

Connecticut State Plan on Aging

October 1, 2006 to September 30, 2009



Aging Services Division
Connecticut's State Unit on Aging
Department of Social Services

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“There is a fountain of youth: it is in your mind, your talents, the creativity you bring to your life and the lives of the people you love. When you learn to tap into this source, you will truly have defeated age.” Sophia Loren

Verification of Intent

The State Plan on Aging is hereby submitted for the State of Connecticut for the period October 1, 2006 through September 30, 2009. It includes the goals and initiatives to be implemented by the Aging Services Division, Connecticut's State Unit on Aging, during this period. The Aging Services Division, in accordance with all requirements of the Older Americans Act, is primarily responsible for the coordination of all state activities related to purposes of the Act, such as the development of comprehensive and coordinated systems for the delivery of supportive services, including health, housing, social and nutrition services and to serve as the advocate for older adults in the state.

The Plan is hereby approved by the Governor and constitutes authorization to proceed with the activities under the Plan upon approval by the Assistant Secretary for Aging.

The State Plan hereby submitted has been developed in accordance with all Federal statutory and regulatory requirements. The State Agency assures that it will comply with the specific program and administrative provisions of the Older Americans Act.

Patricia A. Wilson-Coker, Commissioner
Department of Social Services

Date

M. Jodi Rell
Governor

Date

Table of Contents

Verification of Intent

Introduction	1
Background	2
Accomplishments and Collaborations.....	9
Developing Coordinated Service Systems.....	36
Key Issues and Promising Practices.....	39
Priorities for Federal Fiscal Year 2007 – 2009.....	45

Required Assurances and Exhibits

Appendices

Appendices A	Area Agencies on Aging
Appendices B	Results of Caregiver Survey
Appendices C	Results of the AAA statewide Needs Assessment
Appendices D	Comments on the Plan

References

Acknowledgments

Introduction

The Connecticut Department of Social Services (DSS) is pleased to present the *2006 – 2009 State Plan on Aging* as required by the federal Older Americans Act. This Plan serves as an update to the 2002 – 2005 Plan, and provides an extensive review of trends and issues relevant to today's elders and aging baby boomers.

Many changes have taken place since the development of the last Plan. The Elderly Services Division was renamed the '*Aging Services Division*' and merged into the 'Bureau of Aging, Community and Social Work Services.' The Bureau, along with supporting programs such as Congregate and Home Delivered Meals, Caregiver Support Programs, Elder Abuse Prevention, Employment, Information and Assistance, Health Promotion, also supports Protective Services for the Elderly, Conservator of Estate and Persons, Personal Care Assistance, Domestic Violence Shelters, Shelter Programming for the Homeless, and Energy and Weatherization Programs for Low Income Households.

In 2005, the Aging Services Division received \$17,596,213 in federal funding, including Older Americans Act funding, and \$5,442,186 in State funds to provide services to older adults and their caregivers. We served 1.1 million congregate meals, 2.3 million home delivered meals, 314,000 people were served in adult day care, 213,000 received transportation assistance, 200,000 received home care services including case management, and 150,000 older adults and their care givers received information and assistance.

The Aging Services Division's goal is to assist older adults and adults with disabilities to have a choice in how they want to live, to live with dignity and to maintain their independence. In 2005, the broad themes remain the same: health care, transportation, housing and income security. As the proportion of Connecticut's population over the age of 60 continues to grow, these challenges will affect every aspect of life in Connecticut.

Recognizing that the challenges of tomorrow require different responses, the Connecticut Legislature passed Public Act 05-280 in 2005, establishing a Department on Aging as of July 1, 2007. The Legislature directed that a long-term care needs assessment be completed and the results of the assessment be used to determine the structure of the Department on Aging.

Connecticut can be proud of what has been accomplished to benefit elders and their families since 2002. Included among the achievements is the effective start up of the Family Caregiver Support Program and the most recent efforts around Medicare Part D. We must assure that Connecticut stays on course to further improve the quality of life of our elders and their caregivers in the next three years.

"Age is what you think it is. You are as old as you think you are." Muhammad Ali

Section I

Background

The Older Americans Act requires that each state submit to the federal Administration on Aging (AoA) a two-, three- or four-year State Plan on Aging. At a minimum, this plan must specify:

- The State's goals and objectives for the period of the Plan;
- Statewide program objectives to implement the requirements under Title III of the Older Americans Act (OAA).
- A resource allocation plan indicating the proposed use and the distribution of Title III funds to each Planning and Service Area (PSA);
- The geographic boundaries of each PSA and of the Area Agency on Aging (AAA) designated for each PSA;
- The prior federal fiscal year's information on low income, minority and rural older adults; and
- Compliance with assurances currently required by the OAA of 1965, as amended in 2000 (P.L. 106-501) and Section 1321.17(f) beginning at (f)(1).

The State Plan on Aging is submitted to AoA in compliance with federal law regulations. When approved, the State of Connecticut receives federal funds to administer the State Plan. These federal funds are matched with State funds.

