordinate services and supports beyond what NYSOFA and its area agencies on aging (AAAs) provide directly.

The Older Americans Act and the State Elder Law require NYSOFA to advocate on behalf of New York's 4.3 million older adults ages 60 and older, as well as their informal caregivers (family, friends, and neighbors). There are estimated to be more than 4 million caregivers at any given time annually providing daily or intermittent care for older adults and people of all ages with disabilities. NYSOFA partners with 59 AAAs and almost 1,200 community-based organizations, which provide a wide array of programs, services, and supports that help older New Yorkers stay healthy, access services, prevent and mitigate abuse, stay engaged in their communities, understand and apply for benefits, and maintain their autonomy as they age. This requires strong state and local partnerships across a variety of systems and requires a shared response. New York's Prevention Agenda and Health Across All Policies Approach is an important vehicle to achieve success.

NYSOFA is the state's administrator for the federally designated Aging and Disability Resource Center (NY Connects) as well as the state Long Term Care Ombudsman Program (LTCOP). These statewide programs are not limited to those ages 60 and older.

Roles and Responsibilities of the Aging Services Network

Successful aging has three critical components: the absence or avoidance of disease and the risk factors associated with disease; the maintenance of physical and cognitive function; and active engagement with life. The OAA and NYS Elder Law provide flexibility in how AAAs meet locally determined needs; however, they remain rooted in the components of successful aging.

The OAA was founded on the principle of building local partnerships and leveraging additional resources from these partnerships to expand service delivery and access and to maintain and improve health and functioning while reducing isolation and linking to active life engagement. While the OAA targets funding to those over the age of 60, over time the network's portfolio has expanded to assist other populations. For example, the Health Insurance, Information and Counseling Assistance Program (HIICAP) may be accessed by Medicare beneficiaries of any age and NY Connects (New York's Aging and Disability Resource Center and No Wrong Door)

is available to provide information and assistance to individuals of any age and their families who are seeking long term services and supports (LTSS). The Long Term Care Ombudsman Program (LTCOP) may be accessed by any resident in facilities covered under its jurisdiction.

In New York, the network of aging service professionals provides the following core services statewide:

- Home delivered meals (HDM)
- Congregate meals
- Nutrition counseling & education
- Senior center programming
- Health promotion and wellness
- Evidence-based interventions, i.e., chronic disease self-management, fall and injury prevention, etc.
- Volunteer opportunities
- Social isolation reduction
- Respite and caregiver support
- Legal services
- Minor home modifications, repairs
- Elder abuse prevention and mitigation
- Health Insurance, Information, Counseling and Assistance (HIICAP)
- Personal care level I and II (non-Medicaid)
- Case management
- Ancillary services such as personal emergency response (PERS) and assistive devices
- Consumer directed services
- Social adult day services
- Transportation to needed medical appointments, community services and activities
- Long Term Care Ombudsman Program (LTCOP)
- NY Connects (Aging and Disability Resource Center), offering:
    - Consistent information, assistance, and experience to individuals in need of LTSS across age and disability groups, payer source, and across NYS
    - Information and assistance—via phone; face to face (office, other community locations, in the home, online)
    - A variety of screening (Medicaid eligibility, depression, anxiety, alcohol and substance abuse)
    - Options/person centered counseling
    - Follow up to ensure connection to services

Due to the flexibility in federal funding (Title IIIB) and state funding (CSE) as well as the significant local government contribution, AAAs offer additional services that respond to locally-determined needs.

Network Strengths

The strength of the network is the way it is organized, its partnerships, and its connection to the community. Network strengths include:

- An established infrastructure/network with experience serving vulnerable populations for 40+ years
- Extensive knowledge of community-based provider networks and how to access

them
- Experience with hospital transitions and evidence-based programs
- Cultural and linguistic competence
- Knowledge of the community they serve and their varied needs
- Established relationships and trust across systems and among the public
- Being nimble and able to provide services in the home
- Serving clients for life; not episode focused
- Serving individuals across all care settings
- Serving as the eyes and ears of medical professionals in the home and community
- Providing one door for information, services and supports
- Extensive benefits and application assistance and screening
- Low-cost, high-impact
- Not insurance driven
- Mission driven, but data informed

2017-2018 Network Service Provision

Verified data reporting from the area agencies on aging to the state show that the network served more than 1.3 million people with $497 million invested (all sources) and includes:

- 63,825 older New Yorkers who receive registered dietician (RD) certified home delivered meals.
- 196,547 older New Yorkers who receive RD certified meals in a congregate setting.
- 69,561 older New Yorkers who had case managers to help them maintain their independence and navigate various health and social service systems.
- 13,087 older New Yorkers who received personal care services in their homes.
- 108,044 older adults who receive transportation services to medical appointments, pharmacies, and other community outlets.
- 10,823 received legal assistance.
- 88,921 received nutrition counseling, and education.
- 293,633 received information and assistance.
- 109,144 received health promotion/prevention.
- 248,000 individuals who received Medicare plan and prescription counseling and assistance.
- 13,109 older New Yorkers who received caregiver support services and respite so they can continue to care for a frail loved one.
- More than 250,000 contacts to NY Connects
- 1.5 million page hits on the NY Connects Resource Directory.

Health Across All Policies / Prevention Agenda / Age-Friendly State

Governor Cuomo's Health Across All Policies approach (HAAP) is an approach to public policies across sectors that systematically takes into account the health and health system implications of decisions; seeks synergies; and avoids harmful health impacts in order to improve population health and health equity. The HAAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants and aims to improve the accountability of policymakers for health impacts at all levels of policy making. It also recognizes that 60% of health costs and related issues have nothing to do with health, but instead have to do with individual behaviors (smoking, physical activity, nutrition) and social and environmental factors (poverty, living arrangements,

educational status). NYSOFA's programs and services are key in addressing these social determinants of health.

Creating and supporting an age friendly state and age friendly communities recognizes that the benefits cross the age spectrum and both short term and long term planning around the 8 domains of livability as defined by the World health Organization and AARP are important to the Prevention Agenda goals and the HAAP approach.

Age friendly in New York State is not just about old age—it is about the collective value of people of all ages and abilities and recognizing that addressing the 8 domains improves the health and lives of all populations and is central to supporting the goal of making New York the healthiest state in the nation. It is about designing communities for everyone that strengthen people's connections to each other, improve health, increase physical activity, and support and advance the economic environment through proactive design and future-based planning. From housing to transportation, we have streamlined and improved existing programs to make sure they reach New Yorkers of all ages and abilities in a more effective way. The eight domains include:

1. Outdoor spaces and buildings
2. Transportation
3. Housing
4. Social participation
5. Respect and social inclusion
6. Work and civic engagement
7. Communication and information
8. Community and health services

Being designated the first age-friendly state is not the end of our efforts, but the beginning. New York State will continue to work with local governments, residents, and businesses to embed the 8 domains of age-friendly policy into all aspects of community development to make positive changes in communities that are attractive to all, regardless of age.

Economics of Aging

As in the rest of the nation, New York's population is growing older. For far too long the aging population has been portrayed as one that contributes less and takes more. But the documented social, economic, and intellectual capital that older adults contribute to their communities and to our state is unmistakable:

- New York has the fourth largest population of older adults in the nation: 4.3 million New Yorkers are 60 years of age or older, and 4.2 million are between the ages of 45 and 59.
- By 2025, 33 counties are projected to have more than 25% of their population over 60 with 18 being 30% or more.
- 64% of New Yorkers age 60+ own their own homes and have no mortgage.
- 83 percent of US household wealth is held by people over 50:
    - Direct spending on consumer goods and services, including health care, by those aged 50 and over amounted to $5.6 trillion in 2015. The under-50 population spent $4.9 trillion during the same period.
    - People over age 50 account for the majority of volunteering, philanthropy, and donation activities in the US.
    - Overall, spending by people aged 50 and over in the US in 2015 supported more than 89.4 million jobs and over $4.7 trillion in labor income.

    - Some 61 percent of all US jobs and 43 percent of labor income was related to spending by the 50-plus cohort.
    - According to AARP, people over the age of 50 control 70% of the country's wealth, make up 51% of consumer spending—over $7 trillion.
- With their years of life, work, and family experience, approximately 935,000 New Yorkers over the age of 55 New Yorkers contribute more than 495 million hours of community service at an economic value of more than $13.9 billion annually.
- Older New Yorkers and baby boomers make up 63 percent—$379 billion—of all the household income generated in NYS. They support local businesses and schools through home ownership, contributing significantly to the local and state economy.
- According to AARP, 90 percent of NYS residents surveyed say they want to retire in New York.
- The older population contributes significantly via tourism and are the number 1 age cohort for volunteering, philanthropy giving and contributing to non-profits.

Performance Management

NYSOFA's continued commitment to effective and responsive management remains one of the agency's priorities. As a result, over the course of the next four years, the agency will administer consistent performance management practices that will include but not be limited to, standardized metrics, improved outcomes, and targeted projections. NYSOFA will seek to partner with entities to help demonstrate the efficacy of the Networks interventions and efficacy in programming.

The 2019-2023 State Plan includes goals, objectives, strategies, and expected outcomes but with a mixed methodology approach. Some expected outcomes include outputs which can be conceptualized as products, where other expected outcomes illustrate the expected benefit.

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. However, the younger population block is actually larger than the baby boomers and wants similar things, making the state's effort to improve livability and implement age friendly projects that much more important.

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 2025. As part of the continuing demographic shift nationally, the number of NYS counties where the population aged 60 and over constitutes more than 30% of the total population will grow from 9 to 24 counties. In 2020, population projections (as cited below and in the table to the right) indicate only 4 counties will have populations where older adults (aged 60 and over) make up less than 20 percent of the total population, two counties in New York City, Tompkins County (includes Cornell University), and Jefferson County (includes Fort Drum). By 2025, the number of counties with less than 20 percent of the population aged 60 and over will be three boroughs in New York City and Jefferson County. Overall, the state population is projected to be 24.3 percent older adults, which is comparable to the national projection in 2025.

New York State

62 Counties

Change in Population Aged 60 and Over

2020 to 2025

Proportion of County Population Aged 60 and Over	Number of Counties with Specified percent of Older Persons	
	2020	2025
Less than 20%	4	4
20% to 24%	17	6
25% to 29%	32	28
30% and over	9	24

Source: Woods & Poole Economics, Inc., 2018 State Profile

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

New York's total population is projected for 2020 to be nearly 20 million individuals, and, with 4.3 million individuals aged 60 and older (Woods & Poole 2018 estimate), the state ranks fourth in the nation in the number of older adults behind California, Florida, and Texas, based on the latest data available (the 2017 American Community Survey, one-year estimates). Rich in ethnic, racial, religious/spiritual, cultural and life-style diversity, New York is known for its status as a finance, transportation, and manufacturing center, as well as for its history as a gateway for

immigration to the United States. According to the 2017 American Community Survey, over 23 percent of the state's total population is foreign-born, with 27 percent of the older adult population being foreign born; in addition, 31 percent of the population speaking a language other than English at home.

Racial/Ethnic Diversity and Foreign Immigration

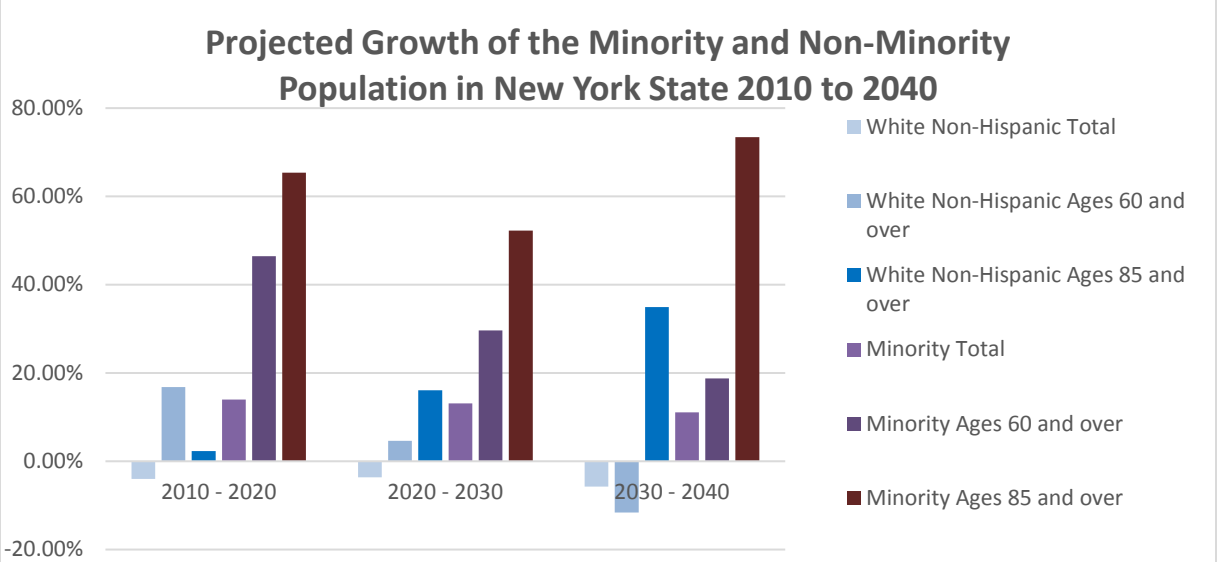
Between the 2000 and the 2010 Census, the minority population aged 60 and over grew by 43 percent, compared to 8 percent for the non-minority population. This high growth rate will continue over the next three decades:

- Between 2020 and 2030, the growth rate for the ages 60 and over population is expected to be 30 percent for the minority population groups, and only 5 percent for the non-minority population.
- Between 2030 and 2040, the non-minority ages 60 and over population will *decline* by 12 percent while the minority population groups will increase by 19 percent, and the minority 85 and over will increase by over 70%.

Between 2010 - 2020, the minority population aged 60 and over is expected to have grown by 47 percent, compared to 17 percent for the non-minority population. This high growth rate will continue over the next three decades.

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

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

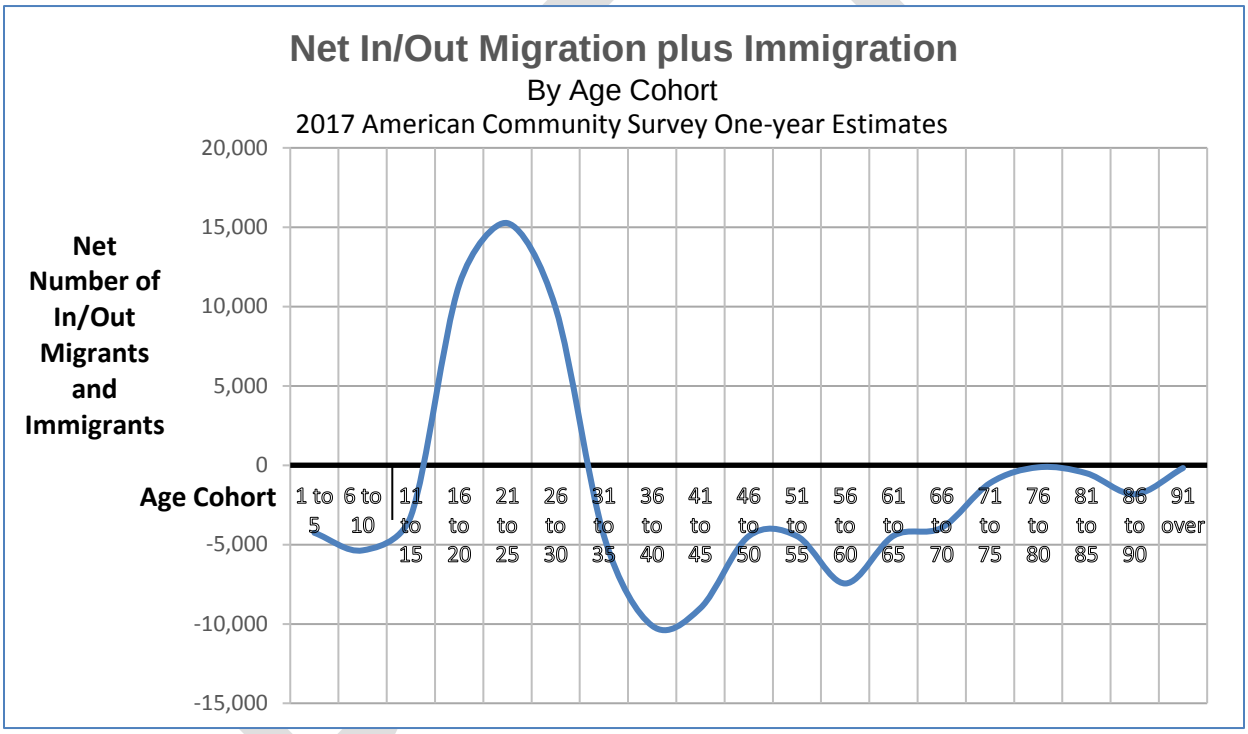


Source: Woods & Poole Economics, Inc., *Complete Demographic Database, 2018*

Migration Patterns

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

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



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

an impact on both the costs and structure of the State's health and long-term care systems. Embedding age-friendly and smart growth principles to state and local policy and redesigning communities to meet the needs and desires of older and younger populations along with other policy changes such as a permanent property tax cap, free college tuition, paid family leave, etc. are designed to not only stem the tide of out-migration for all ages but also make NYS an attractive place to move to, to grow up and grow older.

Income and Poverty

According to most accounts, the past decades have brought tremendous gains in reducing poverty among older adults. Although the official poverty rate for children continues to be near 20 percent, the official poverty rate among older adults is 9.7 percent nationally and 11.5 percent in New York. Pockets of poverty do remain, for example, among older women living alone, but the overall picture is one of progress. However, many New Yorkers live just above poverty: *per capita*, according to the 2012-2016 American Community Survey (Special Tabulation on Aging), while 55% of older adults are at 300% and over poverty range, 33% are clustered between poverty and 250% poverty.

In many ways, New York is a study in contrasts. In terms of income, the 2017 American Community Survey reports the State's median household income as $ 64,894; yet, 14 percent of the population was living in poverty. While economic security is a reality today for more older people than perhaps ever before thanks to Social Security and other benefits, the older adult population remains vulnerable to a range of economic security problems as they age. Poverty and low incomes, prescription drug and other out-of-pocket health care and long-term care costs, energy costs, local property and other taxes and household and housing expenses remain vital concerns of older New Yorkers, particularly with advancing age and among minorities or older individuals with impairments. Paradoxically, the greatest burden in terms of out-of-pocket costs within any age group is borne by persons with the lowest incomes, as they are least likely to carry sufficient insurance coverage (see, e.g., The Commonwealth Fund, "Too High a Price: Out-of-Pocket Health Care Costs in the United States").

Health care costs disproportionately impact older persons and increase with the onset of chronic health conditions as they age. While more older adults are insulated against rising costs by insurance covering gaps in Medicare than were previously, policy changes to Medicare over the past decade have led to higher cost-sharing for older adults and a future that is uncertain in terms of how much of the risk the government will carry. Federal efforts to rollback the Affordable Care Act will further weaken the financial stability of older adults where their health care is concerned, however, NYS codified the Affordable Care Act provisions in NYS law in the enacted 2019-2020 budget.

Household and housing costs also impact disproportionately on older adults. According to the 2013-2017 American Community Survey (Special Tabulation on Aging), while comprising 17 percent of the household population, people 65 and older comprise 26 percent of all householders, owning or renting a disproportionate share of the State's occupied housing units—over 1.9 million of the State's 7.3 million homes.

People aged 65 and over living alone comprise 46 percent of all householders in that age group, and own or rent over 868,000, or 12% of occupied housing units in the State. Approximately 22 percent of these householders are living in poverty on incomes under $12,060 (poverty level published in the 2017 Department of Health and Human Services Poverty Guideline; the 2019

poverty level has increased to $12,490).

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

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

Gender

The experience of women as they age typically are greatly influenced by the roles they assume and the resources available to them. Older women spent less time in the workforce than their male counterparts. This translates into lower pay wages, lower personal earnings and lower retirement income compared with men. Also, the greater longevity among women compared to men tends to translate into women spending more time living alone as they age. Women are more likely to be the primary caregiver to a spouse and more likely to be in need of long-term care services. Therefore, often they rely on Medicaid to finance the support of their care, especially if a spouse were to have consumed the family savings paying for their long-term care services: such situations leave women especially financially vulnerable. Approximately 10 percent of women aged 15 to 64 live alone: this more than triples among women aged 65 and older (35%), and 55% of women ages 85 and older—not in group quarters—live alone. More women than men assume caregiving responsibilities for older family members.

According to a 2015 National Alliance for Caregiving and AARP study, 60 percent of primary caregivers are women; the average caregiver is a 49-year old woman. Most are married or living with a partner, and 28 percent have a child or grandchild under the age of 18 living in their household. Six in 10 are employed (59 percent). Caregivers' median household income of $55,000 compared to the $53,046 for the United States overall. Furthermore, the typical higher-hour caregiver (who provides unpaid care for at least 21 hours a week) has been caregiving for an average of 5-1/2 years and expects to continue care for another 5 years. Nearly half of these higher-hour caregivers report high emotional stress (46 percent). In addition, higher-hour caregivers report difficulty in finding affordable caregiving services, such as home delivered meals, transportation, or in-home health services, in the community for them and their loved ones. Caregivers who live more than an hour away from their care recipient also report higher levels of financial strain (21 percent), perhaps because 4 out of 10 long-distance caregivers report the use of paid help (41 percent).

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 2020, NYSOFA projects (based on Woods & Poole Economics, Population Projections, 2018) that the number of people aged 60 and over with functional impairments will grow by a rate of 11.2 percent, and by over 20% by 2025, comparable to the rate of the overall population growth, with 81% living in the community, and 19% (based on New York's current long-term care structure) living in nursing homes or other group care facilities.

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

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.

Older adults who have health problems and chronic diseases and have lower incomes face very difficult choices in terms of affording their care and financing other important household-related expenses.

The projected increase in the number of older adults in New York State will have a significant impact on health and long-term services and supports and the state's ability to deliver and pay for those services. Recent survey findings ("Facts About 50 Plus in NY -- Health of Older Adults in New York" Gibson et al. 2003) of individuals aged 50 years and over indicate that only approximately one in four) older adults (27 percent of people aged 50 and over) have sufficient resources to pay for long-term care expenses totaling $150,000 over the course of a three-year period, leaving almost *three* out of four who could *not* do so – in total leaving 4.75 million people at risk of impoverishment. The financial burden of health care services is complicated further by the fact that many of New York's older residents live in rural areas where health and long-term care services, and other community-based services are less accessible, may not exist, are more costly to provide, and where availability of specialized services is less likely. In addition, the 2017 American Community Survey indicates that over 114,300 persons in group quarters (i.e., non-household) population are ages 65 and over, 20% of the group quarters population, two-thirds of whom are women, nearly half of whom are living in poverty, and – based on the self-report in these Census data – 91 percent of whom report having a disability: while many of these persons are in institutional facilities, with the increasing emphasis on nursing-home diversions, many are instead living in the community.

Health promotion strategies directed toward all age groups represent another important means to stem rising health care costs since the behaviors that place people at-risk of disease often begin earlier in life. Of particular concern is the rise in the rate of obesity observed among children and young adults and its future, as well as current impact. Communities designed to promote exercise and healthy lifestyles and invest in prevention and behavior change strategies

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. The Governor's Health Across All Policies Approach and embedding healthy aging into government work will have a positive impact on health as it addresses underlying causes of decline.

Growth in Long-Term Care Needs

As noted above, over 114,300 persons aged 65 and over live in group-quarters, over three percent of State's ages 65 and over population. Historically, about 80 to 85 percent of that number would live in nursing homes: in the 2010 Census (the latest data available for institutional group quarters) that number was 96,495, or 86%, but – again – as noted above, the institutional group-quarters population is expected to be dropping significantly, increasing the need for community-based long term care.

In addition, historically, for people aged 60 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, with this number rising to 15 percent for ages 75 and over and to 25 percent for the ages 85 and over; 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. This number rises to one-third for ages 75 and over, and for 50 percent for ages 85 and over.

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 NYS Department of Health data for the year 2016 indicate that 103,696 persons are in nursing homes, most of whom are aged 65 and over population live in nursing homes or other group care facilities, NYSOFA estimates (based on historical data) that approximately 30 percent of the 2,616,716 people 65 and older in New York State (Census 2010) were functionally impaired by chronic health conditions. This includes 8 percent with ADL limitations living at home in the community and 16 percent with IADL limitations living at home in the community.

With the recognition that the majority of health care costs are due to social determinants, home and community-based services and prevention and wellness strategies are becoming increasingly more important to support those with chronic conditions and functional limitations particularly given the effort to assure that individuals live in the most-integrated setting supported by legal precedent (Olmstead v. L.C.) and policy changes (i.e. Balanced Incentive Payment, DSRIP, etc.). For most, residential facilities are not appropriate, and their needs can be met in the community. Data has shown that frail individuals do 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 some functionally impaired older adults, older people following discharge from an acute care setting, and those most disadvantaged and at-risk, the older-old (85+), older women and older minorities. Older people most in need of sound daily diets are, in fact, those who are least able to maintain their nutritional well-being.

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

- Chronic Disease - The nutritional status of older adults has a significant role in disease causation, risk reduction and the treatment of chronic degenerative diseases. The presence of one or more of the chronic diseases that especially affect older individuals with advancing age often requires that they follow a prescribed, therapeutic diet.
- Medications - Side effects and drug-nutrient interactions associated with some medications may cause mal-absorption of nutrients, weight loss, anemia, dehydration, low or high blood sugar, fatigue and depression, all of which may lead to poor nutrition and other serious health complications.
- Oral Health - Poor oral health may limit the type, quantity and consistency of food eaten, increasing nutritional risk.
- Weight Loss - Being underweight often indicates an inadequate dietary intake and is associated with frailty and possible underlying illness.
- Social Activities - Social interaction positively affects an individual's food intake, but its absence, social isolation, may lead to loneliness which can negatively affect dietary adequacy and thereby increase an individual's risk for malnutrition.

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

Community Involvement

Older adults are heavily invested in their communities in a number of ways. Individuals ages 50 and older, according to AARP hold 83% of U.S. household wealth, spend $5.6 trillion annually on consumer goods and services, exceeding the under 50 population. Older adults contribute $1.8 trillion in federal, state and local taxes, supporting 34% of federal tax revenue and 41% of state and local tax revenue collected in the U.S. The 50+ population nationally account for the majority of volunteering, philanthropy and donation activities in the US and this is expected to grow as the population ages. Spending by people age 50 and older supported more than 89.4

million jobs, over $4.7 trillion in labor income and 61% of all US jobs and 43% of labor income was related to spending by the 50+ cohort. According to data compiled by NYSOFA, in NYS the 45+ population accounts for 63% of all household income, or $379 billion annually. Further, more than 900,000 individuals age 55+ contribute 486 million hours of volunteer service at an economic value of $13.6 billion annually. In NYS older adults overwhelmingly own their own homes and most have no mortgages, supporting the local economy and schools without adding additional demands on districts because their children are grown up. It is the intent of this plan, coupled with the Governor's leadership in making NYS the healthies state in the nation through the Prevention Agenda, creating a health across all policies approach and creating an age friendly state to continue to find meaningful ways to engage older adults to volunteer, be civically engaged and active participants in their communities, including their valuable role in the workforce.

Targeting and Equal Access

New York State has a diverse population. According to immigration statistics, the state is a leading recipient of migrants from around the globe. Additionally, the state's three largest cities (New York, Buffalo, and Rochester) have populations that are comprised of over one-half minorities. (58%, 53% and 56% respectively); the following three (Yonkers, Syracuse, and Albany) are over 45%. For this reason, NYSOFA maintains the dedicated position of Advocacy Specialist to promote equal access of all individuals and assure prioritization of services to those in greatest economic and social need, by evaluating changing community demographics and allocation of resources. NYSOFA also seeks to address equal access to services for rural residents, individuals with disabilities, Native Americans, individuals with limited English proficiency, ~~and~~ individuals at risk for institutional placement, and the LGBT community. NYSOFA is focused on providing increased technical assistance to AAAs on strategies to increase efforts to more effectively serve with the LGBT community. NYSOFA began this effort by including questions on its COMPASS (Comprehensive Assessment for Aging Network Community Based Long Term Care Services) which is the assessment used to determine an older persons need for services. Questions are included asking an older adult their gender identity and sexual orientation. In addition, AAAs are also being encouraged by NYSOFA to take advantage of training offered by SAGE on the cultural competency of working with LGBT individuals so that they can enhance their effectiveness in serving this population. Approximately one-sixth of the network is currently "SAGECare certified." This enables individuals who identify as LGBT to search for a qualified, culturally competent provider who is trained in the unique needs and barriers this population encounters. Also, NYSOFA will continue its focus on this topic through its ongoing collaboration with the AIDS institute that helped lead to the development of a guide for training aging network services providers on addressing older adults sexual health matters

Summary

While there are current and future challenges related to the growth of the older population, there are tremendous opportunities. Recent science related to the social determinants of health and the growing recognition of the valuable role the aging network can play, in partnership with the health care system, provides an opportunity to focus and prioritize community based services that improve health, improve function, improve strength and prevent falls, and reduce social isolation. This in turn can prevent higher levels of care, and more importantly, are critical to ensuring that clinical outcomes and personal outcomes are successful. The aging network is the only network that was designed with broad based partnerships as a requirement. It is designed to advocate for the individual and to help navigate, multiple, complex systems.

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

State Plan Context

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 (New York State Elder Law, Article II, Title 1 (previously Article 19-J of the Executive Law), 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 that support and empower older New Yorkers and their families, in partnership with the network of public and private organizations that serve them.

The New York State Plan on Aging for Federal Fiscal Years (FFY) 2019-2023 has been prepared by NYSOFA. The State Plan highlights the demographics and trends of New York State's older population, describes the aging services network, and the goals, objectives and strategies that will guide specific actions over the next four years.

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

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

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

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.

Executive Summary

State Units on Aging, area agencies on aging and their partners provide a variety of services in the home and community and work daily with health providers, law enforcement, state and county government agencies and others to connect the dots to improve overall care and address multi-system needs. Because individuals may have needs that touch different systems, working in a collaborative approach with government and non-government partners is crucial in order to provide the best service possible and serve people holistically. Governor Cuomo's goal is to make New York the healthiest state in the nation through advancing a health across all policies approach to incorporate health considerations into policies, programs and initiatives led by non-health agencies. The long-term goal is to embed health in all policies and healthy aging into all aspects of government work. Achieving this vision and goal will have substantial positive impacts on not only how communities are built/retrofitted but the opportunities the residents have to live healthier, more meaningful and connected lives, which will improve overall population health and improve outcomes for residents of all ages.

Demographic changes are inevitable. It has been a long-held belief that the older population is a drain on resources and their contributions are limited. Data demonstrates that these generalizations and stereotypes are false and it is the service delivery models that have evolved over the decades that are a problem, focusing more on tests, clinical care and utilization of the highest costs services rather than investments in prevention, in community, in interconnects and strengthening the community infrastructure. Governor Cuomo's vision of advancing a health across all policies approach to incorporate health considerations into policies, programs and initiatives led by non-health agencies is an important state policy that better connects state and local agencies, that focuses on prevention activities, and seeks to improve community conditions to improve outcomes. The benefits of this approach for the states older population cannot be understated and through the state's 2019-2024 Prevention Agenda, implementing age friendly and livability concepts into government work as well as making infrastructure investments in NYSOFA is creating an environment where older adults can thrive. The state's value based payment reform activities coupled with NYSOFA's business acumen project will bring together the health care networks and social services network to better align, communicate, contract and work together to improve health outcomes by addressing social determinants and providing services and supports to serve the individual and family holistically. As we continue to design and redesign the health and long-term care systems, the critical role of nutrition, transportation, evidenced-based interventions, socialization, in-home care, volunteerism, management of chronic conditions, etc. needs to be at the forefront. While there are many challenges in the coming years related to the growth of the older population, there are also tremendous opportunities to utilize the strengths and skills of older adults to help address pressing social problems and to be leaders in helping communities implement changes to make communities more livable for people of all ages, benefitting people of all ages. NYSOFA's home and community-based programs provide frail older persons access to a well-planned, coordinated package of in-home and other supportive services designed to support and supplement informal care. These services are even more important in helping older adults maintain good health, as many of the services provided by the aging network are critical to assuring sound discharge planning from hospital to home, or from rehabilitation setting to home. NYSOFA's services are also targeted to well older adults to engage them in volunteer and healthy aging activities, benefits and application assistance and health insurance counseling. Further, New York State area agencies on aging implement more than 40 of the highest level Evidenced-Based Interventions (EBIs) to help manage chronic conditions, prevent falls, improve strength, increase socialization and improve overall health. These are important complimentary strategies to help the entire older population succeed.

The overall goal of the state plan in partnership with a broad network of service providers is to improve access to, and availability of, appropriate and cost-effective non-medical support services for functionally impaired older individuals to maximize their ability to age in their community and avoid higher levels of care and publicly financed care. The health across all policies approach will further these goals by connecting with agencies and interests that may be under the jurisdiction of other agencies such as housing, transportation, parks and recreation, tourism, etc. to address livability and healthy aging into their day to day work. The overall goal is important for older adults who may need some minor assistance episodically, or ongoing, to maintain their independence. It is even more important for individuals who are recovering from an acute care episode and are in need of supports to improve their health functioning. The State Plan provides a summary of the programs and services administered by NYSOFA and the area agencies on aging and *is not intended* to be a collection of independent, unrelated or separate programs. Readers of the Plan should understand that as older adults connect with the area agencies on aging and their partners, a process begins to assess the strengths and needs of the individual and their family and based on the information gathered and the desires articulated by the individual or their representative, a care plan is developed that might include one or more of the services listed in the Plan or services listed outside the Plan or by other agencies and community-based organizations.. The Plan should be viewed in the context of a coordinated system of supports and linkages to maximize independence.

This 4 Year Plan on Aging seeks to expand and strengthen Older American Act core programs by utilizing federal, state and local funding and the flexibility they provide to the greatest extent possible as well as being an active participant in the states Prevention Agenda, health across all policies approach and strengthening New York as an age friendly state. The network of aging providers continue to meet existing needs through a combination of government resources, private fundraising, participant contributions and through building and strengthening new and/or existing partnerships. Further, this Plan seeks to improve the business acumen of the aging network to strengthen partnerships at both the state and local level that will continue to build bridges between systems and to work to position the aging network as a viable resource for the private pay market as well as a compliment and partner with hospitals, primary care physicians, and health networks that are reorganizing to provide more integrated, community-based care. This will be accomplished via a two-year business acumen project that NYSOFA, the Association on Aging in NYS and n4a launched in 2019 to strengthen health and social service connections and opportunities through a structured learning collaborative.

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

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 and their families. The State Plan outlines

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

Introduction

The New York State Office for the Aging (NYSOFA) administers federal funding provided under the Older Americans Act. NYSOFA also administers state general fund dollars that in essence, wrap around and build upon OAA funding and significantly expand and strengthen the OAA core programs. Further, county funds significantly expand service provision provided by the network and represent the single largest source of investments in non-medical home and community-based services delivered by the aging network.

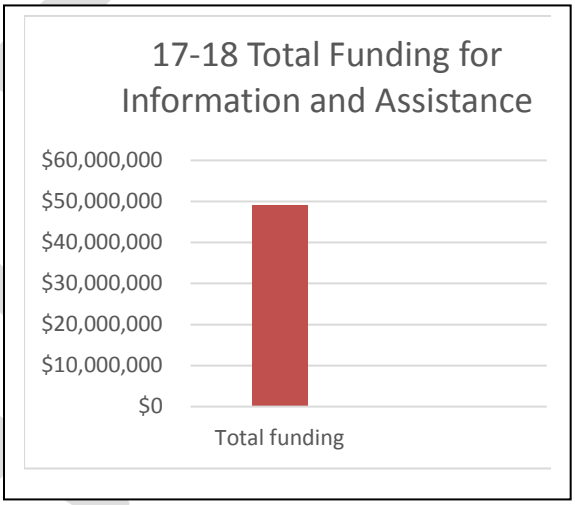
It is important to recognize that Sections A-D follow the prescribed framework laid out by the Administration for Community Living for State Plan submission. The programs and services listed within these Sections are not to be viewed as independent and separate. In practice, they are an integrated and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

Services Provided	Funding Streams Used to Support Services
PC Levels I and II	IIIB, IIIE, EISEP, CSE
Consumer Directed In-Home Services	EISEP, CSE, IIIB, IIIE
Home Health Aide	IIIB, IIIE, CSE
Case Management	IIIB, IIIE, EISEP, CSE, WIN
Home Delivered Meals	IIIC-2, IIIE, EISEP, CSE, WIN
Congregate Meals	IIIC-1, IIIE, EISEP, CSE, WIN
Nutrition Counseling	IIIC-1, IIIC-2, IIID, IIIE, EISEP, CSE, CSI, WIN
Nutrition Education	IIIC-1, IIIC-2, IIID, IIIE, CSE, CSI, WIN
NSIP/Community Food	IIIC-1, IIIC-2, IIIE, EISEP CSE, WIN
Escort	IIIB, IIIC-1, IIIE, CSE, CSI, WIN
Transportation	IIIB, IIIC-1, IIIE, EISEP, CSE, CSI, WIN
Legal Services	IIIB, IIIE, CSE
I & A	IIIB, IIIC-1, IIIC-2, IIID, IIIE, CSE, CSI, WIN
Outreach	IIIB, IIIC-1, IIIC-2, IIIE, CSE, CSI, WIN
In-Home Contact and Support	IIIB, IIIC-1, IIIC-2, IIIE, EISEP, CSE, WIN
Senior Center Programming	IIIB, IIIC-1, IIID, CSE, CSI, WIN, State General Fund
Health Promotion/Disease Prevention	IIIB, IIID, IIIE, CSE, CSI
PERS	IIIB, IIIE, EISEP, CSE
Caregiver Services	IIIB, IIIE, CSE, State General Fund
Adult Day Services	IIIB, IIIE, EISEP, CSE, State General Fund
LTC Ombudsman	IIIB, Title VII, State General Fund
NY Connects (ADRC)	State General Fund
HIICAP (SHIP)	Federal and State General Fund
Naturally Occurring Retirement Communities	State General Fund

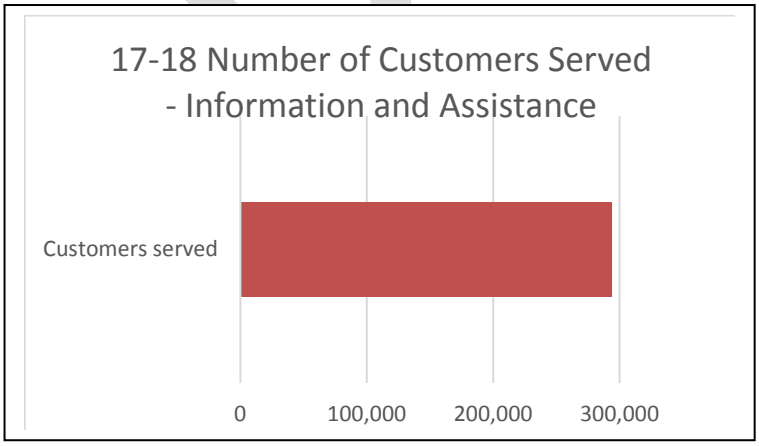
Titles IIIB, C-1, C-2, D and E make up the core programs under the Older Americans Act. In New York State, Title III funding directly supports the services listed in the above chart. OAA Core programs include Access Services; In-Home Contact and Support Services; those that support Aging in Place; Nutrition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

Section A. **Older Americans Act Core Programs**

Access Services – Information and Assistance



Access to objective information, particularly in stressful or crisis situations is paramount to good decision making, assuring appropriate needs are considered and evaluated and the right services or supports are in place. The general public are consistently bombarded with information and determining the most trusted source can sometimes be a challenge. Through NY connects, offices for the aging and community-based organizations, consistent, objective, person-centered information is provided to assist older adults and their families. Choices and decisions about a variety of issues, such as health care, housing, financial management, transportation options, nutrition, and long-term services and supports are provided and connections are facilitated. Federal, state, and local programs are administered by a multitude of different public and private agencies that have differing requirements to be eligible or to access. Older adults and their caregivers often need help to know what services are available, how to access them and whether or not they qualify. The Older Americans Act Information and Assistance (I&A) system in conjunction with NY Connects, helps older adults access a variety of services and make important linkages to non-network services. This system is designed to be person-centered and community-based, and to be a source of accurate and objective information and assistance, that will support all older adults and their caregivers in: assessing their needs, identifying appropriate services, and linking the older persons and caregivers to agencies providing those services. The information and assistance system is the vital link between older persons who need services and those who can provide them and is particularly important during stress and crisis.