Beyond the minimum required information, Connecticut's 2007- 2009 State Plan on Aging addresses:

- Objectives of the Connecticut State Unit on Aging (Aging Services Division of the Department of Social Services) in working with the Area Agencies on Aging to provide cost-effective, high quality services to Connecticut's older adults and their informal caregivers
- Priorities, unmet needs and promising practices identified by Aging Services and the Area Agencies on Aging; and
- Key socio-demographic factors that influence funding needs and priorities.

In addition to OAA programs, Aging Services and the Area Agencies on Aging administer a variety of home and community-based services. Objectives for these programs have also been included in this State Plan.

Connecticut Strategic Planning on Aging Issues:

Over the past several years, a number of planning and report documents have been developed which focused on aging, the Connecticut Long-Term Care Plan, the Senior Employment Services Coordination Plan, the Connecticut Municipal Agent Annual Reports, White House Conference on Aging Reports and national research papers. Aging Services held forums in November 2005 and January 2006. The January forum was geared towards Hispanic stakeholders. Participants who attended both forums were from the agencies on aging, health

care agencies, faith-based organizations, older adults, nursing homes, assisted living, transportation providers, residential care homes, nutrition providers, Hispanic services providers, and others in the aging network. Aging Services staff also met with older adults and caregivers at senior centers, congregate housing, senior community cafés and other community outlets to discuss services.

Aging Connecticut:

In 2004 the number of individuals age 65 and older totaled 36 million nationwide (US Census Bureau 2003). They represented 12.4 percent of the U.S. population. The number of older Americans increased by 12 percent since 1990 compared to an increase of 9.1 percent for the under 65 population. By 2030, the number of people age 65 and older will reach 20 percent of the U.S. population. By 2050, there will be about 79 million older persons, more than twice their number in 2000. Since 1900, the percentage of Americans who are at least 65 years of age tripled. In 1990 these individuals represented 4.1 percent of Americans; in 2000 they represented 12.4 percent.

There are 601,835 people age 60 or older and 470,183 people age 65 or older residing in Connecticut. Nearly 18 percent of all Connecticut residents are age 60 or older and 13.8 percent are age 65 or older.

Older persons who reached age 65 in 1998 could expect to live an additional 17.8 years; women could expect to live another 19.2 years and men another 16 years. There are an estimated 50,454 people living in the U.S. who are 100 years of age or older; Connecticut accounts for 785 of the nation's centenarians.

The largest growth rate of older Americans will occur during the next 30 years as the Baby Boomers, those born between 1946 and 1964, reach age 60. Between 2006 and 2010 the first wave of Baby Boomers turn 60, which will contribute to a significant increase in Connecticut's older adult population. The oldest individuals in this group are eligible for services under the Older Americans Act in 2006 and will be eligible to receive Social Security benefits at a reduced rate in 2008. In the next few years, many of these individuals will also begin to leave the workforce through retirement. According to AARP (2001), 60 percent of workers today take Social Security at age 62, making it the most common retirement age in the US. In 2011 the oldest baby boomers will be 65 years of age and eligible for full Social Security and Medicare benefits.

The aging of the veteran population is a major challenge confronting Connecticut as well as the rest of the country. Today, 9.2 million veterans are age 65 or older, representing 38 percent of the total veteran population. By 2033, the population of older veterans will increase to 45 percent of the total. As in the general U.S. population, those age 85 or older (the "old-old") are the fastest growing segment of the veteran population, representing 4 percent of current veterans.

These projections suggest the far-reaching implications of the aging baby boom generation for the state's capacity to provide health and long-term care services while protecting the economic security of older adults.

Race, Ethnicity and Cultural Factors:

Some racial and ethnic groups have been historically deprived of opportunity and/or have faced the challenges of living in a new culture, which often translated into health and economic disparity. Assistance must be directed to such deprivation and challenges because ethnic diversity enriches our culture and gives us a variety of perspectives, new models for problem solving, and deeper insights into our own values and priorities.

Currently, minority elders comprise over 16.1 percent of all older Americans (65 years of age and older). These numbers are expected to increase in the future dramatically. It is estimated that between 1999 and 2030, the older minority population 65+ is projected to increase by 217 percent, compared to 81 percent for the older white population. Nationally, the number of African-American elders will increase by 128 percent, Asian American elders will increase by 301 percent and the number of Hispanic American elders will increase by 322 percent. American Indian and Alaska Native elders will increase by 193 percent.

Ninety percent of Connecticut's population identify themselves as non Hispanic White, 5.3 percent as African American, three percent as Hispanic or Latino, one percent as Asian and one percent as multiracial (US Census 2000).

African American and other minority adults nationally show both a higher poverty rate, 22.3 percent (US Census Bureau 2001), and lower life expectancy, 71.8 years (CDC 2001) when compared with the White population. Individuals who are not members of a minority group have a poverty rate of 8.3 percent and can expect to live 76.9 years. The life expectancy at birth among minority men, primarily those who are African American is 69 years compared to 75.3 years for White men. Similar concerns also exist for other minority groups such as Latinos, American Indians and Asians, where issues of race, ethnicity and health are closely entwined with the socioeconomic challenges that face these groups.