To empower older New Yorkers, their families, and other consumers to make informed decisions about their care needs, and to be able to

easily access information on the myriad of aging programs and services that best address their needs, NYSOFA has established various methods to provide prompt and thorough I & A. As a result of the cataloging of information provided by the Aging Network and other agencies regarding relevant programs and services that meet specific needs, all New Yorkers and their caregivers are able to learn about services in their communities and become connected to more efficiently access vital supports in their community.

The provision of I & A is one of the most critical services provided by the AAAs and their network of local providers and it is one of the top needs identified by consumers. This service can be provided quickly depending on the nature of the request or it can be much more complex.
Throughout New York State's network of 59 AAAs and their partners, I & A is funded through a combination of federal, State and local funding sources.

Specialized I &A for long term services and supports is funded through NY Connects (New York's ADRC and NWD) which is described in more detail in this Plan.

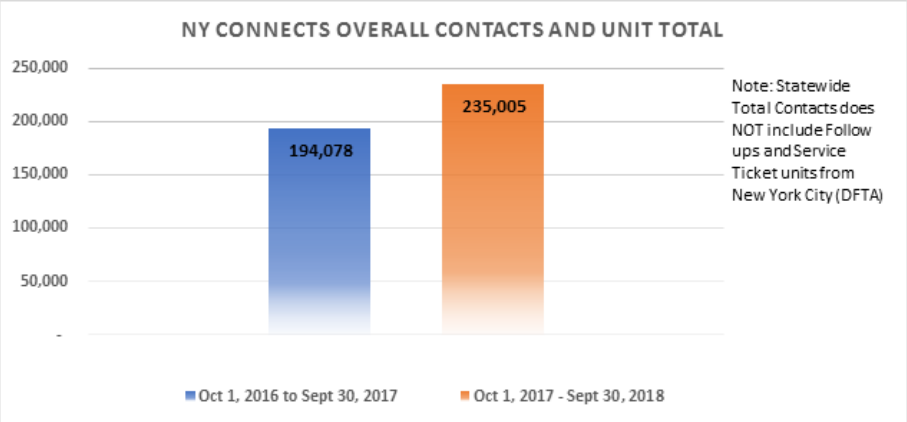
I & A includes three primary components: the provision of information where a question is asked and answered; assistance where information is exchanged so that an understanding of the persons needs can be determined; and making a referral to an appropriate service(s) provider. Each AAA must have an established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

From all sources, New York spends over $49 million annually to support I & A and almost $30 million annually to support the states NWD/ADRC.

Access Services – NY Connects

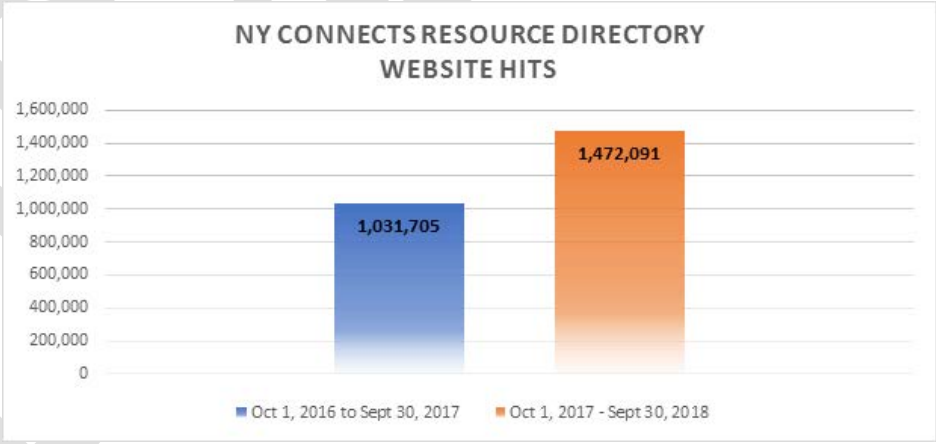
NY Connects is statutorily mandated through the New York State Elder Law §203(8) and complies with federal statute as prescribed by the 2016 Reauthorization of the Older Americans Act (OAA). It serves individuals of all ages seeking assistance with learning about and accessing long term services and supports (LTSS), regardless of payer source. NY Connects is federally recognized as New York's Aging and Disability Resource Center (ADRC). NY Connects is an essential component of the State's efforts to rebalance the LTSS system so that people can live independently and remain in their home and community and is rooted in a person-centered approach. Entities administering and operating NY Connects must adhere to a set of prescribed State Program Standards

The spouse of an 87-year-old veteran contacted NY Connects, and reported that her husband has dementia and has been falling a lot. Through the NWD Screening process and Options Counseling/Person Centered Counseling (OC/PCC), the NY Connects Specialist helped the family define their concerns and goals. There were many concerns: housing issues, accessibility difficulties, and a need for respite. The NY Connects Specialist, who is a trained and certified OC/PCC counselor, helped the family identify both formal and informal caregiving resources. The family chose to have a referral made to the Alzheimer's Disease Caregiver Services Initiative (ADCSI). At the time of follow up by the NY Connects Specialist, the family reported that ADCSI was providing temporary in-home respite care, care consultations, technology safety services and education. The NY Connects Specialist inquired about the need for ongoing care. Per the family's request, NY Connects is working with the family to explore possible veteran's in-home respite and to explore Medicaid Long Term Care. Additionally, the family chose to have a referral made to Department of the Aging who assisted with referrals to USDA for the roof and to Bona Responds for assistance with a ramp.



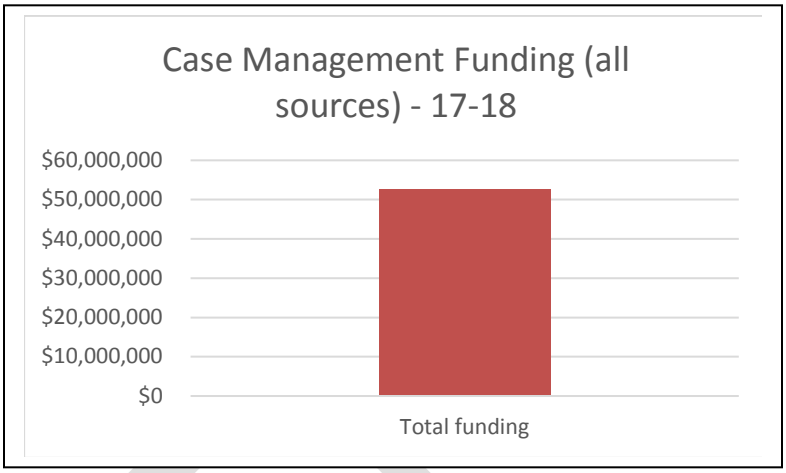
and perform the required core functions, including, administering a No Wrong Door (NWD) Screening process, provision of Information and Assistance (I&A), Options Counseling/Person Centered Counseling (OC/PCC), care transitions, application and enrollment assistance for public benefit programs, facilitation of an active Long Term Care Council (LTCC), and public education. Additionally, local NY Connects offices are responsible for updating statewide NY Connects Resource Directory with locally offered resource listings, conducting evaluation, quality assurance and continuous improvement, data collection and reporting.

NY Connects operates at the county level, in each borough of New York City and two Indian Reservations. Each NY Connects is a collaboration consisting of the Area Agency on Aging (AAA) and/or a subcontractor(s) of an AAA, Local Department of Social Services (LDSS) and the Independent Living Center (ILC). Individuals may call a statewide 1-800 number, or connect with their local office through phone, email, an in-person visit, or through a home visit if preferred or visit www.nyconnects.ny.gov.



As a result of the Balancing Incentive Program (BIP), NY Connects was expanded geographically and enhanced functionally to become a fully functional No Wrong Door (NWD) System. The NY Connects NWD System includes additional state and local partners including the Office for People with Developmental Disabilities (OPWDD) and its regional offices, the Office of Mental Health and its county based Local Government Units (LGUs). This further facilitates linkages between non-medical and medical supports systems, by connecting individuals with essential LTSS that address key social determinants of health and promote access to services in a least restrictive environment, which can improve health outcomes and reduce health disparities, as well as prevent or reduce unnecessary higher-level acute care and readmissions. The NY Connects NWD System serves individuals throughout the lifespan and the focus on improving health and increasing social connections which are key components of the Governor's priority of Health Across All Policies approach and supporting age friendly communities. It is proactive, prevention-oriented, and comprehensive, addressing the full spectrum of LTSS.

Access Services – Case Management



Case management is one of the most important services provided by the network of aging professionals. It is Low-cost and high impact. Case management is a core service provided by the aging network that is person-centered, flexible, cost-conscious and quality driven. Consumer values and preferences strongly influence the timing, duration and intensity of the level of service provided. Case management is at the center of wellness and autonomy for older adults and their caregivers and is essential to breaking down system barriers, advocating for the person, and assuring their care is holistic rather than siloed. Case management provides advocacy, access, assessment, planning, communication, education, resource management, and service coordination.

Ernie is 68 years old man diagnosed with advanced COPD, heart disease, extreme weakness and visual impairment. He was recently hospitalized due to exacerbation of his COPD. Upon discharge to home, he received services from a certified home health aide. His health care provider determined that Ernie was at risk of frequent hospitalizations and poor self- care due to his overall weakened state. Ernie has two sons who have limited ability to help. A referral was made for Case Management to assess Ernie's needs for long term supports. Through the provision of a Personal Emergency Response System and home delivered meals Monday – Friday to ensure he has a hot and nutritious meal as well as an evening meal and frozen meals for the weekend, Ernie was able to remain living independently in his own home, with less risk of rehospitalization. The EISEP Case Manager maintains regular contact to address any concerns, or unmet needs.

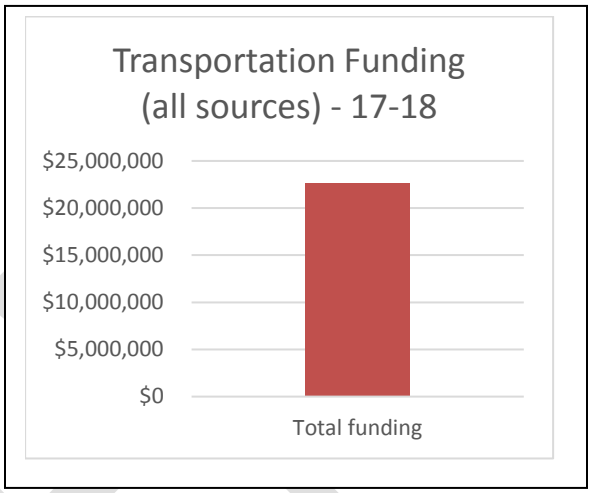
Case Management is supported primarily by state and local funds and through OAA funds. New York State spends more than $52 million annually to support case management activities because of their recognized value to the older adult and family member in helping navigate complex systems, monitoring the individual, applying for benefits and programs, and linking to programs and services. NYSOFA and the AAA network will continue to collaborate with state and local partners to leverage these case management services to expand opportunities among individuals served through private pay arrangements or other publicly funded programs.

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, person- centered, timely, efficient, and equitable. This approach works to achieve optimum value for the client and promotes quality and cost- effective interventions and outcomes.

NYSOFA will continue its focus on case management training. Primarily, NYSOFA will continue to require each case manager to be state certified. The goal of state certification is to raise core

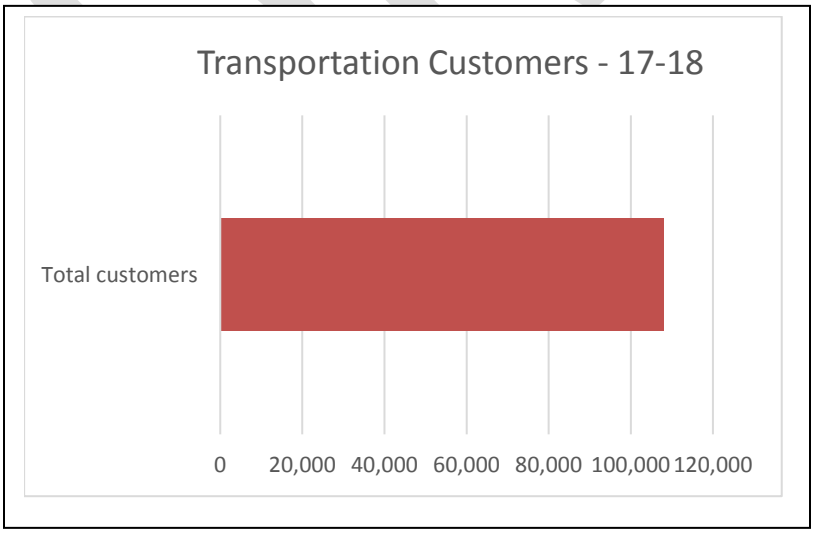
competencies and improve service delivery and to assure the public that case managers are of the highest quality and meets a prescribed set of standards.

Access Services – Transportation



Transportation has been a priority issue for the aging network for decades. Due to the structure and design of communities across the country after World War II, people of all ages rely on their ability to drive in order fully participate in work and community life. Many older adults have to give up driving each year because of health or other conditions. This can be devastating as American culture has a strong foundation in the role the automobile plays in our lives and not having the ability to drive leads to social isolation, which can have devastating effect on autonomy, mental health and mortality. Older people who stop driving become dependent on rides from family and friends if available, particularly in areas where public transit options are limited. If these options are not available, individuals are isolated.

The problem is compounded by where older people are living and how communities have been designed and zoned half of older adults live in a rural or suburban community: 15 percent live in rural areas, compared to 12 percent for the under age 60 population, and over 51 percent of the older adult population live outside of a principal city (by U.S. Census Bureau definition). These areas lack the density to support traditional mass transit. Even in areas where mass transit services are available, diminishing mobility and increasing frailty can preclude older adults from accessing transportation. The Governor's priority to make New York State age friendly and the state's efforts to assist communities to become certified as age friendly will assist in increasing access to transportation for all people, as transportation is one of the 8 domains of age friendly communities. Further, the recent authorization to extend ride sharing to all New York State is promising. It will not only increase access to transportation but can provide additional income to older adults who wish to provide that service for others.



Transportation is a high demand and key service in the array of services that are offered by the Area Agencies on Aging and their local partners in New York State.

Transportation has become more important as the population is living longer, living with multiple and complex conditions, and doing so in their homes. As policymakers work to implement state

plans to comply with the *Olmstead v L.C.* supreme court decision, a broad and creative approach to the delivery of transportation for older adults is necessary.

NYSOFA is committed to a policy of coordinated, shared transportation and testing innovative and replicable models of sustainable, community-based transportation. New York State spends almost $22 million to support community-based transportation for older adults that help them access doctor's appointments, pharmacies, shopping, senior centers, adult day programs and socialization.

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

Mrs. C., an 82-year old woman in a very remote area of the county with no family members was referred for home delivered meals by her physician. She was unable to prepare her own meals due to general debility. The case manager identified the client had higher needs than simply her home delivered meal as the home was overrun with feral cats and she needed personal care assistance. The case manager partnered with adult protective services and the client applied for and received Medicaid coverage. Additionally OFA assisted in obtaining animal control services to assist with removing the cats and also assisted with having the home cleaned. The client was in receipt of meals, and was eventually hospitalized when her home delivered meal driver found her on the floor. Without these services the client could have potentially been on the floor for weeks without anyone ever knowing.

Access Services – Health Insurance, Information, Counseling and Assistance

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

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

HIICAP served 116,934New York beneficiaries

Those individuals assisted saved over $57 million dollars in Medicare premium and prescription assistance.

HIICAP educates the public about Medicare, Medicare Advantage plans and other health insurance issues and saved consumers over $57 million last year by helping them access "Extra Help" programs. HIICAP provides free, accurate and objective information, counseling and assistance on Medicare, Medicare Advantage plans and other health insurance coverage plans. HIICAP also provides information on low income programs such as the Elderly

Pharmaceutical Insurance Coverage (EPIC) Program, Medicare Savings Programs, "Extra Help" prescription assistance and pharmacy discount programs.

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

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

Access Services – Private Pay Model

Federal funding for the services the network provides has not kept pace with population growth or the increase in demand. NYS has taken many steps to improve access and diversify funding streams. The state and county governments provide hundreds of millions of dollars to support the service infrastructure and NYSOFA is working with many state and local partners and philanthropy to improve coordination and access. In 2019, the enacted state budget included a provision granting NYSOFA the authority to develop a private pay market for many of the services that it provides. The private pay model will be available to counties who want to participate, and it will be available to individuals who earn 400% of poverty or more. There are almost 1.6 million people over the age of 60 in NYS that meet this income threshold and as importantly, many children of older adults can afford to contribute. The value of the services provided are not in question, but due to inadequate resources and targeting criteria, states do not have the authority to develop a market for middle and higher income earners. The private pay model will increase access to services for middle and higher income older adults and their families and any additional revenue that is generated through private pay are required to be put back into service provision, helping to fund additional services to those who are most in need but cannot afford them.

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

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

The average EISEP Customer:

- Widowed female
- Age 83
- Low income
- 3.5 ADL limitations
- 6 IADL limitations
- 4+ chronic conditions

The following services are provided under EISEP:

- Case Management – To help older persons and their families assess their needs and develop, implement, and
  maintain an appropriate plan of services and how they are to be delivered. It brings order to the confusing array of services and benefits that an older adult might need.
- In-Home Services – 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, shopping, etc.). Personal care level II provides assistance with both instrumental activities of daily living and activities of daily living (e.g., dressing, bathing, transferring in/out of bed/chair, etc.).
- 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.

EISEP offers a consumer directed option. Consumer direction under EISEP is a person-centered planning approach that empowers the older adult by enabling him/her (or his/her representative) to hire, train, and oversee their In- home workers. It is currently being implemented in 35 counties and is important in helping to mitigate the aide shortage that many counties experience.

EISEP is not an entitlement program. It operates under a fixed, capped budget consisting of state, county and private funds. In order to maximize resources and expand service capacity, the program was designed to include a cost sharing component. A cost sharing requirement begins for individuals whose income is at or above 150% of the Federal Poverty Level. The program participant's cost share increases proportionally with income up to 250% of poverty, where there is 100% cost share.

A variety of strategies are being employed to expand and strengthen EISEP. Through revisions to the EISEP Rate Cap Policy, AAAs were granted more flexibility in establishing home care rates. The ability to negotiate rates allows the program to compete for aides payed for by other funding sources. Additionally, the expansion of the consumer direction model of EISEP provides consumer control over services to address many of the identified gaps in the LTSS system (e.g. workforce shortage, caregiver burden, consumer satisfaction). Another approach to strengthen the EISEP program was to amend regulations pertaining to Ancillary services, whereby AAAs could allocate up to 33% of their EISEP funding for the purchase of an expanded listing of goods and services that support an individual's choice to reside in their home.

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

In New York State, the Community Services for the Elderly (CSE) program is similar to Title IIIB, providing a flexible funding stream designed to meet the individual program and service needs of the area agency on aging and their planning and service area. CSE funds a myriad of community services, some directly and some as a supplement to other network funding sources, that enable older adults to remain in their homes and participate in family and community life. CSE allows localities to fund gaps in services that address specific unmet needs while enhancing the cooperation and coordination among the many service providers to shape the way the delivery system is organized to respond. including the Older Americans Act titles and other State-funded programs.

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

New York spends almost $40 million annually under CSE to provide community-based services based on the individualized needs identified by AAAs.

Supporting Aging in Place – Age Friendly New York State

Programs and services administered by NYSOFA and provided directly or indirectly via AAAs are all designed to support aging in place. There has been a movement however to also promote changes in how communities are planned for, designed or redesigned that consider features that are important for people of all ages to help make them more livable. Prior to the WHO/AARP designation of Age Friendly communities, NYSOFA created Livable New York. All Livable New York activities are now part of the Governor's priority to make NYS the first age friendly state in the country.

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

Through Governor Cuomo's efforts, in 2017, New York State was designated the first age-friendly state in the nation by the World Health Organization (WHO) and AARP. This achievement was a result of the Governor's directive to include healthy aging in state agency policymaking, an effort that will result in more livable communities for people of all ages and enable more New Yorkers to age comfortably in their homes. Municipalities throughout the country, including 21 in New York, have earned the age-friendly designation, but New York is the first state to have achieved this honor.

To achieve this designation, New York ranked high in the eight age-friendly and livable community domains outlined by WHO and AARP, which include:

- Outdoor spaces and buildings;
- Transportation;
- Housing;
- Social participation;
- Respect and social inclusion;
- Work and civic engagement;
- Communication and information; and
- Community and health services.

Age friendly in New York State is not just about old age—it is about the collective value of people of all ages and abilities and recognizing that addressing the 8 domains improves the health and lives of all populations and is central to supporting the goal of making New York the

healthiest state in the nation. It is about designing communities for everyone that strengthen people's connections to each other, improve health, increase physical activity, and support and advance the economic environment through proactive design and future-based planning. From housing to transportation, we have streamlined and improved existing programs to make sure they reach New Yorkers of all ages and abilities in a more effective way.

NYSOFA will continue to work with our Health Across All Policies Team and public and private stakeholders to embed the 8 domains of age friendly communities into government planning and procurement and to assist communities to receive the official WHO/AARP designation.

Supporting Aging in Place – Naturally Occurring Retirement Communities (NORCs)

New York currently funds two models of naturally occurring retirement communities. The first is the Classic Naturally Occurring Retirement Community Program (Classic NORC) model and second is the Neighborhood Naturally Occurring Retirement Program (NNORC) model; collectively known as the NORC Program. A Classic NORC is an apartment building or housing complex, and a Neighborhood NORC is a residential dwelling or group of residential dwellings in a geographically defined neighborhood or group of contiguous neighborhoods, both of which were not originally built for older adults but are now home to a significant proportion of older adults. The overarching goal of a NORC/NNORC program is to maximize the health of its community. This is accomplished by these programs facilitating and integrating the health and social services already available in the community, as well as organizing those necessary to help meet the goal of enabling older adults to remain at home.

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

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

Mr. & Mrs. L joined our NORC last year and presented as quite isolated due to their language barrier. Our Mandarin & Cantonese speaking social worker worked with them to help them feel welcome and comfortable and encouraged them to come for events and activities, which they began to do, and continued to build their rapport with the social worker. It quickly became clear that Mr. & Mrs. L were not accessing benefits they are entitled to due to their language barrier and social isolation.

Mr. & Mrs. L had no stable income and received only minimal financial support from their daughter when they came to the NORC. They expressed their desire to live more independently by applying for eligible benefits, which the NORC social worker helped them explore. Mr. L turned 65 last year, but he did not know that he could and should apply for Medicare benefits and get his social security when he retired, their language barrier and general isolation preventing them from receiving this crucial information. The NORC social worker assisted Mr. L in applying for Medicare and his social security benefits and is in the process of looking into other options such as SSI and SNAP. Mr. & Mrs. L are now able to be more independent and self-sufficient.

-NORC Program Director

NORC programs operate through multidisciplinary partnerships that represent a mix of public and private entities and provide on-site services and activities. At the core of each partnership are social service and health care providers; housing managers or representatives of neighborhood associations; and, most important, the community's residents, especially its older residents. These core partners connect to the many other stakeholders in a community –

typically, local businesses; civic, religious, and cultural institutions; public and private funders; and local police and other public safety agencies. The goals and objectives of the NORC Program are a great example of Governor Cuomo's Health Across All Policies Approach, engaging various cross systems partners and stakeholders that represent the community at large and creating a better place for older adults to live and for people of all ages. In addition to supporting older residents to age successfully, the NORC program model also promotes community change. It offers opportunities to 1) empower older adults to take on new roles in shaping communities that work for them, 2) weave a tighter social fabric and foster connections among residents and 3) maximize the health and well-being of all older adults in the NORC.

This program model is built from the ground up, in response to what it learns about the community after assessing its needs. Inevitable challenges to healthy aging often include environmental factors, social factors, health and social service gaps, transportation difficulties, lack of infrastructure, or a frayed social fabric. NORC programs provide a variety of services tailored to the individual resident's wants and needs while addressing many of the 8 Domains of Livability and the social determinants of health by providing directly, or connecting to outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, and community health services.

Activities for Health, Independence and Longevity – Foster Grandparent Program

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

The efforts of 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. Volunteers who meet income guidelines receive a modest hourly tax-free stipend as well as transportation and meals, providing them with economic stability. Through FGP, volunteers remain socially engaged and active in their community.

Activities for Health, Independence and Longevity – RSVP

The state provides additional resources to the Retired and Senior Volunteer Program (RSVP) and 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 older adult volunteers over the age of 55 in a variety of community-based human service agencies helping to create age friendly and healthy communities. RSVP priority areas include: education, healthy futures, economic opportunity, veterans and military families, environmental stewardship, and disaster services; with many NYS RSVPs providing health promotion and wellness programs for older adults; assistance to frail and vulnerable older persons in the areas of home visiting, escort,

transportation, and home-delivered meals as well as cross- generational efforts in tutoring and mentoring children. RSVP provides a way for volunteers to remain strongly connected to their communities while providing many important direct services as well as organizational support to local area agencies on aging and other community-based organizations.

Activities for Health, Independence and Longevity – Senior Community Services Employment Program (SCSEP)

Senior Community Services Employment Program (SCSEP) is a community service and work-based training program for older workers. SCSEP was authorized by Congress in Title V of the Older Americans Act of 1965 and is funded by the U.S. Department of Labor; it is the only job training program specifically designed for older adults. SCSEP provides subsidized, part-time, community service training for unemployed, low-income persons 55 or older who have poor employment prospects. SCSEP participants are placed in a wide variety of community service activities at non-profit and public facilities, including day-care centers, senior centers, schools and hospitals, where participants provide a valuable service while getting on the job experience and training.

These community service training assignments promote self-sufficiency; aid organizations that benefit from increased civic engagement; and support communities, as well as help participants obtain economic stability thru paid job training and job placement partnerships. These assignments are intended to serve as a bridge to unsubsidized employment by helping job seekers improve their skills, obtain training, gain confidence, and become employed in the private sector. In turn, regional economies and employers benefit from an expanded pool of experienced, dependable labor in the local workforce.

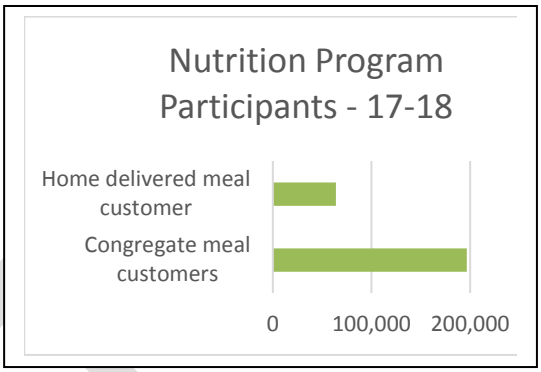
Activities for Health, Independence and Longevity – Civic Engagement/Volunteerism

Research clearly demonstrates that volunteering benefits the physical and mental health of a person, while also helping address pressing social issues. In February 2019, the Corporation for National and Community Service (CNCS) released a longitudinal study that found that Senior Corps volunteers reported feeling significantly less depressed and isolated compared to non-volunteers. They also rated their health higher than those in similar circumstances who did not volunteer. Volunteers found their community service satisfying and meaningful, and reported having opportunities for personal growth, a sense of accomplishment, and friend-making, all factors associated with improved health, psychological and emotional wellbeing and connection to the community. These findings according to the Corporation for National and Community Services are particularly relevant today as the numbers of volunteers age 55 and older is expected to increase significantly over the next decade. Further, NYSOFA's service infrastructure would not be able to offer the level of service it does without volunteers, nor would many community- and civic organizations without volunteers. There are almost 1 million volunteers ages 55+ in NYS providing 495 million hours of service at an economic value of more than $13 billion annually. This labor could not be replaced. Promoting increased civic engagement, volunteerism, respect and social inclusion are domains of age friendly communities and are very important for the health and well being of the volunteers, but also to the individuals, families, organizations and communities they serve. As the population gets older, NYSOFA will continue to seek enhanced strategies to recruit older volunteers.

Nutrition Services – Nutrition Program for the Elderly

New York has the largest nutrition program in the country. New York State's commitment to healthy, nutritious meals and providing nutrition counseling, nutrition education and evidence

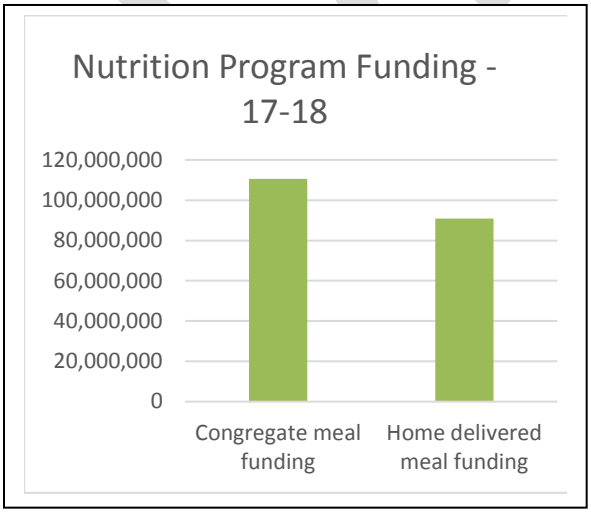
based interventions in settings where older adults congregate for nutrition is unparalleled. New York serves more than 22 million meals annually to more than 260,000 older adults in their homes and in congregate settings.



Since its inception, the Nutrition Program for the Elderly (NPE) has operated statewide through 59 AAAs, including two Indian Tribal Organizations (ITOs). Services are provided directly or through contract. Funding for nutrition services comes from a combination of federal, state, and local government sources, program income (contributions), and other sources at the local level coordinated into a single statewide nutrition program. Since 1984, New York State's Wellness in Nutrition (WIN) program provides funding primarily for home- delivered meals to frail older persons who are unable to prepare meals for themselves. This funding also support access to nutrition counseling, education and congregate meals. Nutrition services are 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. They are also a gateway to other services provided by the Network.

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

- Community dining options at congregate sites to improve food and nutrient intakes and offer choice (culturally appropriate, entrees, salad bars, and restaurant vouchers) and meet special dietary needs (low sodium, low fat).
- Home-delivered meals that meet dietary reference intakes 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.



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 may include health risk assessments; routine health screening (hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, bone density, and nutrition screening); nutritional counseling and educational services; evidence-based health-promotion programs, including those related to the prevention and mitigation of the effects of chronic disease, alcohol and substance abuse reduction, smoking cessation, weight loss and control, stress management, falls prevention, physical activity and improved

nutrition; physical fitness programs; home injury control services; mental health screening services; and information and education about Medicare preventive-care benefits including influenza and pneumonia vaccinations.

The Senior Farmers Market Nutrition Program (SFMNP) has operated in New York since 1989, when it began as a State initiative. Under the auspices of the U.S. Department of Agriculture, the New York State Department of Agriculture and Markets works with NYSOFA, DOH and Cornell University (Cornell Cooperative Extension) to administer the program. The largest segment of the program operates statewide through New York's 59 AAAs, including two ITOs. This program provides income-eligible (185 percent federal poverty level) older adults with a one-time $20 allotment, as coupons, to use at farmers markets. Federal money is the primary funding source for the program. In 2018 NYSOFA allocated 138,780 booklets with a total value of $2,775,600 to the AAA network.

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

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

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

Erie and Albany Counties recently received an ACL grant to support Innovations in Nutrition programs. NYSOFA is supporting the efforts of Erie and Albany Counties to develop a technology driven congregate dining program that includes a number of local restaurants and a tracking system that provides eligible diners with key card access to these meals. Selected restaurants will have scanners to record the meals and be able to report back to the county aging offices on the utilization of these programs. This will provide dining options for older adults who have traditionally been limited to congregate dining programs at community centers and senior housing facilities. The program seeks to target lower income older adults who may have food insecurity, lack access to healthy meals and live in areas that do not have available congregate programs.

Restaurants participating in this pilot program will meet all ADA requirements and will provide a menu based on the USDA Older Americans Act ("OAA") nutritional requirement standards.

Along with older adults' nutritional needs, the program is meant to address a number of growing issues as aging services' networks move towards a self-directing style. The restaurant congregate dining program will provide a new choice for individuals to eat well-balanced meals at their convenience. Participants may wish to utilize their benefit in conjunction with others such as friends, family, and neighbors, thereby helping to minimize the prevalence of social isolation.

Interacting with other customers and restaurant staff is intended to promote intergenerational connections and increased community engagement, which are critical components of Erie County's Age Friendly Community Initiatives. It is anticipated that this type of service will be very popular among both older adults and businesses; for older adults, it provides a casual and self-driven experience while local restaurants will benefit from an increased customer base and the opportunity to play a vital role in supporting a critical community function.

NYSOFA will be seeking to replicate this innovative program across the state.

Nutrition Services – Supplemental Nutrition Assistance Program Education (SNAP-Ed)

NYSOFA, through a multi-year agreement with the New York State Office of Temporary and Disability Assistance (OTDA), administers a statewide Supplemental Nutrition Assistance Program Education (SNAP-Ed) program that promotes nutrition education and obesity prevention interventions specifically among low-income older adults. Four partner Area Agencies on Aging (AAAs) deliver SNAP-Ed nutrition education and obesity prevention interventions to low-income older adults in a multi-county region. The program includes evidence-informed Eat Healthy-Be Active workshops, Healthy Eating Resource Fairs, Food Box Distribution Programs and Statewide Social Marketing. SNAP Ed interventions are provided at congregate meal sites, senior centers, Naturally Occurring Retirement Communities (NORC's) as well as other eligible community sites. These activities act on multiple social determinants of health (social and community context, health, and economic stability) as well as multiple Domains of Livability (social participation, communication and information, and community and health services). The program is funded by USDA and is anticipated to reach over 270,000 older adults annually. NYSOFA will be working with OTDA to expand to other regions.

Disease Prevention and Health Promotion Services

Approximately 6.2 million adult New Yorkers (41.1%) suffer from a chronic disease such as arthritis, asthma, stroke, heart disease, diabetes, or cancer and New Yorkers with chronic diseases are more likely to report poor health status and activity limitations than those without a chronic disease. Individuals with one or more chronic diseases have increased risks of adverse outcomes, including mortality, hospitalizations, and poor functional status. More than 80 percent of New York State residents age 60 and older have one or more chronic diseases. And, almost all of these older adults are living in the community. Even the highest quality of clinical care to individuals with chronic conditions will not guarantee improved health outcomes. Individuals must be informed, motivated, and involved as partners in their own care. Evidence-based interventions (EBIs) have been proven effective to help people develop self-management skills and adopt behaviors to prevent and/or manage their conditions—leading to enhanced well-being and improved health outcomes. Evidence-based programs are shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce the use of costly medical services. Priority is given to serving older New Yorkers living in medically underserved areas or who are of greatest economic need.

NYSOFA implemented the requirement for all Title III-D programs and activities to meet the highest tier definition of evidence-based effective April 1, 2015 to coincide with the start of the 2015-2016 Annual Implementation Plan (AIP) and with the State's submission of its 2015-2019 Four Year State Plan to ACL/AoA. Thus, since April 1, 2015, all Title III-D expenditures in NYS were for programs meeting the highest-level criteria as defined in the ACL/AoA new definition of evidence-based. In order for NYSOFA to approve expenditures for health promotion programs under Title III-D, a program must also be considered to be an evidence-based program by any

operating division of the U.S. Department of Health and Human Services (HHS). New York was first in the nation to implement this requirement.

All AAAs in NYS implement at least one Evidence Based Interventions (EBIs). A total count of 137 EBIs have been implemented across NYS AAAs, with a total of over 18,000 participants annually.

In parallel, NYSOFA has successfully applied for and secured numerous competitive federal grants to advance and bring to scale a select set of EBIs that comprise the Chronic-Disease Self-Management Education programs (CDSME) among the aging, health and disability networks. NYSOFA, in partnership with the NYSDOH and the former Quality and Technical Assistance Center of New York (QTAC- NY), have worked collectively to yield substantial gains to increase availability of and access to these programs statewide. Since 2006, NYSOFA and partners have utilized various federal funding sources to build out the statewide infrastructure to establish over 120 CDSME active system level/host providers and 1,200 delivery sites, serving thousands of people. Currently, approximately half of the AAA network is engaged in supporting CDSME. In 2018, a decision was made by the SUNY Research Foundation to close the QTAC-NY. To facilitate a smooth a transition to maintain the CDSME (and larger EBI) infrastructure, NYSOFA secured a CDSME umbrella license in which the current local partners could continue to deliver these important workshops and a license for the continued use of a web-based data management and reporting system that is needed for delivery partners to effectively carry out this work. NYSOFA will continue to apply for available federal funding to expand activities while also exploring other emerging opportunities to secure training, technical assistance, data management, reporting, and sustainability.

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

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

Disease Prevention and Health Promotion Services – Health Indicators Program

The Health Indicators Program is a data driven, performance improvement program that is a way for organizations to identify the needs of its clients and target interventions at both the individual and group level with the goal of achieving measurable outcomes. Originally created by the United Hospital Fund as part of their Health Indicators in NORC Programs Initiative that was supported by New York City's Department for Aging, the program is now incorporated in NYS Elder Law, requiring all state funded NORC programs to provide this program. Health Indicators involves the administration of a comprehensive health survey, data tracking, and data analysis as well as post intervention follow up. These activities will help NORC programs target priority services to individual clients as well as implement appropriate health promotion group programming. It is also intended to provide programs with the information and tools they need to

shift from a reactive practice that responds to crises to a proactive practice that is targeted and systematic. The long term goal is to expand Health Indicators to other network programs and services, strengthening the link between health programs and social services to improve prevention efforts, improve outcomes and reduce health care costs.

Disease Prevention and Health Promotion Services – Sepsis Prevention

Sepsis kills someone in the US every 2 minutes, hospitalizes someone every 20 seconds, is the leading cause of hospital readmissions, is the top cost for avoidable hospitalizations in NY's Medicaid population, costing more than $27 billion in hospital care each year. Sepsis is the body's overwhelming and life-threatening response to any infection. Sepsis is *not* a particular kind of infection, it is the body's dysregulated response to an infection. Sepsis a top cause of catastrophic, life-altering and deadly illness, that can often be prevented and/or with swift recognition symptoms and start of treatment, mitigated. Eighty to ninety percent of sepsis related infections originate in home and community. Adopting good infection prevention and control practices, and spotting and acting on signs and symptoms early are key. Anyone can develop sepsis – the young, the old, the physically fit, and the frail. But among the high risks are: older adults, the very young, individuals with chronic conditions, the medically frail, individuals with recurrent pneumonia or urinary tract infection, with vulnerable source sites for infection (like catheters and central lines). These high risk populations are routinely within the reach of the home health system.

NYSOFA is an active participant in the NYS Sepsis Alliance and will work with our provider network to provide education and training resources to identify Sepsis early so that the devastating effects of Sepsis can be avoided.

Supporting Caregivers – National Family Caregiver Support Program (NFCSP)

In New York State approximately 4.1 million caregivers provide more than 2.6 billion hours of care to loved ones at any given time each year. According to AARP, the economic value of this care is estimated to be over $32 billion dollars in New York if the caregivers were being paid at market rate. As the role of the informal caregiver has become increasingly complex due to level of care needs of individuals being cared for at home, the importance of supporting caregivers in their role continues to grow. In NYS, the three-prong approach being applied to expand long term services and supports is providing the right care, at the right time, in the right place. To accomplish this, caregivers need to be supported through a variety of services and supports.

NYSOFA administers programs and services that are designed to help older adults live as independently as possible. These services also support caregivers of older persons (e.g., by providing respite to the caregiver), in addition to the program funds designated to support caregivers specifically. NYSOFA/AAA spending on supporting caregivers is estimated to exceed $100 million through the provision of services though Title III funded programs, state/local funded respite and social adult day services, caregiver resource centers, Lifespan Respite grant-related services, personal care, case management, home delivered and congregate meals, transportation, shopping assistance and meal preparation, etc.

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

Services provided include:

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

For the caregiver to be eligible for these services, the care receiver must have a cognitive impairment, or be unable to perform at least two Activities of Daily Living (ADLs). These services work in conjunction with other state and community-based services to provide a coordinated set of supports. Studies have shown that these services can reduce caregiver depression, anxiety, and stress, and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care.

Supporting Caregivers – Social Adult Day Services

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

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

SADS programs and services are being strengthened and expanded under the states "care

management for all model" under Medicaid. SADS services were included as an available waivered service under the states managed long term care program which has led to a significant growth in the number of SADS programs statewide.