The North Central and Southwestern regions are experiencing growth in their Russian populations. Providing culturally appropriate outreach and assistance to this group and other minority individuals who reside in the State is essential for overcoming disparities in access to health and social services. These issues, however, add to the complexity and costs for delivering services to such persons.

"The older I get, the greater power I seem to have to help the world; I am like a snowball, the further I am rolled, the more I gain."

Susan B. Anthony

Gender and Marital Status:

Older women numbered 20.6 million nationwide in 2000 while older men numbered 14.4 million. The ratio of older women to older men was 146 to 100 respectively. Connecticut reported a similar gender ratio with 147 older women to 100 older men. Fifty-six percent of persons between the ages of 65 and 84 are women; women comprise 60 percent of individuals' age 85 and older. Twenty-seven percent of women between the age 65 and 84 have lost their spouse, 61 percent of those age 85 and older are widowed. Women have a longer life expectancy than men; they also tend to marry men who are two or three years older than they are; hence, they have a much higher probability of losing their spouse.

Being unmarried (widowed, divorced, separated, or never married) increases a woman's vulnerability to poverty. (Weitz and Estes 2001). According to the Social Security Administration (1998), 50 percent of older unmarried women rely on Social Security for 80 percent of their income. Social Security is the sole source of income for 25 percent of the nation's older women.

The higher rate of poverty among older women remains a primary issue today. Older women have a poverty rate of 11.8 percent compared to 6.9 percent for older men. Several major factors contribute to their diminished economic circumstances. During their working years, women continue to lag behind men in earnings and benefits. According to the Census Bureau (2001), the median earnings for full-time, female employees in Connecticut in 2000 were \$24,978 or 77 percent of men's earnings. One explanation of the lower earnings by women is their intermittent work history due to their roles as the primary family caregiver of children and parents. Furthermore, by virtue of living an average of six years longer than men, women are more likely to decrease their financial security by financing the uninsured medical and long-term care expenses incurred by ill husbands. Because of these and other factors, women age 75 and older are twice as likely to be poor as men the same age. African American women 75 and older are six times as likely to be poorer than White men the same age (IRWG 2002).

Older women living in retirement are at greater economic risk than men. In 1993 women age 65 and older had a median annual income that was 57 percent that of their male peers. In 1995 the average Social Security benefit for women was \$538 per month compared with \$858 for men. Not only are women's Social Security payments less than men's but also such payments are likely to be their only source of income. Economic disparities may decrease in the future as more women receive higher retirement income benefits from Social Security, pensions and other retirement savings. The women, however, who are most likely to have increased Social Security benefits, are wealthier baby boomers, who are likely to be white. Women of color will likely continue to be poorer.

“Old age is like everything else. To make a success of it, you've got to start young.” Fred Astaire

Health Status

The dramatic gains in life expectancy that occurred during the 20th century were primarily due to the advances in sanitation, medical care and the use of prevention health services. These factors also account for a major shift over the past century in the leading causes of death from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses.

In 2000, the top three leading causes of death for all ages were heart disease (30 percent of all deaths) cancer (23 percent) and stroke (7 percent). These three leading causes of death account for 60 percent of all deaths among older adults.

Many of these leading causes of death, however, can be prevented. Although the risk of disease and disability increases with age, poor health is not an inevitable consequence of aging. Three factors, namely, smoking, poor health and physical inactivity were the actual causes of almost 35 percent of U.S. deaths in 2000.

These behaviors often lead to the chronic disease killers: heart disease, cancer, stroke, and diabetes. Adopting healthier behaviors (regular physical activities, a healthy diet, and a smoke-free lifestyle) and getting regular health screenings (e.g., mammograms, colonoscopies, cholesterol, bone density, etc.) can dramatically reduce the risk of most chronic diseases.

Healthy People 2000 set targeted goals for improving the health of all Americans. *The National Report Card on Healthy Aging* reports on 15 key indicators included in the Healthy People 2000 report that present a comprehensive picture of the health of older adults age 65 and older. This report card shows the most current data for each indicator and assigns a “pass” or “fail” based on the Healthy People 2000 targets (see Table I). Connecticut’s ranking among the nation is also included.

Comparatively, Connecticut’s overall scores for Preventive Care and Screenings were “passing” with 81 percent of older women having mammograms within the past two years and 86 percent of older adults having a cholesterol check in the past five years. Connecticut failed, however, in two Health Behavior measures. Thirty-one percent of older adults indicated that they engaged in no leisure time physical activity in the past month and only 36 percent ate five fruits and vegetables daily.

If Connecticut’s older adult card were analyzed by race and ethnicity and by count, other trends would emerge. For example, older African Americans (47 percent) and Latinos (45 percent) did not receive a flu vaccination in the past year. African Americans have a significant higher smoking rate (14 percent) than other racial and ethnic groups (8 percent).

Older Latinos and those with limited English abilities have the worst health profiles compared to statewide averages.

The National Report Card on Healthy Aging provides good indicators for where additional attention needs to be focused to improve the health of Connecticut's older adults in Aging Services' priorities for Federal Fiscal Years 2007-2009, which is presented in Section V.