Supporting Caregivers – Respite Services

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

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

Information about existing respite services may be found in the NY Connects Resource Directory (www.nyconnects.ny.gov), which offers LTSS support information across the age and disability spectrum. Respite services may include adult day services and group respite, in-home companions, in-home personal care and home health care, institutional respite, and consumer- and caregiver-directed programs. In 2017-18, the NY Connects system helped 19,019 caregivers of care recipients across age and disability types, representing approximately 18 percent of all calls to NY Connects. Caregiver supports ranked third in requested information topics in NY Connects.

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 Family Caregiver Support Program funded under Title III-E of the Older Americans Act, and the State-funded Expanded In-home Services for the Elderly Program. Funding is also used to provide extended hours of respite services in the evening (after 5 PM), on weekends, and on an emergency basis. These respite programs provide a variety of services on a temporary and short-term basis, including home care, overnight stays in nursing homes, and social adult day services. The state-funded respite program awards over $1 million annually through grants to ten programs across the state to provide respite to caregivers of any age who provide support to older adults. In addition, many of these programs also provide other supports to caregivers, such as case management, counseling, support groups/training and information and assistance.

The NYS budget annually includes $25 million to assist caregivers of persons with Alzheimer's disease and related dementias. The Alzheimer's Disease Caregiver Support Initiative takes a two-prong approach by providing 1) support to caregivers of individuals with Alzheimer's disease and other dementias (AD). and 2) funding and support to health and health related organizations that work to decrease the burden of AD on individuals, caregivers, and families throughout NYS. The goal of the program is to promote early diagnosis of AD, delay the institutionalization of individuals with AD, and maintain the best quality of life for the patient with AD and his or her caregivers and family members. Respite is one of the core services offered through this initiative. Currently, 32 AAAs are involved in this initiative.

Supporting Caregivers – Caregiver Resource Centers

New York State also provides funds to 17 local Caregiver Resource Centers (CRC). The CRCs provide caregivers with information, assistance, and counseling/support group/training, as well as initiatives including specialized training curricula for caregivers of developmentally disabled adults, minority populations, and caregivers of grandchildren. Since the advent of the Title III-E funded caregiver program in 2000, these programs have coordinated their CRC programs with their Title III-E programs so that, from the caregiver perspective, there is a program consisting of a coordinated array of services that are comprehensive, complementary, and supplemental in nature. Further, NYSOFA undertakes, in partnership with others, Regional Caregiver Forums annually, providing training and technical assistance to AAAs and CBOs that serve and support caregivers.

Emergency Preparedness

As a member agency of the NYS Disaster Preparedness Commission, NYSOFA collaborates with multiple public and private partners at the Federal, State, and local levels toward the goal that emergency planning needs of older New Yorkers are addressed and met. Partners include the Administration of Community Living at the Federal level, the New York State Division of Homeland Security and Emergency Services (DHSES) and the New York State Department of Health (DoH) at the state level, and Area Agencies on Aging at the local level, and a number of human service and other agencies such as the Red Cross and Salvation Army. The coordinated involvement of NYSOFA with these various entities is necessary to ensure that planning for, preventing, and responding to emergencies and disasters -- declared or otherwise -- is done in the most efficient manner possible. NYSOFA cooperates with the DHSES to assist in assuring that all levels of governments, voluntary organizations, and the private sector identify areas of vulnerability that can be address and mitigated.

At the State level, NYSOFA coordinates with DHSES and is a member of Emergency Support Function (ESF) Six (Mass Care, Emergency Assistance, Housing, and Human Services), which will activate in situations where a State level multiagency response is needed to support and facilitate coordination of the above noted functions in the event of an emergency or disaster. During times of activation, NYSOFA reports to the State Emergency Operations Center (EOC) and works with the multitude of participating agencies. The Office of Emergency Management (OEM) operates the State's Watch Center, which operates a continuous alert and warning system that is designed to provide local, State, and Federal agencies with notification and support in responding to incidents. NYSOFA assists OEM in the dissemination of public health and safety information during a disaster in coordination with DoH. At the local level, in times of emergency, NYSOFA coordinates and supports the relief efforts provided by AAAs, which play a critical role in identifying and planning for the provision of services to older adults during a crisis.

At the community level, NYSOFA requires each AAA to participate in their County Emergency Operations structure and to include details of their emergency planning efforts within their Annual Update or Four-year Plan submitted to NYSOFA. It includes how they are integrated in local disaster planning coalitions, the protocols and processes established when an emergency/disaster occurs, and information on any vulnerable registries maintained within their communities. This inclusion of disaster/emergency preparedness processes within the annual planning documents coupled with increased statewide and local training and practice exercises has led to a proactive interchange of information between the State and the counties before, during, and after any emergency. Because an emergency or disaster puts vulnerable older

adults at greater risk, the aging network has an especially active role in both the response and the recovery phases of any event.

NYSOFA worked with the Corporation for National and Community Service (CNCS) to jointly offer a training to RSVP program directors and select partners (AAA staff, local EOC staff, etc.). The focus of this training was how to elevate the role of national service in disaster response and recovery operations by engaging Senior Corps projects and directors alongside state and community partners, with the support of NYSOFA and NYS DHSES. This was the first time CNCS's disaster unit has hosted a training in New York State. NYSOFA will continue to engage with CNCS to further develop RSVP volunteers as a resource in times of disaster.

To assure that NYSOFA can respond in an emergency, NYSOFA requires that all staff complete the Introduction to Incident Command System (ICS-100) training, which is available through the National Incident Management System (NIMS) and offered through FEMA. This training outlines a comprehensive national approach to emergency management. It enables federal, state, and local government entities along with private sector organizations to respond to emergency incidents together in order reduce the loss of life and property and environmental harm.

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

Lifespan Respite

The Lifespan Respite program, funded by a three-year grant awarded by the ACL (2017-2020) is a continuation of the successful partnership of a core team that includes the New York State Office for the Aging (NYSOFA), the Monroe County Office for the Aging (MCOFA) and the New York State Caregiving and Respite Coalition (NYSCRC) sponsored by Lifespan of Greater Rochester NY Inc. Each member of the core team has developed work plans to define their respective roles in meeting the objectives of the grant and integrating and coordinating their work. The core team is working to expand available respite using both volunteer and consumer-directed models, integrating the Lifespan Respite Program into the state Long Term Services and Supports system (LTSS), and integrating information on respite services into the NY Connects Resource Directory. The core team will continue to reach out to stakeholders across the state including many who were part of a "THINK GROUP" formed during the first grant period to help "think" about current respite available and respite not currently available but needed across the state.

The Lifespan Respite program is designed to:

- Increase number of respite volunteers through additional training and recruitment activities;
- Expand available respite services statewide through formalizing a caregiver-directed respite model;
- Expand access to caregiver services through improved respite listings in the NY Connects Resource Directory across age and disability types; and
- Implement and continue to update the Statewide Action Plan for Lifespan Respite Care sustainability.

Medicare Improvements for Patients and Providers Act (MIPPA)

MIPPA was enacted in 2008 to support targeted Low-Income Subsidy/Medicare Savings Program (LIS/MSP) enrollment for Medicare beneficiaries who were eligible for the benefits but not yet enrolled. The MIPPA funding provides education and outreach directed at raising beneficiary awareness and understanding of Part D and available preventive and wellness benefits.

The ACL MIPPA funding enables New York State to issue grants to the local HIICAP, NY Connects and to AAAs to support efforts to educate and assist eligible Medicare beneficiaries with enrollment into the Medicare LIS/MSP); to provide counseling and assistance on accessing the Medicare Prescription Drug Coverage Part D, especially for those beneficiaries who are low-income, underserved, and/or residing in rural areas; and to promote the availability of Medicare preventive and wellness services.

The primary role of HIICAP Counselors throughout the state is to provide objective information and assistance on health insurance options to Medicare beneficiaries. The role of NY Connects Specialists is to provide screening, information and assistance, and options counseling/person centered counseling to individuals of all ages on LTSS. Collectively, HIICAP, NY Connects and the AAA's, have the best ability to reach MIPPA target populations particularly in the underserved zip codes identified by CMS, and in the hard to reach rural areas of New York State.

NYSOFA will continue to support the AAAs, HIICAPs and the NY Connects partners in their coordinated efforts to inform and assist Medicare beneficiaries with the available Federal and State benefits and to ensure that their county/designated catchment area achieves all goals, objectives, deliverables, measurable outcomes, and targets set forth in the NYSOFA required MIPPA Work Plan and annual Minimum Targets Table.

No Wrong Door (NWD) Business Case Development

In 2018, ACL, CMS, and the Veterans Health Administration (VHA) issued a funding opportunity to support the development of a business case for high performing, streamlined No Wrong Door (NWD) Systems. Establishing a business case creates the foundation for transforming states' access systems and provides information to address the challenge of sustainability. New York was one of ten states selected to receive the "No Wrong Door Business Case Development" funding, which totals over one million dollars during a two-year period (9/1/2018-8/30/2020). The goal of this project is to construct a methodology for calculating Return on Investment (ROI) and demonstrate the impact that the NWD System has on multiple populations, health care utilization, and streamlined access to community-based long term services and supports. The objectives are to: 1) identify and evaluate the data elements that are necessary to determine how the NWD System delays or prevents the use of more costly care; 2) expand one existing select evidence-based and implement a new evidence-informed program within two partnering counties that have demonstrated capacity to engage in ROI project activities; 3) identify data elements that will demonstrate the value of OC/PCC; and 4) enhance the existing data collection system to track necessary data elements that will inform the calculation of ROI.

NYSOFA is partnering with Broome and Chautauqua counties to implement evidence informed care transitions interventions in each respective county. Broome County NY Connects is implementing a care transitions program in partnership with a local skilled nursing facility (SNF). This opportunity is enabling a formalization of a targeted approach working with the SNF to identify and serve those residents who wish to return to the community. NY Connects is helping them to make informed decisions about where and how they want to live. Select individuals will continue to receive Options Counseling/Person Centered Counseling (OC/PCC), including follow-up, and be tracked over time to determine success in the community. Chautauqua County NY Connects is collaborating with a local hospital to provide care transitions to individuals who don't meet current eligibility criteria. They will assist with the transition home, facilitating the linkages to necessary community-based long term services and supports.

Under guidance from ACL and its external partners, NYSOFA will enhance its statewide client data system to track and report on the data elements determined necessary for an ROI calculation. These system enhancements will enable determination of the success of the interventions and the value of care transitions and OC/PCC as a key provision of the NWD System. A primary outcome of this grant will be the development of a business case report that demonstrates the value and impact of the NWD System in New York State. The completion of this report will be a joint effort of participating state grantees and federal partners. NYSOFA will share this and other products with the NY Connects NWD network to better position it to engage with the health care community and payors to promote the services it provides that address social determinants of health. Additionally, NYSOFA is interested in utilizing the information to demonstrate cost effectiveness and quality outcomes to state decision makers and state partner agencies

In 2019, NYSOFA launches a statewide business acumen project with the Association on Aging

in NYS and n4a to further efforts to facilitate better coordination and partnerships among the health providers and community-based organizations.

The principal goals of this project are to:

- enhance the local AAAs strategic organizational growth,
- help the AAAs more broadly engage in health care partnerships that will improve coordination, and
- address the social determinants of health across the communities they serve through an intensive participatory curriculum.

NYSOFA and partners are in the developmental stage of this project. NYSOFA will convene an Advisory Group (AG) to meet on a regular basis to commence in spring 2019. The AG will conduct an environmental scan of behavioral and social determinants of health, policy review, and analyses of integration barriers/opportunities. The AG's composition is expected to include key stakeholders in health care and Community Based Organizations (CBOs), insurance industry representatives, health care policy representatives, AAAs and other subject matter experts.

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

Accelerating Integrated, Evidence-Based, and Sustainable Service Participant-Directed Service Delivery

NYSOFA has made person-centered and directed service delivery a priority and will continue to do so. NYSOFA and partner AAAs are able to demonstrate the impact and importance of flexible, person centered service delivery from both a system and an individualistic perspective. This approach provides individuals with information and assistance needed to choose and plan for services and supports that work best for them. This approach puts individuals' goals, preferences, needs, and choices at the center of the planning process.

> Mrs. J., age 81, was living alone in her home in Greene County. She fell, which required multiple surgeries on her right hip and knee. Additionally, Mrs. J. has Parkinson's disease, making it increasingly difficult for her to live independently. Together, Mrs. J and her daughter decided that a permanent move to her daughter's home in Livingston County would be best. This would enable her daughter to provide better assistance and care for Mrs. J, with the support of aging network services. This client has been enrolled in EISEP, EISEP Consumer Directed Program, and Respite, which supports her daughter in her caregiving role.

NYSOFA continues to take steps to expand participant-directed service options and its goal to increase the number of AAAs providing participant directed services in order to increase consumer control and address many of the identified gaps in the long term services and supports system. To accomplish this, NYSOFA will:

- Provide additional outreach and technical assistance to AAA Directors who have not yet incorporated participant direction into their programming. Efforts will include the continued sharing of developed resources (e.g. program manuals, Q&As, care plan and enrollment forms) and technical assistance will continue to be offered on a case by case basis.
- Continue to provide ongoing technical assistance to AAAs incorporating participant directed services under EISEP, Title III-B, and Title III-E funds.
- Encourage case managers to participate in state trainings relative to participant direction topics.

Embedding Person Centered Counseling within the NY Connects No Wrong Door System

NYSOFA's goal is to provide Administration for Community Living recommended training for Person Centered Counseling (PCC) to all NY Connects staff. Staff completing the training receive a Certificate of Completion in Person Centered Counseling for the No Wrong Door System. The training of staff at the local level continues to be a priority for NY Connects. NY Connects staff must provide PCC to those individuals/families needing a deeper level of support to assist them in making informed choices to meet their identified needs and preferences. Key components of this process include the provision of decision support through a personal interview, the development of a person-centered plan that focuses on the goals and preferences of the individual, and a follow up to check that services are being initiated and meeting the individual's needs.

- NYSOFA enhanced local NY Connects staffing qualifications by requiring training on Options Counseling/Person-Centered Counseling (PCC) for all NY Connects staff who are providing options counseling.
- NYSOFA contracted with nationally recognized training vendors to purchase a federally recommended PCC training curriculum (combination of online and in-person learning

developed under an Administration for Community Living grant).

- To sustain the ability to offer the PCC training, NYSOFA adopted a train the trainer model with State staff now certified trainers in the curriculum. Local staff that complete a required six course online series and attend a day long intensive in-person training are then issued a certificate of completion for the Person-Centered Counseling Training Program for the No Wrong Door System.
- Starting in 2018, NYSOFA successfully completed the first annual training series to reaching over 200 NY Connects staff statewide in the first year. Training will continue on an ongoing basis each year to accommodate new staff at the local level.

Person-Centered Planning: Comprehensive System Transformation Statewide Training Initiative

The Centers for Medicare and Medicaid updated the regulations for Medicaid-funded home and community-based services (HCBS), to include requiring those providing HCBS to follow revised person-centered planning guidelines. In January 2019, the New York State Department of Health (Department) launched the Person-Centered Planning Comprehensive System Transformation Statewide Training Initiative. This training initiative is sponsored by the Department of Health to support best practices and compliance with Home and Community-Based Services (HCBS) Person-Centered Planning and practice throughout the State. New York State's HCBS for individuals with disabilities and disabling conditions, including physical, behavioral, developmental, age-related, or cognitive/intellectual, take place in a variety of settings such as private homes, group homes, scatter site apartments, adult care facilities, day habilitation sites, adult day health care centers, and social adult day programs. Regardless of where individuals receiving HCBS live or receive services, or through which service system they are accessed, all HCBS recipients are required to have Person-Centered Service Plans/Recovery Plans/Resident Care Plans/Life Plans/etc., that afford them informed choice of services, supports, and residences in compliance with the Person-Centered Planning standards of the HCBS Final Rule. NYSOFA is participating on the interagency workgroup for this training initiative.

Section D. **Elder Justice**

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

Elder Justice – Legal Assistance Program

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

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

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

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

NYS Judicial Committee on Elder Justice

Through NYSOFA's past work on the Legal Services Initiative, work has continued through the NYS Judicial Committee on Elder Justice under the leadership of the Hon. Deborah A. Kaplan, Statewide Coordinating Judge for Family Violence Cases and Chair of the NYS Judicial Committee on Elder Justice. Now a standing committee of courts, the New York State Judicial Committee on Elder Justice, has been charged with developing programs and protocols to improve how the court system addresses the growing number of cases involving the state's older population. NYSOFA staff are represented on each subcommittee and work to improve many facets of this system. Work to date includes improving orders of protection, creating information cards to inform older adult litigants, increasing physical accessibility of courtrooms, and more.

Elder Justice – Long Term Care Ombudsman Program

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

The 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. In New York, the program is administratively housed within NYSOFA, and advocacy services are provided through a network of 15 regional ombudsman programs hosted by 14 not for profit organizations and 1 county -based Area Agency of Aging (AAAs). Each ombudsman program has a paid coordinator who recruits, trains and supervises a corps of volunteers (currently 485 statewide) that provide a regular presence in nursing homes and adult care facilities.

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

Elder Justice – Elder Abuse Education and Outreach Program

Elder abuse includes physical, emotional/psychological, and sexual abuse; financial exploitation; and neglect (including self-neglect). It is found in all communities and is not limited to individuals of any particular race, ethnic or cultural background, or socio-economic status. Often this abuse is hidden and goes unrecognized, and because the definition of elder abuse varies from state to state, both the incidence and prevalence of elder abuse have been difficult to articulate with great confidence on the national level. According to the study, Under the Radar: NYS Elder Abuse Prevalence Study (2011), only 1 in 24 cases of elder abuse is reported to authorities and for financial abuse, that number is only 1 in 44 cases. The demographic reality of an aging population means these numbers are likely to increase. New York has undertaken a variety of initiatives to educate about elder abuse, conduct outreach, and develop and implement intervention strategies to help serve victims of abuse.

New York State funds the Elder Abuse Education and Outreach Program to provide education and outreach to the general public, including older persons and their families and caregivers in order to identify and prevent elder abuse, neglect, and exploitation. The program includes two components: grants to local agencies to establish or expand upon existing local elder abuse education and outreach programs in their communities, and grants that are broad-based and have statewide focus, designed to support a statewide effort to increase awareness and prevention of elder abuse. The funding also is used to support the New York State Coalition on Elder Abuse, which is a multi-disciplinary, statewide network of over 1,800 individuals, organizations and government agencies working together to protect older adults from abuse, neglect and exploitation.

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

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

Elder Justice – OVS/VOCA Elder Abuse Interventions and Enhanced Multi-disciplinary Team Initiative

Enhanced Multidisciplinary Teams (E-MDTs) investigate and intervene in complex cases of elder abuse. They bring together professionals in each county of operation from various disciplines, including but not limited to Adult Protective Services, local offices for the aging, human services, community legal services, mental health, law enforcement, and health care, to provide an effective and efficient means of addressing complex cases of abuse of older adults (aged 60 and older). The enhancement comes with access to forensic accountants, geriatric psychiatrists, and community legal services.

The E-MDT model was piloted in New York State (NYS) from 2012-2016 with a federal grant under the Prevention and Public Health Fund through the Affordable Care Act. It was implemented in seven counties in the Finger Lakes region (Monroe, Ontario, Wayne, Livingston, Yates, Seneca, and Cayuga) and in the borough of Manhattan, to prevent and address financial exploitation and elder abuse. During 2016-2017, NYS funded the program to sustain existing E-MDTs, expand the initiative to Western NY (Erie), Central NY (Onondaga), and the Southern Tier (Schuyler and Chemung), as well as enhance the Brooklyn MDT to become an E-MDT. A total of thirteen (13) E-MDTs were sustained, enhanced, or newly established with state funds during State Fiscal Year (SFY) 2016-2017.

Due to the demonstrated effectiveness of the NYS E-MDT model to address elder abuse and the recognized need for the E-MDT intervention to be available statewide, in 2018 the NYS Office for Victim Services (OVS) and New York State Office for the Aging (NYSOFA) partnered to establish and implement the three-year OVS/VOCA Elder Abuse Interventions and E-MDT Initiative (Initiative) to support existing E-MDTs, expand E-MDTs statewide by 2020, and develop technical assistance and other supports for successful statewide implementation. The county-based E-MDTs are being implemented through an E-MDT Regional Hub model, in which a host organization is responsible for E-MDT establishment, coordination, and implementation in each of the counties in its E-MDT region. There are 11 regions that have been established for this Initiative. E-MDTs are currently operating in thirty-three counties in eight Regional Hubs, covering seventy-two percent of the over-60 population in the state (as of April 2019). The Initiative will continue its expansion to achieve statewide coverage through 11 regional hubs covering all 62 counties by September 30, 2020.