"You are never too old to set another goal or to dream a new dream."
Les Brown

Table I**Healthy Aging – How Connecticut Scores on a National Report Card**

Health Indicator/Status	Data Year	Data (%)	Connecticut's National Rank	Grade
Physical unhealthy days (means number of days in a past month)	2001	5.1	12	N/A
Frequent mental distress	2000 - 2001	5.2	9	N/A
Oral health: Complete tooth loss	2002	15.9	5	Pass
Disability (%)	2001	27.8	9	N/A
No leisure time physical activity in past month(%)	2002	31.1	17	Fail
Eating 5 or more fruits & vegetables daily (%)	2002	36.0	8	Fail
Obesity (%)	2002	17.6	13	N/A
Current Smoking (%)	2002	9.4	16	Pass
Flu vaccine in past year (%)	2002	71.4	17	Pass
Ever had Pneumonia Shot (%)	2002	64.5	18	Pass
Mammogram in past 2 years (%)	2002	81.9	7	Pass
Ever had Sigmoidoscopy/ Colonoscopy (%)	2002	63.3	10	Pass
Up-to-date on select preventive services-men (%)	2002	42.5	10	N/A
Up-to-date on select preventive services-women(%)	2002	39.6	6	N/A
Cholesterol checked in past 5 years (%)	2001	86.7	16	Pass

Source: Center for Disease Control, 2003.

Section II

**Accomplishments and
Collaborations**

Accomplishments

Aging Services continues to work with other public and private organizations to organize and coordinate joint initiatives addressing the concerns of Connecticut's aging population. Through the Division's research and planning staff person, Aging Services has collected data on the social, economic and demographic character of the state's elderly population that serves as the catalyst for aging initiatives. Aging Services has recently embarked upon a new system for tracking client and service data associated with the National Aging Program Information System (NAPIS). Utilizing SAMS (a Synergy Technologies web-based program) Aging Services and the Agencies on Aging are working closely to develop instructional materials for all of its users – grantees and sub-grantees – in order to help ensure a smooth transition from NAPIS to SAMS.

The following provides some highlights of the many accomplishments achieved by Aging Services and its partners during the 2002-2005-plan period.

Caregiving

- With the creation of the National Family Caregiver Support Program (NFCSP) in OAA Title III-E to support informal family caregiver's providing support to elders aged 60 and over and grandparents 60 and over who raise children, Aging Services worked with the Area Agencies on Aging to develop and implement the program. Over 25,000 caregivers have received assistance through support groups, training, respite and supplemental services. Over 9,500 people have been educated on the caregiver program through various media outlets. Aging Services works jointly with the Area Agencies on Aging each year to recognize November as National Family Caregivers Month. In recognition of caregivers, several activities were conducted including, training caregivers, providing conferences designed for caregivers, giving caregiver presentations to businesses, making public service announcements regarding caregivers, holding "lunch and learn" sessions for caregivers and training DSS' staff on caregiving.
- Title III-E has funded such initiatives as the "Caring for the Caregiver" program of The Kennedy Center, Inc. of Trumbull, Connecticut in the Southwestern region. Recognized by Aging Services with the Christine M. Lewis Award for Excellence in Aging Programs, this program addresses the confusing role reversal faced by developmentally disabled children who face the dilemma of aging parents. Parents who have cared for their children their entire lives are becoming unable to provide the same level of care. Since 2003, this first of its kind program has worked with families, providing case management, counseling, information and referral, respite planning and, as the cornerstone, functional skill development. Program outcomes indicate that parents are more able to allow their sons/daughters to assume some of the caregiving responsibilities of the family and the younger members of the

family are rising to the occasion to successfully complete many new daily living tasks.

- DSS received \$463,830 from a drug settlement lawsuit as a result of a nationwide anti-trust settlement with Mylan Laboratories. The Attorney General and Commissioner of Social Services announced that the Department would fund projects with this money, which would serve individuals with Alzheimer's disease and their caregivers. The New England Cognitive Center of Hartford and Mulberry Gardens of Southington were chosen by Aging Services through a competitive RFP process with each receiving half of the money to provide innovative services for a two-year period.

The New England Cognitive Center project provides a cognitive training model, known as *Brain G.Y.M.M. (Get Your Mind Moving)*, for participants with early-stage Alzheimer's disease. This model offers a cognitive "workout" on the computer, which allows persons to actively work their minds in an attempt to reduce cognitive decline and to give persons an active role in combating the disease. The other part of the project focuses on research that evaluates the effectiveness of the training with respect to slowing the decline in memory of persons with Alzheimer's. Anecdotal reports from persons involved in this model suggest that Brain G.Y.M.M. is helpful in improving cognitive functioning, including memory. An in-depth study is examining the nature and pattern of these cognitive changes. This project is believed to be one of the first of its kind in the nation and has subsequently received funding to continue from the state legislature.