Goals, Objectives, Strategies and Expected Outcomes

NYSOFA's continued commitment to effective and responsive management remains one of the agency's priorities. As a result, over the course of the next four years, the agency will administer consistent performance management practices that will include but not be limited to, standardized metrics, improved outcomes, and targeted projections. Further, NYSOFA will continue to work with our federal partners, national associations and individuals to improve the business acumen of the network to better engage and coordinate within major reforms in health care and long term care delivery systems. A two-year business acumen project launched early in 2019 will be the basis for improving collaboration and coordination with health systems that in the end will result in stronger partnerships and contracting opportunities for the network of aging professionals.

The 2019-2023 State Plan includes goals, objectives, strategies, and expected outcomes but with a mixed methodology approach. Some expected outcomes include outputs which can be a conceptualized as products, where other expected outcomes illustrate the expected benefit.

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

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

Access Services – Information and Assistance

Objectives:

1.1 Increase the availability of information and assistance provided by the AAAs through the increased availability of web-based applications.

1.2 Foster effective and efficient means by which information can be shared between the AAA and the providers where callers are referred.

1.3 Increase the ability of the AAAs and their community partners to share information quickly as part of a "no wrong door" in assisting consumers and caregivers access services and supports in their time of need.

1.4 Increase the capacity to provide I & A to older adults and caregivers through the recruitment and retention of volunteers for programs as appropriate and needed.

1.5 All OAA funded I & A programs operated through the AAAs will function with a uniform set of policies.

1.6 Maintain a network of highly trained I & A staff statewide who are knowledgeable and capable of providing timely, accurate and quality information and assistance to older adults and their caregivers on program and services which can assist them in living independently in their community.

1.7 Clarify the operational relationship and opportunities for collaboration of Older Americans Act (OAA) funded I & A and the provision of I & A through New York Connects, the Health Insurance Information, Counseling and Assistance Program (HIICAP), and the Long Term Care Ombudsman Program (LTCOP), state and national organizations who provided I & A to older adults and caregivers.

1.8 Information and Assistance services will be accessible and inclusive of persons with disabilities and individuals with limited English proficiency. Disabilities including but not limited to mobility, hearing, speech and visual impairments may be

accommodated with assistive technology and individuals with limited English proficiency may be accommodated with telephonic interpretation.

Strategies:

- Continue to improve listings in the statewide NY Connects Resource Directory, a web-based directory and system that enables older adults, persons of all ages with disabilities, their caregivers, and helping professionals to find information on long term services and supports, link to resources to complete benefits applications for programs such as SNAP and HEAP and share information across systems to improve quality and reduce duplication.
- Work with the Association on Aging – NY to assess the training needs of I & A staff statewide and develop and conduct trainings to meet identified needs.
- Work jointly with NY Connects staff to train I & A staff establishing minimum training standards for all staff providing I & A to older adults, persons of all ages with disabilities and their caregivers through the AAAs network, including cross-systems training.
- Identify new statewide partners to establish opportunities for collaboration, cross training and coordination of provision of I & A to older adults and their caregivers.
- Provide ongoing training and technical assistance focused on expanding outreach and providing I & A services to underserved populations including minorities, low income individuals, frail individuals, and vulnerable individuals (this category includes rural residents, individuals with limited English proficiency, LGBT, persons at risk of institutionalization, caregivers of individuals with developmental disabilities, individuals with Alzheimer's disease and other forms of dementia) to ensure that consumers and caregivers are served to the maximum extent feasible.
- Explore the coordination of recruitment and training of I & A volunteers with HIICAP and LTCOP programs to build capacity.

Objective	Expected Outcome	Target Date
1.1	A single vendor will continue to implement and enhance the statewide web-based application for AAAs and other identified users for information capture and sharing about consumers and caregivers to best meet their needs and preferences.	Ongoing
1.2 **1.3**	The web-based system will continue to enable older adults, individuals with disabilities, caregivers, and helping professionals with information and assistance through a "no wrong door" system for long-term services and supports.	Ongoing
1.4	Volunteers will be trained in I & A to assist and help expand the reach of I & A services on the state and local level.	2020-2023
1.5	A uniform set of standard policies for the provision of I & A services will be established and utilized by all AAAs.	Ongoing
1.6	All I & A staff statewide will be trained and knowledgeable about programs and services in their service area through a standardized training program.	Ongoing

1.7	Collaborations will be established and strengthened among programs and providers of I & A services on a state and local level to reduce duplication, leverage existing resources, and build capacity of I& A services available to older adults, individuals with disabilities, and their caregivers.	Ongoing
1.8	Information and Assistance services will be accessible and inclusive of persons with differing abilities and persons with limited English proficiency.	Ongoing

Access Services – NY Connects NWD System

Objectives:

1.9 Reach statewide coverage of the NY Connects NWD system.

1.10 Improve and continue to support the local NY Connects NWD partnerships between the aging services and disability services networks.

1.11 Support NY Connects NWD partners to provide core functions to additional populations including persons served by the Department of Health (NYSDOH), Office of Developmental Disabilities (OPWDD), and the Office of Mental Health (OMH) and Office of Alcoholism and Substance Abuse Services (OASAS).

1.12 Support NY Connects NWD partners to adhere to the NY Connects Program Standards.

1.13 Continue to maintain accurate, quality listings in the NY Connects Resource Directory.

1.14 Continue to implement quality assurance, evaluation, and sustainability protocols for the NY Connects NWD system and NY Connects Resource Directory.

1.15 Engage in and support long term care systems reform at the State and local level.

1.16 Support NY Connects NWD partners to assure all information is provided to individuals in their preferred mode of communication (by phone, email, etc.) to be inclusive of accessibility for individuals with disabilities and individuals with limited English proficiency.

1.17 Provide ongoing Person Centered Counseling training to NY Connects NWD staff.

Strategies:

- Issue grants to qualified local organizations to ensure statewide coverage of the NY Connects NWD system.
- Develop and issue appropriate Technical Assistance Memoranda, Informational Memoranda, and Program Instructions to the NY Connects partners to support the continued enhancement and expansion of the NY Connects NWD system.
- Provide contract management to NY Connects partners through report review and assistance, regularly hosted teleconferences and webinars, and periodic check-ins with local NY Connects staff.
- Provide necessary training to NY Connects staff on required program development and enhancement. Monitor NY Connects partner compliance with accessibility accommodations for people with special needs and individuals who speak languages other than English.
- Maintain the statewide the automated toll-free telephone number to access NY Connects from any location.
- Provide technical assistance to all local NY Connects partners to ensure that the NY Connects Resource Directory is being fully utilized.
- Monitor compliance with the NY Connects Resource Directory to ensure that provider

listings are maintained and updated.

- Continue to monitor the expanded data collection and reporting system that captures local NY Connects partner activities to
- Ensure local NY Connects partners continue to utilize materials that adhere to the prescribed New York State branding, design, and logo requirements.
- Continue to explore Medicaid Administrative Claiming and Medicaid time studies to assist with the development of sustainability plans.
- Collaborate with State partners on long term services and supports system reforms and share progress with local NY Connects programs to guide and assist with parallel local level reform activities.
- Provide ongoing annual Person-Centered Counseling (PCC) training to NY Connects staff that includes statewide management and monitoring of local staff turnover to identify training needs, registration of new training participants, delivery of training via NYSOFA trainers, and the issuance and tracking of certificates of completion.
- Convene the State NY Connects NWD Interagency Workgroup, comprised of NYSOFA, NYSDOH, OPWDD, OMH, and OASAS, quarterly.

Objective	Expected Outcome	Target Date
1.9	NY Connects is operational in every county in New York State Connects in New York State.	2020
1.10	NY Connects NWD partnerships among AAAs and ILCs will be maintained	Ongoing
1.11	All local NY Connects partners will have the information and support needed to effectively operate and sustain their programs.	Ongoing
1.11	State level interagency team will engage in NWD review of implementation and coordination improvements across service systems.	Ongoing
1.11 **1.12**	All local NY Connects partners will have demonstrated capacity to serve all required populations.	Ongoing
1.12	All local NY Connects partners demonstrate continued compliance with the NY Connects Program Standards.	Ongoing
1.13	All local NY Connects partners will maintain up-to-date, accurate web-based NY Connects Resource Directory listings in accordance with established criteria.	Ongoing
1.14	All local NY Connects partners will continue to adhere to evaluation, quality assurance, and sustainability plans to maintain operation of core functions.	Ongoing
1.15	Long term care systems reform has been conducted statewide through the administration of both local and state level Long Term Care Councils.	Ongoing
1.16	All local NY Connects core functions will continue to be provided in a manner inclusive of individuals with disabilities and individuals with limited English proficiency.	Ongoing
1.17	All local NY Connects staff who provide Options Counseling will be trained in Person Centered Counseling for the NY Connects NWD System.	Ongoing

Access Services – Case Management

Objectives:

1.18 Provide training and technical assistance to aging services providers' case managers to support the provision of person-centered case management.
1.19 Increase cultural competency and understanding of Sexual Orientation and Gender Identity of older adults and caregivers.
1.20 Develop a case manager certification program in NYS.
1.21 Assure all case managers funded with state and federal funds are state certified

Strategies:

- Develop and issue Technical Assistance Memoranda, Informational Memoranda, and Program Instructions to the network of aging services providers.
- Assess training needs of case managers and develop training based on identifiable needs.
- Case management staff will participate in the NYS DOH sponsored Person-Centered Planning Comprehensive System Transformation Statewide Training Initiative. Provide case manager training at the Aging Concerns Unite Us (ACUU) conference, Adult Abuse Training Institute (AATI), and through web-based and in person trainings.
- Offer behavioral health training though CADER to case managers to help them identify, screen, and make appropriate referrals.
- Offer dementia capable training to assure that case managers have the knowledge and skills to appropriately assist individuals with dementia and their caregivers.
- Continue training related to the Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) and its use as a person-centered assessment tool in the Statewide Client Data System. This training will continue to include building skills of Case Managers to increase cultural competency and understanding of Sexual Orientation and Gender Identity of older adults, dementia capability, and needs and preferences of caregivers in addition to older adult consumers as appropriate.
- Engage Case Managers and Caucus Regions to participate in an ongoing work group to suggest changes and improvements to the COMPASS assessment annually.
- Develop protocols between AAA case managers and NY Connects specialists about roles and responsibilities of each discipline, including referrals for services and supports, and the interface between I and A and case management.
- Promote the use of CADER statewide training to certify case managers working in the aging services network.

Objective	Expected Outcome	Target Date
1.18	Clients, and caregivers will receive case management services that are dementia capable, person-centered, flexible, cost-conscious, and quality driven.	Ongoing
1.19	Clients and caregivers will receive case management services that are culturally and linguistically competent,	Ongoing
1.20	Case managers will be trained to be culturally and linguistically competent, and to be skilled in sexual orientation and gender identity aspects of working with older adults and caregivers.	Ongoing
1.21	All AAA case managers will be certified through CADER.	Ongoing

Access Service – Transportation

Objectives:

1.22 Enhance AAA collaboration with other agencies in their planning and service area to improve coordination and sharing of available transportation resources.
1.23 Encourage communities to replicate innovative transportation models.
1.24 Promote safe driving among older adults.
1.25 Educate all AAAs on the federal 5310 program which is administered by the State DOT which provides funding to counties for the purchase of accessible transportation – which will help to meet the needs of those older adults with access and functional needs.

Strategies:

- Provide information and educational presentations to strengthen the capacity of AAAs to collaborate with other agencies in their planning and service area to enhance coordination and sharing of transportation resources.
- Provide informational to communities on tested innovative models of transportation that are replicable.
- Include impaired driving material in NYSOFA public information literature, and other modes of communication including electronic forms of distribution.
- NYSOFA Advocacy Specialist will coordinate ADA Technical Assistance Center to provide educational opportunities to increase the AAA networks knowledge of available funding.

Objective	Expected Outcome	Target Date
1.22	There will be an increase in the number of collaborations between AAAs and other agencies to provide increased transportation opportunities for older adults.	2023
1.23	Information will be provided to all AAAs regarding replicable innovative transportation models.	2023
1.24	NYSOFA will work with county offices for the aging, other state agencies and local stakeholders to reduce drugged driving among older adults and to increase utilization of driver safety training programs.	Ongoing
1.25	NYSOFA will provide technical assistance in collaboration with the ADA Technical Assistance Center to increase the AAAs knowledge of funding opportunities which will increase access to transportation services for all older adults in the planning and service areas.	Ongoing

Access Services – Health Insurance, Information, Counseling and Assistance Program (HIICAP)

Objectives:

1.26 Provide ongoing education, technical assistance, and training to the HIICAP programs to provide high quality, objective, one-on-one counseling to Medicare beneficiaries and their caregivers.
1.27 Ensure that HIICAP continues to assist individuals in accessing the Medicare Savings Program and Medicare health and wellness, prevention and screening benefits, and coordinates with NYS SMP grantee.

1.28 Provide outreach and education to those identified by CMS, ACL and the National Council on Aging (NCOA) who are low-income, live in rural, non-English speaking communities as well as individuals with disabilities.
1.29 Accurately reflect all client data and public outreach reporting data.
1.30 Increase the current volunteer network.
1.31 Expand counselor training and certification to other network staff to increase certified counselor pool.

Strategies:

- Provide up-to-date training on Medicare rules and policy during two-Day Annual Coordinator's Conference and seven regional trainings prior to Medicare's Annual Election Period (AEP).
- Provide educational information through recorded webinars to HIICAP counselors and volunteers.
- Provide program and Medicare updates through monthly coordinator conference calls and agency HIICAP Update notices.
- Increase the availability of educational information to HIICAP Counselors, such as program fact sheets, low-income guidelines through a "HIICAP Corner" section located within the Agency's website.
- Increase public awareness of Medicare changes and health care reform through local program newsletters, press releases, outreach events, enrollment events, and other electronic media activity avenues.
- Provide materials available in alternative formats and other languages to reach disabled, rural and non-English speaking beneficiaries.
- Increase the number of local counseling sites and partners.
- Increase the HIICAP program's volunteer base through ongoing promotion and outreach. In addition to volunteer recruitment and retention conducted through state and federal SHIP funding, when feasible, NYSOFA will dedicate non- program state funding to establish and monitor the impact of a new volunteer recruitment and retention stipend model.
- Increase the number of HIICAP counselors by encouraging cross training of other aging services network staff.
- Increase the technical knowledge to all HIICAP counselors and volunteers on the federal STARS reporting system by providing webinars.
- Increase HIICAP's performance measures by providing direct technical assistance, written material, and learning webinars.

Objective	Expected Outcome	Target Date
1.26, 1.27 1.28	Total Client contacts and public and media events will increase by two percent, annually.	Ongoing
1.29	Client Contact information will increase two percent, annually with performance measures on reporting age, low-income status, low-income assistance.	Ongoing
1.30	Total number of trained counselors will increase by two percent, annually.	Ongoing
1.30	Volunteer stipend program administered in select areas in the state will result in an increase in volunteers and volunteer hours, associated with counseling individuals in health insurance.	2019 and ongoing
1.31	All HIICAP volunteers and paid counselors will complete the NYS HIICAP online counselor certification exam, annually.	Ongoing

Access Services – Private Pay Model

Objectives:

1.30 Develop private pay models for implementation at county AAA level and for CBO's working with AAA's

1.31 Develop training and implementation resources to county AAA's that want to opt-in

1.32 Market the private pay model to the general public and to business acumen and other partners.

1.33 County AAA's will opt-in to providing the private pay option.

Strategies:

- Coordinate internal workgroup to develop implementation guidelines.
- Develop program and financial reporting systems prior to implementation
- Provide in-person and web-based training to counties who choose to opt-in
- Develop marketing material for local governments, the general public and health care partners.

Objective	Expected Outcome	Target Date
1.30	Private pay model will be fully developed and implemented	2020
1.31	A variety of training and TA will be developed on how to implement private pay models.	2020
1.32	Marketing material will be developed describing the value of this model and how to participate	2020-2023
1.33	10 counties will opt-in to providing the private pay option	2022

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

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

Objectives:

2.1 Provide technical assistance and training to AAAs to support the delivery of EISEP to older adults and their caregivers.
2.2 Increase the number of AAAs providing consumer directed EISEP.
2.3 Expand the use of Ancillary services through EISEP funding for clients.
2.4 Provide EISEP services in a manner inclusive of individuals aged 60 and older, with functional impairments and who may have limited English proficiency.
2.5 Expand the use of EISEP funding to provide respite care for informal supports.
2.6 Develop tools and resources to assist EISEP Case Managers.

Strategies:

- Assess the training needs of the Aging network and provide education on relevant topics for EISEP Case Managers at the annual Aging Concerns Unite Us (ACUU) conference and annual Adult Abuse Training Institute (AATI).
- Facilitate EISEP case manager conference calls to discuss relevant topics and share good practice models.
- Provide technical assistance to AAAs and NYSOFA staff via email and phone calls regarding various aspects of EISEP (i.e. administration, case management, assessment, services, eligibility, cost share, consumer directed, and discharge).
- Provide additional outreach and technical assistance to encourage AAA Directors to incorporated consumer direction into their EISEP program.
- Encourage EISEP case managers to participate in relevant monthly Caregiver Coordinator Webinars.
- Promote the use of assistive technologies under Ancillary Services as a means to support individuals and reduce the reliance on more costly services and personnel.
- Provide training to EISEP Case Managers relative to conducting outreach and/or public education to various populations, including limited English proficiency. Additionally, make available all public facing vital documents in languages specified by the Governor's Executive Order #26.
- Promote the use of the revised EISEP Rates Policy to provide more flexibility in allowing AAAs to negotiate provider rates that are equitable with the rates providers are receiving through other payer sources.
- Promote the use of EISEP funding to provide respite care for informal supports.
- Engage AAAs' participation in work groups to collaborate on development of tools and resources that incorporate the ideas and feedback of case managers and/or AAA Directors to support the application EISEP.

Objective	Expected Outcome	Target Date
2.1	AAAs will have the information and support needed to effectively and efficiently manage and deliver EISEP services and supports to older adults and caregivers.	Ongoing
2.1	EISEP training will be implemented at the annual ACUU Conference and AATI Conference.	Ongoing

2.2	Increase the number of AAAs providing consumer directed EISEP from thirty-five to statewide.	2023
2.3	Increase AAAs use of the allowable Ancillary services funding through EISEP for clients who would benefit from allowable services, items/goods and other supports.	2023
2.4	Increase the number of individuals served by EISEP, inclusive of individuals who may have limited English proficiency.	2023
2.5	Increase the number of informal supports provided respite care through EISEP funding.	2023
2.6	Produce tools and resources that incorporate the ideas and feedback of case managers and/or AAA Directors to support the application EISEP.	Ongoing

In-Home Services – Community Services for the Elderly Program (CSE)

Objectives:

2.7 Provide replicable good practices to AAAs as they work to develop appropriate community service projects that will improve coordination and the delivery of services for older residents within each county.

2.8 Use CSE funds to bridge gaps in programs and services

Strategies:

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

Objective	Expected Outcome	Target Date
2.7	Innovative programs implemented by the AAAs will be identified and shared with all the AAAs	Ongoing
2.8	Local program and service needs will be met through flexibility of CSE funding.	Ongoing

Supporting Aging in Place – Age Friendly State

Objectives:

2.9 Embed the 8 domains of age friendly and healthy aging in government work.

2.10 Increase the number of communities officially signed on as WHO/AARP certified age friendly

2.11 Market the benefits of age friendly domains to the general public, businesses, and public and private organizations.

2.12 Embed age friendly goals and objectives in the counties' next four-year plan to the state.

2.13 Provide data to the general public regarding the value older New Yorkers are to their families and communities.

Strategies:

- Work with the Health Across All Policies interagency workgroup to provide assistance to agencies on embedding healthy aging and the 8 domains of livability in their state and local plans and procurement
- Release an RFA to fund communities to be designated as age friendly, replicate NYS age friendly executive order and create age friendly regional assistance centers.

- Continue to demonstrate the value of older New Yorkers economically, socially and intellectually to their to their families and communities, to combat ageism and stereotypes.