Settlement funds also provided seed money for Mulberry Gardens of Southington to develop training programs for caregivers at home and in assisted living communities. The project provided by Mulberry Gardens, an assisted living community that specializes in Alzheimer's care, includes adult day programs with flexible hours, including evenings and weekends. It also includes educational programs for service providers and caregivers, a geriatric assessment and resource center, caregiver support groups, short-term care for caregivers and a senior wellness and exercise program. Educational programs for the general public and resources for caregivers are offered through a newly developed Connecticut Center for Healthy Aging.

- Aging Services, in collaboration with the Area Agencies on Aging and the Connecticut Chapter of the Alzheimer's Association, provided information and direct services to over 2000 persons with Alzheimer's and related diseases and their families through the Connecticut Statewide Respite Care Program during the last Plan period.
- Aging Services collaborated with AARP, the Connecticut Department of Public Health and North Central Area Agency on Aging to provide *Caring for Yourself, Caring for Your Grandchildren*, a health fair, which targeted African American and Hispanic grandparents raising grandchildren. The fair

provided free blood pressure, vision and glaucoma testing as well as information regarding wellness, Medicare and volunteer programs.

- Caregiver.com, Aging Services, the Connecticut co-sponsored the “Fearless Caregiver” conference in 2004, attended by over 150 family and other caregivers.
- Aging Services collaborated with the Commission on Aging and AARP to sponsor “Family Conversations that Help Parents Stay Independent,” which provided families and caregivers an opportunity to learn how to begin conversations about long-term care and family caregiving in a comfortable setting.
- In 2005 Aging Services also collaborated with AARP to sponsor a caregivers conference for over 300 participants. The conference provided information on Medicare Rx, data from an AARP study on individual caregiver’s perspective on the role of caregiving, and suggestions for dealing with difficult caregiving situations. Approximately 20 booths provided information to help caregivers in their role, including how to access respite services and health-promotion services that assist care recipients.
- Aging Services collaborated with the Connecticut Department of Public Health in 2004 to sponsor a caregiver conference including such topics as: caring for the caregiver, finding and embracing the humor in caregiving, navigating the system, financial and legal issues for caregivers, finding community resources and the family dynamics of caregiving.
- An Aging Services staff member was appointed as a Commissioner of the City of Hartford Grandparent Commission, which is the first Commission of its kind in Connecticut that is dedicated to the concerns and issues of grandparents raising grandchildren.
- Connecticut legislators enacted provisions for a Kinship Navigator Program. This program ensures that grandparents and other relative caregivers are given the opportunity to receive information on various state services and benefits for which they may qualify, including subsidized guardianship. An additional appropriation of \$91,000 was provided to DSS to enhance the current 2-1-1 Infoline to include information about services available to grandparents.

Elder Rights and Advocacy

- Two initiatives born out of a Legal Assistance Summit held by Aging Services that came to fruition for legal and aging network advocates during this period included the formation of the Kinship Care Legal Issues Task Force and the development and funding of the Consumer Law Project for Elders.

The Kinship Care Legal Issues Task Force, coordinated by Aging Services, received a \$7,500 grant from the Partnership in Law and Aging Program of the American Bar Association to conduct a series of seminars for professionals in four different regions of the state. The series of four seminars included issues faced by kinship caregivers including state funding programs, custody options, court proceedings, and special educational and medical needs. Preparation of the grant was a collaborative effort among Aging Services, Legal Services organizations, Agencies on Aging, Probate Court, AARP, Connecticut Bar Association, Connecticut Children's Hospital, and the Connecticut Department of Children and Families. These early morning seminars were conducted over the period of a year, bringing together a new network of attorneys, court and state/community agency personnel, and social workers from each of the regions.

Connecticut Legal Services, Inc. and Aging Services brought together an impressive collaboration of legal, aging and community partners to begin operation of a Consumer Law Project for Elders, including a Hotline, with seed funding from OAA Title IV funding from AoA. Now in its second funding cycle from AoA, this project has grown beyond a hotline model, involving outreach to the homebound and vulnerable non-English speaking seniors and development of a mobile consumer law team.

- DSS, in collaboration with the Connecticut Coalition Against Domestic Violence, sponsored "Aging and Domestic Violence: Ensuring Awareness and Enhancing Expertise" for advocates, caseworkers, policy specialists, social workers, program managers and others working with the aging population. Workshops included Elder Abuse and Potential Legal Remedies, Financial Abuse and Safety Planning, and Safety Planning in Later Life. Similar regional seminars were sponsored by each of the Agencies on Aging, with Protective Services for the Elderly, Office of the Chief State's Attorney, and law enforcement personnel to relate causes, warning signs, and protocol for cases of abuse and neglect. The goal of these sessions was to improve communication throughout the community with the groups most likely to be involved in elder abuse prevention and reporting.
- DSS and aging advocates joined with the Attorney General's Office, the Office of the Chief State's Attorney, the Connecticut Police Chief's Association and People's Bank to form the Connecticut Triad Advisory Board.