Objective	Expected Outcome	Target Date
2.9	Guidance documents will be created to assist state agencies in implementing healthy aging in their work	2020
2.9	Review, comment and offer guidance to agencies in their local, state and federal plans embedding healthy aging and 8 domains of age friendly as appropriate.	2021
2.10	Increase by 10 the number of communities who commit to receiving age friendly certification by WHO/AARP via RFA	2022
2.10	Develop 5 regional age friendly technical assistance resource centers and learning collaborative.	2022
2.11	Present the Governor's vision for a health across all policies approach and healthy aging to all 10 regional economic development councils.	2023
2.11	Present the Governor's vision for a health across all policies approach and healthy aging to community groups, philanthropy, conferences and other appropriate public venues.	ongoing
2.12	Age friendly domains will be included in county plans to the state	2019
2.13	Provide data that shows the value older New Yorkers are through their incomes, volunteerism, civic engagement, mentorship and through the workforce to combat ageism.	ongoing
2.13	Implement a campaign to combat ageism	2019

<u>Supporting Aging in Place – Naturally Occurring Retirement Communities (NORCs)</u>

Objectives:

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

2.15 Provide assistance to NORC programs on how to increase resident participation in program planning, implementation, and evaluation.

2.16 Provide ongoing training and technical assistance to NORC/NNORC programs.

Strategies:

- Program standards will be developed and implemented by the NORC programs.
- Develop and implement a monitoring tool to evaluate NORC programs based upon standards.
- Ongoing technical assistance and training will be provided to programs.

Objective	Expected Outcome	Target Date
2.14 **2.15**	A minimum of 25 percent of the NORC programs will demonstrate an increase in older adult resident participation in program planning, implementation and evaluation.	2021

2.16	NORC programs will receive ongoing training and technical assistance.	2019-2023

Activities for Health, Independence and Longevity – Foster Grandparent Program (FSP)

Objectives:

2.17 Increase participation in the Foster Grandparent Program through the recruitment of new volunteers and the retention of existing volunteers.

2.18 Ensure the Foster Grandparent Program is accessible to people of all backgrounds by increasing participation by culturally diverse volunteers and those from underserved communities.

Strategies:

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

Objective	Expected Outcome	Target Date
2.17	The number of new volunteers recruited will be increased by a minimum of five percent from State Fiscal Year 2018-2019 levels.	2021
2.17	Existing volunteers will remain with the program for a minimum of one year.	2021
2.18	The number of new volunteers from culturally diverse backgrounds or underserved areas will be increased by at least five percent from State Fiscal Year 2018-19 levels.	2021

Activities for Health, Independence and Longevity – RSVP

Objectives:

2.19 Increase participation in the Retired Senior Volunteer Program (RSVP) through the recruitment of new volunteers and the retention of existing volunteers.

2.20 Ensure the Retired Senior and Volunteer Program is accessible to people of all backgrounds and ability levels by increasing participation by culturally diverse volunteers and those from underserved communities including individuals with disabilities.

Strategies:

- Provide additional guidance to programs to encourage new and/or innovative methods of recruitment and outreach as well as retention strategies for the program.
- Develop strategies to assure existing volunteers are retained.
- Work collaboratively with the Corporation for National and Community Service to

enhance opportunities for volunteers.

- Review statistical data annually from all programs to determine existing level of diversity in RSVP Programs.
- Provide guidance to programs concerning recruitment methods targeted to individuals of diverse cultural backgrounds and provide technical assistance as needed.
- RSVP Programs will conduct targeted outreach to culturally diverse and other underserved older individuals.

Objective	Expected Outcome	Target Date
2.19	The number of new volunteers recruited will be increased by a minimum of five percent from State Fiscal Year 2018-2019 levels.	2021
2.19	Existing volunteers will remain with the program for a minimum of one year.	2021
2.20	The number of new volunteers from culturally diverse backgrounds or underserved areas will be increased by at least five percent from State Fiscal Year 2018-19 levels.	2021

Activities for Health, Independence and Longevity – Senior Community Service Employment Program (SCSEP)

Objectives:

2.21 Enhance employment opportunities for older New Yorkers by promoting older workers as a solution for businesses seeking a trained, qualified, and reliable workforce.

2.22 Utilize Labor Market Information (LMI) to facilitate the transition of SCSEP participants into unsubsidized, in-demand employment.

2.23 Increase recruitment of those individuals with the greatest economic need and with poor employment prospects.

Strategies:

- Require all SCSEP sub-grantees to utilize training provided by local One-Stop Career Centers.
- Maintain an active role on the NYS Workforce Innovation and Opportunity Act (WIOA) Interagency Team at the state level and help foster relationships on the local level between sub-grantees and the local workforce development boards.
- Utilize LMI information to identify and match individuals with in-demand employers.
- Encourage sub-grantees to speak to growth employers to determine the specific skill sets required by potential candidates.
- Provide program guidance to insure sub-grantees continue to give special attention to recruiting and training those most in need.

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

2.23	SCSEP core performance measure, established by USDOL, for Service to Most in Need, will meet or exceed by 2.5% its targeted goal.	Ongoing

Activities for Health, Independence and Longevity – Volunteerism

Objectives:

2.24 Enhance the rates of older adults participating in volunteer service.
2.25 Reduce the rate of social isolation among older adults.
2.26 Increase community organizations' use of the state volunteer website www.newyorkersvolunteer.ny.gov to match volunteers with meaningful volunteer experiences.
2.27 Develop positive outreach messages on aging including the economic, intellectual and social value of older adults.

Strategies:

- Increase interagency collaborations.
- Promote listing volunteer opportunities through the NYS Commission on National Community Service
- Prepare statistics about the social and economic contributions of older adults to their communities.
- Identify best practices regarding civic engagement activities for volunteers
- Develop PSAs for county use to recruit volunteers.

Objective	Expected Outcome	Target Date
2.24	There will be a statewide increase in the number of older New Yorkers who volunteer based on SFY 2018-19 levels.	2019-2023
2.24	HIICAP and LTCOP will test the use of stipends for volunteer recruitment and retention.	2021
2.25	There will be a reduction in isolation among older adults through efforts to increase volunteerism.	Ongoing
2.26	There will be an increase in the number of volunteer postings on the New York Commission on National and Community Services website that would be of interest to older adults.	Ongoing
2.27	Positive messaging will be developed and distributed that portray the wealth of knowledge, experience, economic support, intellectual and contributions that older adults make to their families and communities throughout NYS	Ongoing

Nutrition Services – Nutrition Program for the Elderly

Objectives:

2.28 Expand the provision of healthy, balanced congregate and home delivered meals that are reflective of the preferences and cultures of older New Yorkers.
2.29 Target nutrition programs to older individuals in greatest economic and social need throughout the state.
2.30 Expand opportunities for older adults to access other benefits and services through the nutrition program.
2.31 Support local efforts to expand nutrition services within communities through partnerships and contracts with managed long-term care plans and other payers.

2.32 Encourage nutrition provider network to purchase locally grown fruits and vegetables and commodities.
2.33 Implement the newly revised nutrition standards and regulations.
2.34 Continue to increase use of nutrition counseling, nutrition education and evidence-based interventions that promote healthy living.

Strategies:

- Continue to monitor and provide technical assistance to all AAA's in meeting the 2015 HHS & USDA Dietary Guidelines.
- Annually monitor AAAs for compliance with nutrient requirements and dietary guidelines for meals.
- Working collaboratively with the NYS Department of Health, conduct annual food safety training statewide for program coordinators, registered dietitians and meal site and preparation kitchen staff.
- Maximize the distribution of annual Senior Farmers Market Nutrition Program (SFMNP) coupons to eligible older New Yorkers.
- Continue existing collaborations with other State agencies and community partners to provide nutrition services responsive to the needs of older New Yorkers.
- Provide ongoing technical assistance to local programs to enhance their nutrition education programs and nutrition counseling services.
- Provide support and guidance in the growth of person-centered nutrition programs which reflect the diversity of the AAA planning and service areas.
- Provide technical assistance to local programs on how to assist older adults in better utilizing Medicare preventive benefits, particularly immunizations, flu shots, mammograms and other preventive screenings.
- Promote the integration of evidence-based and nutrition programs.
- Facilitate partnerships between local farmers and growers' associations and the nutrition programs.
- Encourage more regional approaches to issues that come up in the administration of the nutrition programs – such as lack of meal providers for contracts; decreasing volunteers; expanding home delivered meal programs; facing increased costs with limited program dollars; and other topics.
- Work on creative solutions to halt the decline in congregate dining in Upstate New York counties by supporting pilot programs which enhance self-directed dining options

Objective	Expected Outcome	Target Date
2.28	The AAA network will expand nutrition options to include restaurant dining programs, multi-cultural menus and meal sites which offer additional health promotion activities.	Ongoing
2.29	Annual monitoring of the demographic profile of older adults served by the nutrition program will reflect increases in access by targeted populations.	Annually and ongoing
2.30	Continue to work with AAAs to accept USDA SNAP funds for contributions at meal sites and for home-delivered meals.	Ongoing
2.30	Application assistance for public benefits, including USDA SNAP and HEAP will be provided at congregate dining sites across the state.	Ongoing

2.31	AAAs will be provided with training and technical assistance to increase their business acumen; enhancing their ability to successfully contract with Managed Long Term Care plans and other payors for congregate & home-delivered meals	2019 and ongoing
2.32	Expand the use of locally grown 'in season' produce within the nutrition programs throughout the state.	Ongoing
2.33	The nutrition standards issued in 2019 will be fully implemented statewide.	2020
2.34	Increased prevention and management of chronic disease associated with diet and weight resulting from wider integration	Ongoing

Nutrition Services – Supplemental Nutrition Assistance Program Education (SNAP-Ed)

Objectives:

2.35 Provide SHINE SNAP-Ed which includes evidence-based nutrition education and obesity prevention interventions and projects for older New Yorkers eligible for the Supplemental Nutrition Assistance Program (SNAP) through complementary direct education, multi-level interventions and community and public health approaches to improve nutrition in the target population, in four regions of the State.

2.36 Ensure that SNAP-Ed is available to older individuals in greatest economic and social need in the implementing regions of the state.

2.37 Increase capacity of AAAs to deliver, or partner with others in delivering SNAP-Ed in partner regions of the state.

2.38 Secure other federal and State resources to support continued delivery, expansion and sustainability of SNAP-Ed for older New Yorkers throughout the state.

Strategies:

- Participating Area Agencies on Aging will provide SNAP-Ed interventions at community sites where the target population can be reached, such as congregate meal sites, senior centers, public housing serving older adults, as well as sites located in Naturally Occurring Retirement Communities (NORCs).
- Throughout FFY 2019, utilize NYSOFA network of service providers as well as various media (including print media, social media) to reach low-income older New Yorkers with nutrition education geared specifically to older adult nutritional needs/requirements.
- Participating AAAs will coordinate one or more Healthy Eating Resource Fairs at Eat Healthy, Be Active workshop sites to provide resource information to the target population.
- Participating AAAs will develop a Food Box Distribution Program at 1 to 2 sites in their target region to increase access to fresh fruits and vegetables to the target population.
- Recipients of Food Boxes will be educated on how to store and prepare the contents of the food boxes in a healthy way.
- Monitor participating AAAs for compliance with SNAP-Ed program requirements.
- Collect data from pre and post-tests completed by participants of the Eat Healthy, Be Active workshops to determine behavior changes regarding attitudes, perceptions, and thoughts related to healthy eating materials/information provided in the workshops.
- Conduct training and technical assistance for program coordinators, nutrition educators and other AAA staff regarding SNAP-Ed programs and resources.
- Facilitate partnership development between participating AAAs and neighboring counties in the region.

Objective	Expected Outcome	Target Date
2.35	Annually reach over 3000 older adult participants with Eat Healthy, Be Active Community Experiential Workshops, taught by qualified nutrition educators through partner AAAs in 4 regions.	Ongoing
2.35	85% of older adults participating in Eat Healthy, Be Active Community Workshops will report behavior changes with regards to attitudes, perceptions, and thoughts related to materials/information provided in the nutrition education workshops.	Ongoing
2.35	Annually, over 250,000 older New Yorkers will have increased awareness and knowledge of SNAP-Ed approved nutrition education via Social Marketing.	Ongoing
2.35	Annually, over 1000 older New Yorkers will have increased awareness of community resources to support healthy eating as a result of Healthy Eating Resource Fair attendance.	Ongoing
2.36	Annually, SHINE SNAP-Ed interventions will be delivered at over 50 sites statewide which meet low-income eligibility criteria.	Ongoing
2.37	SHINE SNAP-Ed sites will expand reach into parts of regions in which implementation has not yet occurred.	Ongoing
2.38	Funding will be secured to expand SHINE SNAP-Ed to be available to older adults in additional planning and service areas of the State.	2020 & Ongoing

Supporting Caregivers – National Family Caregiver Support Program (NFCSP)

Objectives:

2.39 Assist informal caregivers - spouses, adult children, other family members, friends and neighbors in their efforts to care for older persons who need help with everyday tasks.

2.40 Assist older relative caregivers in their efforts to care for dependent children under 18 years old or adult children with a disability, age 18-59 years old who are living with the older relative caregiver.

2.41 Caregiver support services enable caregivers to care for older persons with chronic illnesses or disabilities so they are able to remain in their own homes in the community.

2.42 NY Connects NWD system will be able to provide information and assistance to caregivers to access appropriate programs that can assist them.

2.43 New models and collaborative relationships will be developed to increase access to caregiver services and supports.

2.44 NFCSP services will be provided in a manner inclusive of caregivers who meet program requirements, including those with disabilities as well as those who may have limited English proficiency.

2.45 Standardized process and protocols for serving family caregivers.

2.46 Provide technical assistance and training to AAAs to support the delivery of NFCSP services.

Strategies:

- Assess training needs and provide training/technical assistance to AAAs, NY Connects, and/or caregiver support staff on relevant topics, including workshops at the

annual ACUU and AATI.

- AAAs will share innovative, successful practices with other AAAs and community organizations serving caregivers with Bring, Brag, and Borrow Webinars, a component of the Caregiver Coordinator call series.
- NYSOFA will explore other consumer directed payment models to help expand current in-home respite options for caregivers and their loved ones.
- NYSOFA will explore other consumer directed respite care options to help expand service delivery.
- Develop a caregiver assessment tool to identify caregiver goals, preferences, needs, values, culture, etc.
- Engage subject matter experts to assist AAAs in NFCSP development.
- Engage AAA participation in work groups to collaborate on development of tools and resources that incorporate the ideas and feedback of caregiver coordinators and/or AAA Directors to support the application of the NFCSP.

Objective	Expected Outcome	Target Date
2.39, 2.40, 2.41	Caregivers will be better able to continue in their caregiver role while receiving services and supports through this program.	Ongoing
2.41	Increase availability of caregiver directed respite to improve options and choices to meet caregiver needs and needs of their loved ones.	2023
2.42	Caregiver resources, services, and provider listings will be available in a single statewide web-based resource directory.	Ongoing
2.43	Explore and expand other models of consumer directed respite care.	Ongoing
2.44	National Family Caregiver Support Program services will be provided in a manner inclusive of caregivers who meet program requirements, including those who may have limited English proficiency. For the caregiver to be eligible for respite and supplemental services, the care receiver must have a cognitive impairment, or be unable to perform at least two Activities of Daily Living (ADLs).	Ongoing
2.45	All AAAs will utilize standards established for serving family caregivers established to meet program requirements.	2023
2.46	AAAs will increase their knowledge base to develop innovative practices and effectively serve family caregivers.	Ongoing

<u>Supporting Caregivers – Social Adult Day Services</u>

Objectives:

2.47 Annually monitor Social Adult Day Services (SADS) programs directly funded by the New York State Office for the Aging (NYSOFA) for compliance with the state regulations.

2.48 Annually monitor the Area Agencies on Aging (AAAs) that fund SADS to determine compliance with program requirements and regulations.

2.49 Support professional development activities that provide technical assistance for new start-ups and statewide training on SADS best practices.

Strategies:

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

Objective	Expected Outcome	Target Date
2.47	All NYSOFA funded SADS programs and AAA funded SADS programs will meet state minimum standards which is inclusive of serving individuals who are functionally impaired due to physical, cognitive, or psychosocial limitations and/or who may have limited English proficiency.	Ongoing
2.48	Caregivers and care recipients who utilize adult day services will receive quality services that meet state standards.	Ongoing
2.49	The SADS professional development contractor will continue to provide training and technical assistance to SADS programs.	Ongoing

Supporting Caregivers – Respite

Objectives:

2.50 Provide programs and services to ensure that informal caregivers will benefit from utilizing respite services.

2.51 Increase, through collaboration with other state agencies and the New York State Caregiving and Respite Coalition additional respite options, including caregiver directed respite and volunteer-based respite.

2.52 Train volunteers to provide respite services.

Strategies:

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

Objective	Expected Outcome	Target Date
2.50	Informal caregivers indicate benefits from utilizing respite care services for their loved ones through self-reports and other survey methods.	Ongoing
2.51	AAAs will provide a variety of types of respite including in-home, group settings, and overnight care.	Ongoing
2.52	Volunteers will be identified and trained to provide in-home and community-based group respite.	Ongoing

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

Disease Prevention and Health Promotion Services

Objectives:

3.1 Increase availability and access to EBIs for older adults throughout NYS.
3.2 Increase capacity of AAAs to deliver, or partner with others in delivering, EBIs.

Strategies:

- Further expand NYSOFA's internal EBI Team and resources to provide ongoing support to the AAAs and the larger local EBI delivery network.
- Provide technical assistance and training to NYS AAAs and other EBI network partners to enhance their understanding of Evidence- Based Health Promotion, Wellness and Disease Prevention EBIs.
- Encourage the sharing of best practices and lessons learned among the EBI local partner network.
- Maintain a robust web-based data collection, reporting and local EBI management system to support the existing infrastructure of EBI delivery.
- Convene regular administrative and operational forums to foster sharing of resources among the New York State Evidence-Based Interventions Leadership Team that consists of NYSOFA and various Bureaus within the NYSDOH.
- Develop and issue appropriate Technical Assistance Memorandums, Informational Memorandums, and Program Instructions to the AAAs and NY Connects to encourage referrals to EBIs (with a focus on CDSME).
- Provide technical assistance to AAAs on effective utilization of Older American Act Title IIID funding to support the delivery of CDSMEs in their localities.
- Work with State and federal partners to secure grants and other resources to support CDSME.
- Provide technical assistance and support to the AAA nutrition, HIICAP, and NY Connects networks to further promote Medicare preventative benefits.

Objective	Expected Outcome	Target Date
3.1	Increase types and numbers of EBIs offered in NYS to older adults.	Ongoing
3.1	Annual increase in the number of older adults EBI participants served by AAAs (directly or through contract).	Ongoing
3.1	As demonstrated by EBI network data, at least 4,000 individuals with chronic conditions and/or disabilities participate in a CDSMEs annually.	Ongoing
3.2	Increase understanding of Evidence-Based Health Promotion, including strategies for the delivery of EBIs, by AAA staff.	Ongoing
3.2	EBI state level activities are coordinated and sustained by the Evidence-Based Interventions Leadership Team.	Ongoing
3.2	Area Agencies on Aging and NY Connects will have the information and support to contribute to the delivery of CDSMEs.	Ongoing
3.2	Area Agencies on Aging will effectively utilize all of annual Older Americans Act Title IIID funding to support the delivery of EBIs in their localities.	Ongoing

3.2	NYSOFA will have applied for or requested funding from federal and/or State sources to support CDSME.	Ongoing
3.2	Annual increase in the use of Medicare preventive and health screening benefits. (Source: CMS published claims data)	Ongoing

Disease Prevention and Health Promotion Services – Health Indicators Program

Objectives:

3.11 Implement Health Indicators Program for performance improvement in all NORC programs.

3.12 Provide ongoing training and technical assistance to all NORC programs.

Strategies:

- Develop guidelines for administering Health Indicators survey.
- Establish protocols for both individual and group interventions based on survey results.
- Create benchmarking for determining performance improvement as a result of implemented interventions.
- Provide training and technical to programs on identifying individual residents as well as groups of residents in need of health promotion programming or referral.
- Work collaboratively with the New York City Department for Aging and share ideas and best practices.

Objective	Expected Outcome	Target Date
3.11	Use Health Indicators survey results to establish a baseline of NORC clients health status.	2021
3.12	NORC programs will receive ongoing training and technical assistance.	Ongoing

Disease Prevention and Health Promotion Services – Sepsis Prevention

Objectives:

3.13 Provide community-based providers and the general public educational resources to identify Sepsis earlier and treat it to reduce its devastating consequences.