Although modeled after the National Triad organization, this Board is the first in the nation to involve a private industry partner – People's Bank – as one of the "triad" of central organizations: Aging Network, Law Enforcement, and Private Industry. People's Bank employs a staff member to head its "Master's Program" and is primarily responsible for organizing Triad teams consisting of law enforcement, aging, and private business members in local towns and cities. The Board supports these formations and subsequent operation of

community Triads throughout the state using its aging and law enforcement network partners to address senior safety and rights issues. The Board has also sponsored several statewide conferences for Triad members and teams, including such topics as Financial Exploitation, Consumer Protection and Crime Prevention and Safety Issues.

Triad Advisory Board members also became a part of the Connecticut State Police “Distance Learning” initiative, providing educational presentations concerning elder issues to local and state law enforcement re-certification training to troopers through the internet. Troopers are able to keep up with training sessions at home, in the library and even in patrol cars that have computers.

- Initially through Title VII Elder Abuse funding, and now with other Title III and Senior Medicare Patrol funds from AoA, the Southwestern Connecticut Agency on Aging spearheaded the development and publication of a manual, *Law Enforcement Response to the Needs of Connecticut's Elderly*, for distribution to the Connecticut State Police Training Academy and police departments throughout the state. The Guide not only includes legal issues relating to the elderly, but also general elder issues and concerns, and resources. With the support of the Triad Advisory Board, the Guide has gone through several updates and is the basis for state training programs.
- Great strides have been made in the area of Advocacy. The Aging Services Division has a unique and important relationship with the Connecticut Elder Action Network (CEAN). Through the independent Connecticut Commission on Aging, CEAN was formed to advocate for responsible public policy for older adults in CT. CEAN members include: the CT Commission on Aging (Chair and Manager), the Connecticut Association of Area Agencies on Aging (CAAAA) and AARP-Connecticut, the Center for Medicare advocacy, Inc., Connecticut Community Care, Inc., Connecticut Association of Municipal Agents for Elders, Connecticut Coalition on Aging, Connecticut Association of Senior Center Personnel and Connecticut Legal Services. CEAN spearheads a unified advocacy campaign to bring elder issues to the forefront of policymakers' concerns. The Connecticut Association of Area Agencies on Aging (CAAAA) not only participates as a member of the Executive Committee of CEAN, but engages in its own complimentary advocacy work. Over the past five sessions, the Agency on Aging of South Central Connecticut has drafted uniform legislative position statements and background materials, drafted and disseminated weekly legislative updates throughout the state, presented testimony before legislative committees and participated on convening groups such as the Connecticut Long-Term Care Advisory Council.
- Legislation supported by aging and legal advocates to revise the Health Care Planning laws in Connecticut was recently passed by the General Assembly and signed into law by the Governor. One of the most significant aspects of the legislation was expanding the use of the planning documents from merely

a “living will” addressing issues of life support, to include expressions of general health care instructions as well.

- The Southwestern Connecticut Agency on Aging, in partnership with AARP, began administering the Connecticut Money Management Program (MMP) in the southwestern region of the state. MMP recruited, interviewed and oriented 40 new volunteers to assist older adults who have difficulty with check writing, budgeting, paying bills on time and balancing their checkbooks.

Employment

- The Division continues to annually co-sponsor the Employer Recognition Breakfast with The American Legion. The breakfast honors and celebrates Connecticut employers who have demonstrated exemplary hiring practices for participants of the federally funded Senior Community Service Employment Program (SCSEP). During this period, the breakfast recognized employers who recruit, hire and implement working environments conducive to hiring older workers.
- Aging Services provided two additional Title V trainings, one for older workers and one for staff of the state’s One-Stop Centers. Motivational training was given to older workers to expand their thinking and expectations in regards to leaving the Title V program and securing employment. The training encouraged older workers to consider non-traditional employment options and discussed coping mechanisms and skills for producing positive outcomes regardless of placement. Participants worked specifically on issues related to motivations for working, ageism, strategies for counteracting stereotypical behaviors, recognizing limitations and identifying high growth industries and occupations.
- Sensitivity training was provided for staff of the One-Stop Centers. Training focused on increasing or renewing awareness of the needs, barriers and expectations of older individuals who use One-Stop Centers. Participants worked specifically on cultural attitudes, definitions and stereotypes of elders, why older adults are working or seeking work, training older workers, responsibilities as a One Stop Center employee and pointing older workers to community resources.
- Aging Services conducted quarterly trainings for SCSEP sub-grantees and national sponsors. The training provided sub-grantees and sponsors the opportunity to discuss various employment-related issues such as SCSEP operation and performance measures, job development, supportive services for participants and updates on activities associated with the local Workforce Investment Boards, One-Stop Centers and the updates from the Connecticut Department of Labor.

- Aging Services collaborated with the Connecticut Department of Labor in planning and presenting “Connecticut Learns and Works Conference: The Adult Journey-Options for Seniors,” a forum consisting of professionals – including the Aging Services Field Representative, Workforce Investment Board, directors and case managers of nonprofit organizations, training services providers and the Department of Labor.
- Aging Services organized and hosted the first Regional SCSEP Training Conference for SCSEP grantees. The US Department of Labor provided trainers from Mathematica, The Charter Oak Group, Inc., and Agewise to conduct the two-day training. SCSEP state grantees and national SCSEP sponsors from Maine, Rhode Island, New Hampshire and Massachusetts also participated.
- Aging Services developed and submitted the 2005 State Senior Employment Coordination Plan to the US Department of Labor, which recognized it as a model to be shared with other states.

Nutrition

- Aging Services, Agency on Aging Executive Directors and grantee staff formed a Nutrition Task Force to address nutrition standards and procurement processes statewide. One of the goals of the Task Force was to establish a collaborative process for developing a model Request for Proposal for nutrition services that could be used by each of Connecticut’s five planning regions. This initiative began when an opportunity to work on a new prototype for evaluating nutrition caterers’ proposals arose in the South Central region. Aging Services sponsored a day-long session with the Area Agencies on Aging to discuss the development of a new prototype, impact of changes in the Older Americans Act that affect the existing state nutrition regulations and roles various parties have in the nutrition program. The group also addressed issues regarding the existing appeals process and the formulation of a model RFP and its procedures.

The Task Force began meeting two to three times each month in April 2003 and formed subcommittees, which worked on initial drafts of different sections of the proposal such as the application and budget, the evaluation, bid specifications and the appeal process. As a result, the Task Force published a comprehensive Elderly Nutrition Program Resource Manual encompassing all aspects of the procurement process. The new procurement process was piloted for the first time for the FFY 2006 cycle in three regions, underwent some revisions and is being piloted by the final two regions for the FFY 2007 cycle.

- In 2002 Aging Services sponsored domestic abuse training for Meals on Wheels volunteers and other aging services staff in an effort to help identify

rural elderly victims of domestic violence. Kelly Silva O'Rourke, Director of the Rural Victimization project at Florida State University School of Social Work, provided the training. Among materials received by participants was a train-the-trainer manual. The training covered: how to identify and report cases of alleged abuse, the dynamics of domestic violence, the impact of such violence on the elderly, characteristics of perpetrators and victims, the role of Meals on Wheels volunteers in identifying victims, the possible connection between nutrition and domestic violence, assessment of domestic violence in clients, assessing and overcoming rural barriers to assistance and how to access domestic violence resources. Only five other states have received this training.

- During each year of the 2002-2005 State Plan, Aging Services has celebrated National Nutrition Month. In 2003, Aging Services' nutritionist hosted a series of workshops on "Improving Wellness through Nutrition and Activity" for DSS employees. A presentation showed the dramatic reduction in cardiovascular disease and mortality risk that occurs by eating a variety of foods such as fruits, vegetables and whole grains and by eating less meat. Workshop participants were shown the benefits of moderate and vigorous exercise on health and life expectancy. A self-monitoring exercise incentive program, "The Connecticut 1000 Miler," was presented. In addition the Aging Services Unit produced a poster and table-trees that promoted good nutrition and health habits. This material was distributed throughout the state to community cafes and home-delivered meals participants.
- Aging Services participated in a Connecticut Public Television series, "*Seniors Living a Quality Life*," which focused on a variety of issues related to older adults. Included was a program on Connecticut's Elderly Nutrition Program. The Aging Services nutritionist wrote an article titled, "*Dining Options for Seniors*," which appeared in Connecticut Public Television's resource magazine that accompanied the television series.

Housing

- A new brochure was prepared to market the State's Reverse Annuity Mortgage (RAM) program for older adults. The brochure was updated with new information and designed to be more user-friendly.
- Since 1993, Aging Services has administered the HUD/RHS Congregate Housing Services Program, in partnership with HUD, Rural Housing, and two of the Area Agencies on Aging. The Program provides assistance to enable occupants of Rural Housing to maintain their independent living condition. Since the expiration of the initial five-year grant period, HUD has authorized funding to continue on an annual basis. Services include case management, meals, personal assistance, adult day care, and transportation for medical appointments, foot care and overnight companions.

- Aging Services assisted the Connecticut Legislative Program Review and Investigations Committee by providing data and opinions concerning mixed populations in senior housing. A report on this topic was submitted to the Connecticut General Assembly in December 2004.
- Two affordable assisted living communities opened during 2002-2005 State Plan period. These communities are part of a State initiative to help make assisted living services more affordable for low-and middle-income individuals.
- Aging Services funds a housing option program called Project Home Share. Three Projects in the state enable older people to avoid or delay nursing home placement and remain in their communities longer by sharing their homes for either a financial contribution or services, or both.

Long-Term Care

- The Long-Term Care Ombudsman Program partnered with various organizations to address issues of nursing home residents and those living in assisted living facilities.

In 2005, together with the Connecticut Workgroup on Challenging Behaviors, it hosted *Caring for Residents with Challenging Behaviors: What Managers Need to Know..* More than 200 administrators and managers of nursing homes and assisted living communities attended. Instructional topics focused on best practices in prevention, assessment, care planning and service delivery. Expert trainers in the behavioral health continuum provided interactive workshops designed to complement the “risk management” message discussed in the keynote address.

Partnering with AARP, Assisted Living Association, Connecticut Association of Not-for-Profit- Providers and the North Central Area Agency on Aging, the Program held a consumer forum on assisted living. The forum not only addressed the expansion of the Long-Term Care Ombudsman Program into assisted living communities, but also explained Medicare Part D and the tools available to assist in plan selection.