Strategies:

- Survey AAAs, Case Managers as to whether they would like in-depth training on Sepsis Screening Tool
- Get Sepsis Zone Tool out to Aging Network
- Use social media to get information and facts about Sepsis out bi-weekly or monthly
- Create a Sepsis Section on NYSOFA Website that links Directly to Sepsis resources
- Add Sepsis signs and symptoms to NYSOFA's comprehensive assessment tool
- Provided Sepsis Zone Tool at great NYS Fair
- Develop Sepsis PSA (NYSOFA/HCA) for distribution among all our networks

Objective	Expected Outcome	Target Date
3.13	AAAs will be surveyed to determine interest in sepsis screening tool training, linking with local sepsis champions	2019-2020

3.13	Print and distribute sepsis zone tool, provide to AAA's and distribute at events, great NYS Fair, etc.	2019-ongoing
3.13	Distribute facts and signs and symptoms of sepsis to raise awareness through social media	2019
3.13	Create PSA regarding signs and symptoms of sepsis and prevention	2019
3.13	Add sepsis identification language to state comprehensive assessment tool - COMPASS	2020

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

Integration of grants within OAA Core Programs	Objectives	Target Date
Lifespan Respite	Build upon prior and current Lifespan Respite initiatives by engaging key stakeholders to increase and expand access to respite services statewide and enhance partnerships for education, outreach, and service provision to advance development of a Lifespan Respite Care System.	2020
MIPPA	Continue to support the AAAs/HIICAPs and the NY Connects System in their coordinated efforts to inform and assist Medicare beneficiaries with the available Federal and State benefits and to ensure that their county/designated catchment area achieves all goals, objectives, deliverables, measurable outcomes, and targets.	Ongoing
No Wrong Door Business Case Grant	Construct a methodology for calculating Return on Investment (ROI) and demonstrate the impact that the NWD System has on multiple populations, health care utilization, and streamlined access to community-based long term services and supports.	2020

Lifespan Respite

Objectives:

4.1 Increase number of respite volunteers through additional training and recruitment activities.

4.2 Expand available respite services statewide through formalizing a caregiver-directed respite model

4.3 Expand access to caregiver services through improved respite listings in the NY Connects Resource Directory across age and disability types.

4.4 Implement and continue to update the Statewide Action Plan for Lifespan Respite sustainability.

Strategies:

- The Lifespan Respite Core Team will continue to build on the strong working relationship developed during the prior (2014-2017) Lifespan Respite grant initiative.
- The NYSCRC Director will continue proactive efforts to build recognition of NYSCRC as a partnership of dedicated organizations and individuals committed to supporting respite for the millions of informal caregivers throughout the state.
- The NYSCRC Director, working closely with NY Connects, will help to connect caregivers with respite and information, training and support services critical to successfully caring for a loved one at home.
- Develop and implement quality assurance plan to review and improve respite listings in the NY Connects Resource Directory.
- Establish a NY Lifespan Respite Virtual Resource Center (VRC), to be housed in

NYSCRC to further coordinate information about caregiving and respite training, technical assistance, and related materials and develop a Lifespan Respite system.

- Develop Program Instruction to formalize and communicate caregiver-directed policy under the OAA III-E that is available to AAAs.
- Distribute, promote, and provide technical assistance to AAAs on the caregiver-directed OAA III-E Program Instruction. Encourage connection to NY Connects for additional assistance for other LTSS if needed.

Objective	Expected Outcome	Target Date
4.1	100% statewide implementation of REST model of training for respite volunteers.	2020
4.1	30% overall increase in REST Companion volunteers.	2020
4.2	Increased number of AAAs offering caregiver-directed model for respite care.	2020
4.3	Increased number of individuals that received information and assistance on caregiver supports through NY Connects.	2020
4.3	Completed qualitative review of respite listings in the NY Connects Resource Directory.	2020
4.4	An Action Plan to sustain the Lifespan Respite program in New York State and sustain the New York State Caregiving and Respite Coalition (NYSCRC) beyond the grant period will be developed by the Core Team for this grant working with an advisory group of key stakeholders.	2020
4.4	Develop and disseminate a guide for businesses to support employed caregivers so they can achieve effectiveness both in and out of the workplace.	2020
4.4	Increased knowledge about respite and caregiving through Caregiver Simulations among nine higher education institutions and three private sector business entities.	2020

Medicare Improvements for Patients and Providers Act (MIPPA)

Objectives:

4.5 Raise Medicare beneficiary awareness of and enroll Medicare beneficiaries in the LIS and/or MSP benefit, particularly in the underserved zip codes identified by CMS and in the hard to reach areas of New York State.

4.6 Target outreach efforts to raise Medicare beneficiary awareness of the LIS and MSP in rural and hard to reach areas.

4.7 Educate Medicare beneficiaries across New York State on Medicare preventive and wellness benefits and the importance of these services.

4.8 Educate and enroll Medicare beneficiaries across New York State on Medicare benefits, including the Part D benefit, focusing on the underserved and hard to reach areas of the State.

Strategies:

- Provide the AAAs, NY Connects, and HIICAPs (local MIPPA partners) with training and educational information to assist individuals with the application and enrollment processes for MSP and LIS.
- Provide the local MIPPA partners with training on MSPs and LIS budgeting, and other MIPPA topics.
- Ensure that the local MIPPA partners have training on and access to the CMS Mapping Tool to identify areas where significant populations of LIS eligible beneficiaries reside to target outreach and assistance activity.
- Provide goals in a Minimum Targets Table to the local MIPPA partners for outreach events on Medicare preventive and wellness benefits to Medicare beneficiaries to ensure that the audience is reached.
- Assist the local MIPPA partners to develop cost effective strategies innovative outreach strategies (e.g. public service announcements, home visits, working with the local Long Term Care Councils, etc.) to target potential LIS/MSP eligible residing in rural/underserved areas as well as culturally diverse individuals and those with limited English proficiency.
- Monitor the reporting practices the local MIPPA partners use to document outreach events on Medicare preventive and wellness benefits to Medicare beneficiaries and provide ongoing technical assistance to increase accuracy.

Objective	Expected Outcome	Target Date
4.5	Increase number of Medicare beneficiaries enrolled in LIS and MSP benefit	Ongoing
4.6	Increase number of rural Medicare beneficiaries enrolled in LIS and MSP benefit	Ongoing
4.7	Increased number of outreach events about Medicare Preventative and Wellness benefits	Ongoing
4.8	Increased number of outreach events about Medicare Part D and other Medicare benefits	Ongoing

No Wrong Door Business Case Development

Objectives:

4.9. Identify and evaluate the data elements that are necessary to determine how the NWD System delays or prevents the use of more costly care.

4.10. Expand and adapt an existing care transitions intervention to serve additional eligible individuals and implement a new evidence-informed care transitions intervention within two partnering counties that have demonstrated capacity to engage in ROI project activities.

4.11. Identify data elements that will demonstrate the value of OC/PCC.

4.12. Enhance the existing data collection system to track necessary data elements that will inform the calculation of ROI.

Strategies:

- Participate in collaborative calls and webinars with other state grantees and federal partners to discuss existing efforts in business case development and identify preliminary data elements for ROI calculation.
- Issue contracts to partnering counties to facilitate the administration of their care transitions interventions and their provision of OC/PCC services.

- Provide technical assistance to local partners that supports any enhancements to staffing and system-level capacity necessary to meet project deliverables.
- Work with necessary partners, including Peer Place, to make enhancements to the existing Statewide Client Data System to better facilitate the delivery, data collection, and reporting of care transitions and OC/PCC.
- Modify the existing Statewide Client Data System as needed to include those data elements that will inform the ROI calculation.
- Establish agreements with ACL and other federal partners that would enable the sharing of data to inform the ROI calculation.
- Conduct continuous quality improvement and monitoring of program delivery and outcomes that will inform the outcomes noted in the development of a business case report.
- Participate in the development of a business case report that will be shared with the NY Connects NWD network to facilitate the replication of those processes and strategies identified in the report.

Objective	Expected Outcome	Target Date
4.9	Data elements are identified that will inform an ROI calculation	2019
4.10	350 people will be served by evidence-informed care transitions intervention in the partnering counties	2020
4.11	The Statewide Client Data System contains those data elements, forms, and fields that will enable tracking of consumers over time	Ongoing
4.12	A sustainable business case is developed that demonstrates the value and impact of the NWD System in NYS through quantifiable data	2020

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

Elder Justice – Legal Assistance Program

Objectives:

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

Strategies:

- Maintain and build upon partnerships developed through the Legal Services Initiative and with other advocacy program such as the Long-Term Care Ombudsman Program and the Office of Children and Family Services Adult Protective Services Unit.
- Establish a workgroup to: review current state regulations and program standards; develop model approaches for outreach, access to legal assistance, monitoring, reporting, and program assessment; and develop a uniform reporting format.
- Provide technical assistance to AAAs to coordinate OAA funded legal assistance with Legal Services Corporation (LSC) projects and to collaborate with the local legal and advocacy communities (including the private bar and nonprofit organizations providing legal assistance), and LTCOP to protect the rights of older adults. In addition, the Legal Services Developer will review the services provided by the state's legal services providers for depth and scope of coverage.
- To detect and prevent problems that would jeopardize the independence and dignity of the older adult, the State Legal Assistance Developer will collaborate with LSC grantees, legal assistance providers, and other elder rights advocacy programs for the development and dissemination of educational materials and education activities/workshops to increase awareness of and understanding by older New Yorkers, their families, and caregivers about the legal issues they might encounter (including problems related to fiduciary relationships, housing, health care, and long-term care).

Objective	Expected Outcome	Target Date
5.1	Expand partnerships at state and local levels to coordinate delivery of legal assistance to older New Yorkers with greatest economic and/or social need	Ongoing
5.2	AAAs will be able to expand access to legal assistance for older adults with the greatest economic and/or social need by identifying and utilizing existing resources among local legal and advocacy communities to protect the rights of older New Yorkers	Ongoing
5.3	Provide more comprehensive legal service assistance to individuals in need of the service.	Ongoing
5.3 **5.4**	There will be reliable sources of information available for older adults, caregivers, and those who interact with them to better enable them to protect their rights, recognize legal issues, and identify resources for legal assistance as needed.	Ongoing

Elder Justice – Legal Services Initiative / NYS Judicial Committee on Elder Justice

Objectives:

5.5 Interested individuals and organizations will develop and implement strategies to address the limitations and gaps in legal assistance identified through the surveys.

Strategies:

- Organize stakeholders to develop strategies for addressing gaps in legal assistance.
- Maintain and build upon existing collaborations of legal service providers, elder justice advocates and NYC Office of Court Administration.

Objective	**Expected Outcome**	**Target Date**
5.5	Actions, steps, and activities will be planned, developed, and implemented by interested individuals and organizations.	Ongoing

Elder Justice – Long Term Care Ombudsman Program

Objectives:

5.6 Continue to strengthen the regionalization model of LTCOP.

5.7 Enhance the capacity and efficiency of regional ombudsman programs and representatives to provide effective individual and systems advocacy.

5.8 Improve resident and family access to information and assistance which helps them understand and exercise their rights, secure the benefits to which they are entitled, and resolve problems in the most efficient and effective way possible.

5.9 Maintain the number of volunteer ombudsmen working with LTCOP.

Strategies:

- Require the statewide Ombudsman Program network of regional ombudsman programs to provide volunteer management and advocacy services to protect the health, safety, welfare and rights of residents in long-term care facilities.
- Provide technical assistance to help regional programs improve volunteer recruitment and retention, including recruitment of volunteers from culturally diverse backgrounds.
- Develop and initiate volunteer recruitment and retention efforts through a survey of current volunteers, a pilot program utilizing a volunteer stipend in selected regions, and increasing training opportunities through the use of technology.
- Establish regular communication, including training activities, with other Elder Rights programs, especially legal services, to promote greater coordination and to develop formal/informal referral protocols.
- Coordinate with agencies and organizations that assist residents with addressing their individual and common concerns with facility administration, to improve resident care and quality of life.
- Collaborate with other state agencies, such as DOH, to identify common resident concerns, and research potential funding resources to allow more residents to access advocacy services and help through LTCOP.

Objective	Expected Outcome	Target Date
5.6	Update program contracts to strengthen regionalized LTCOP model.	2020
5.7	Data provided by each regional program will be more effectively collected to allow the State Ombudsman to address commonly identified concerns of residents and families through a Systems Advocacy Advisory Council.	Ongoing
5.7	The percent of satisfactorily resolved complaints investigated by LTCOP will increase from 58 percent to at least 85 percent.	2021
5.8	The percentage of nursing homes that receive regular visits from a regional ombudsman representative will increase to at least 90 percent.	2023
5.8	Enhanced coordination/training with legal service providers (Title III), HIICAP. and other advocacy services, and an increase in the number of older adults and their families appropriately referred to those services for assistance.	Ongoing
5.9	Volunteers will increase by 5% over SFY 2017-2018 levels.	2021

Elder Justice – Elder Abuse Education and Outreach Program

Objectives:

5.10 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.

5.11 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.

5.12 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.
- Partner with the Office of Children and Family Services (OCFS) on an annual Adult Abuse Training Institute for adult protective services, AAA case managers, and other aging network partners.
- Encourage state collaboration using the Memorandum of Understanding (MOU) between the New York State Office for the Aging (NYSOFA) and (OCFS) on Protective Services for Adults.
- Encourage local collaboration using the MOU template 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.
- Continue to share best practices (e.g., shelter, money management, other services) for possible replication.

Objective	Expected Outcome	Target Date
5.10	Elder Abuse awareness and access to services and supports through public awareness presentations, training of professionals and non-professionals working with older people, provision of social work interventions to elder abuse victims, and geriatric addiction services to older persons in an 11 county region.	Ongoing
5.11	Elder abuse awareness and access to information and services through the New York State Coalition on Elder Abuse, acting as a clearinghouse through its web site and through, dissemination of news bulletins, Enhance education and outreach through monthly information sharing of resources and tools to AAAs for public outreach and education on elder abuse issues	Ongoing
5.11	Coordination and collaboration will continue between the New York State Office for the Aging and the Office of Children and Family Services, in order to facilitate and support better coordination of services on the local level between adult protective services and aging services.	Ongoing
5.12	The MOU template between adult protective services and aging services enables strengthened coordination and referrals between local Area Agencies on Aging and Local Departments of Social Services.	Ongoing

Elder Justice – OVS/VOCA Elder Abuse Interventions and Enhanced Multi-disciplinary Team (E-MDT) Initiative

Objectives:

5.13 Expand the E-MDT model into all counties across the state.
5.14 Implement a uniform, statewide set of E-MDT policies.
5.15 Develop methods for data collection that will be useful in measuring performance, evaluating outcomes, and reporting to State and Federal funders.
5.16 Develop training and technical assistance protocols to ensure uniform Statewide implementation and assistance.
5.17 Utilize technology and other innovative methods for elder abuse interventions.
5.18 Increase use of E-MDTs for elder abuse interventions.

Strategies:

- Issue Requests for Applications to identify new E-MDT Regional Hubs including E-MDT coordinator role for all counties in Hub regions.
- Convene workgroups consisting of NYSOFA staff and/or local partners to develop statewide policies, establish a web-based data collection and reporting system, and provide uniform technical assistance to E-MDT coordinators.
- Use intake, tracking, outcome, and referral forms for development of a secure, web-based data collection system for use by E-MDT coordinators and others for data tracking, monitoring, action steps, reporting, and program evaluation.
- Pilot the use of technology to provide medical and mental health services to abuse victims as appropriate.
- Develop materials and conduct presentations and workshops that highlight the success of the E-MDT model in addressing elder abuse.

Objective	Expected Outcome	Target Date
5.13	E-MDTs will be operational in all 62 counties in New York State.	2020
5.14	Statewide set of policies will be designed and implemented, guiding the development and work of all E-MDTs funded through this Initiative.	2019
5.15	Web-based data collection and reporting system will be implemented for client data management, tracking, monitoring, action steps, reporting, and program evaluation .	2020
5.16	Effective technical assistance and training will be provided by the contractor and their subrecipients as applicable via regularly scheduled technical assistance and training calls and site visits with E-MDT coordinators and others as appropriate.	2017-2020
5.17	Effective technology will be piloted and evaluated for use, including telehealth and telemental health, to provide services to abuse victims.	2020
5.18	E-MDTs will be effectively used to identify interventions in elder abuse cases.	2020

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

Objectives:

6.1 NYSOFA staff continue to be trained in basic disaster/emergency preparedness activities.

6.2 NYSOFA Disaster Response staff continue to be trained for and are prepared to assist in emergency/disaster preparedness activities.

6.3 NYSOFA implements protocols as appropriate for AAAs to inform when there is a service disruption or program closure associated with a weather event, manmade or natural disaster.

6.4 NYSOFA continues the development and implementation of local special needs registry that enhances the ability of local governments to reach out and assist older adults and persons with disabilities during a disaster of emergency.

6.5 All AAAs are included in emergency planning activities at the State and local level.

Strategies:

- Provisions of updates on disasters to affected counties and collection of status reports from the AAAs in these areas.
- Provide that NYSOFA staff are trained in FEMA and NYS Dept. of Homeland Security and Emergency Services (DHSES) emergency preparedness protocols as appropriate to their roles.
- Partnerships with DHSES, the Disaster Preparedness Commission (of which NYSOFA is a member), and with Area Agencies on Aging.
- Continue assisting DHSES with disaster recovery operations when requested as a member of Emergency Support Function (ESF) Six.
- Continue participating on various standing committees and ad hoc work groups when requested.
- Assist in the development of state and local plans for assisting individuals with special needs.
- Continue to work with the AAAs in emergency preparedness planning and relief/ recovery efforts.
- Provide services during emergency situations, including assisting AAAs in home delivered and congregate meals as may be appropriate.

Objective	Expected Outcome	Target Date
6.1	All NYSOFA staff trained in (FEMA Course "Introduction to the Incident Command System, ICS 100."	2019 and ongoing
6.2	In addition to the above required course, NYSOFA Disaster Response staff complete all required FEMA and DHSES courses, including the FEMA "Basic Incident Command System for Initial Response, IS 200" and the DHSES "Emergency Operations Center" & "NY Responds" [the Emergency Operations Center software] courses.	2019 and ongoing
6.3	NYSOFA is informed of program disruptions in event of emergency/disaster conditions at the local level.	2019 and ongoing
6.4	State and local level ongoing development and maintenance of special needs registries continues.	Ongoing

Goal #7: Enhance the capacity of the AAA network to develop business acumen strategies to engage with and integrate into emerging health care delivery system transformation activities that foster outcomes-driven population health approaches.

Objectives:

7.1 Prepare the aging network to develop business acumen strategies and engage in coordinated contracting models.

7.2 Market the value of aging services as part of work towards integration of health care and human services systems.

7.3 Strengthen partnerships and contracting opportunities with health care providers and systems and other payers.

Strategies:

- Identify and engage stakeholders and subject matter experts to help inform curriculum development, promote the training program to the network and CBOs and provide guidance to the Business Acumen Training Initiative.
- Develop competency-based learning objectives and curriculum that encompassing the three objectives.
- Assess participants learning level by administering the Aging and Disability Business Institute's Readiness Assessment tool.
- Engage the network and CBOs through in-person regional meetings and monthly web-based trainings.
- Monitor training modules to analyze performance measures to ensure training is effective and to identify training components that may need revisions.
- Explore connecting to the Statewide Health Information Network for New York (SHIN-NY) which would permit the AAAs to receive hospital admission alerts or patient discharge summaries and share key information from the AAAs with health and hospital systems.
- Develop a pilot project in which select AAAs would be contracted with MCOs under the value-based payment (VBP) arrangements.

Objective	Expected Outcome	Target Date
7.1	Increased AAA network understanding and knowledge of health care systems, operations, payor sources, and health care contracting.	2019
7.1	Increased demonstration of AAA network skills to engage and contract with health care payers for expanding integrated care contracting.	2021
7.2	Increased AAA network knowledge of strategies for developing value propositions of aging services to health care systems.	2021
7.3	Increased AAA knowledge of business strategies that may lead to contracts with health care systems.	2019
7.3	Implementation of connectivity of the NYSOFA Client Data System through the SHIN-NY Qualified Entities to enable bi-directional information sharing between health system providers AAAs, with appropriate protocols and consents.	2021
7.3	AAA network has secured contracts with managed care organizations (MCOs) on value based payment (VBP).	2021-2022