The Program also continued to sponsor an annual Statewide VOICES Forum, co-sponsored by DSS and the Statewide Coalition of Resident Councils (SCRC). This forum gives residents an opportunity to bring their concerns to the public policy level and to elected officials who can influence decisions pertaining to their quality of care and quality of life. With movement of the Program into assisted living communities as well, these residents are now being included. Of particular interest was the fact that panelists for the first time in 2005 publicly expressed residents’ fear of retaliation as an issue, and concern about the instability of many homes due to the frequent turnover of high-level management and staff.

- The Long-Term Care Ombudsman Program and AARP-Connecticut successfully advocated for expansion of Ombudsman services in assisted living communities. In addition to approving this expansion, the General Assembly also passed Public Act 04-158 – *An Act Concerning Services Provided by the Long-Term Care Ombudsman in Managed Residential Communities and Patients’ Bill of Rights for Residents of Nursing Homes and Chronic Disease Hospitals*, mandating the Program to develop an Assisted Living Pilot Project.
- The Connecticut Partnership for Long-Term Care, a State of Connecticut Program that helps people to plan ahead for future long-term care needs, has continued to make great strides toward increasing the numbers of long-term care insurance policyholders through its information and education program. The information program distributes free easy-to-read publications, offers one-on-one counseling with Aging Services’ staff and trained volunteers, and conducts six public forums annually to educate large groups of people. The Connecticut Office of Policy and Management conduct additional group presentations for civic groups and corporations.

During this period, the forums were held in 24 different Connecticut towns, primarily in public middle schools and libraries because of the size of the auditoriums. Each forum was co-sponsored by either the host school system or town, by the town’s adult education program, or an Agency on Aging. Co-sponsorship increased Program credibility in the local communities, reached a broader audience through extra publicity outlets and saved money on facility rental costs. Two of our forums were televised by Connecticut Public Television and broadcast several different times at all hours of the day and night. We received over 200 calls from viewers of the televised forums.

Since 1993, Aging Services has planned almost 80 public forums with more than 8,000 attendees, featuring impartial, informative presentations by Connecticut State Employees with no sales pressure from insurance agents.

- The Connecticut Long-Term Care Initiative Training and Outreach Committee was formed to begin development and implementation of statewide outreach initiatives to increase awareness on the importance for long-term care.

Health and Wellness

- Aging Services, the Connecticut Coalition to Improve End-of-Life Care and the University of Connecticut School of Social Work collaborated to hold a conference, “A Good Death: an Opportunity for Education and Advocacy on End-of-Life Issues.” The keynote speaker for the conference was Dr. Diane E. Meier, MD, FACP. Dr. Meier is Director of the Hertzberg Palliative Care Institute, Director of the Center to Advance Palliative Care, Professor of

Geriatrics and Internal Medicine. She gave an in-depth address of Palliative Care in the United States. Other presentations included: Palliative Care Models within the Community: Nursing Homes and Hospice Home Care, Developing a Palliative Care Program within a Hospital Setting, Cultural Issues Affecting the Dying Process and Poetry Readings – a Patient’s Perspective. Poems were written and read by a cancer patient. The poems depicted his experiences as they related to treatment and to daily life as the possibility of death looms. Participants evaluated the conference positively and reported that all the sessions were beneficial, but it seemed that the poetry readings were the most poignant in making palliative care issues real, personal and thought provoking. Aging Services has continued its education regarding End-of –Life issues through producing and distributing various publications and sponsoring conferences throughout the years.

- In 2004, Aging Services demonstrated its support for the U.S. Department of Health and Human Services’ campaign to close the health gap among African American and Hispanic elders by placing ads in four of the state’s major newspapers to promote “Bring a Loved One to the Doctor Day.”
- Aging Services embarked upon a joint venture with the Fair Haven Community Health Center in New Haven, Connecticut to help encourage exercise among older adults. Cardiac, diabetic and pre-diabetic patients of the Center and residents of Bella Vista Senior Housing was encouraged by physicians and nurses of Fair Haven Community Health Center to exercise more by using step counters as an incentive. The affect of exercise on various health-related parameters, including weight, blood pressure, heart rate, cholesterol and glucose, was measured. In addition, observations were made regarding the extent to which step counters improve elderly persons’ daily activity.
- Another initiative honored with the Christine M. Lewis Award for Excellence in Aging Programs was the “Senior Civil Preparedness Program” in East Hartford, Connecticut. The local housing authority partnered with such agencies as the local department of health and social services, Retired Senior Volunteers Program (RSVP), the Office of Emergency Management, and the Community Renewal Team. The two-year federal grant set in motion a plan to help seniors and residents with special needs to become better prepared for all types of disasters by organizing, mobilizing, and uniting the community to assess disaster and emergency needs in preparedness and response.
- Aging Services initiated a partnership with the University of Connecticut Center on Aging to collaborate in producing educational seminars on aging issues specifically geared toward medical and dental students. The goal is to improve the teaching of medical students on issues related to communication between health care providers and older adults and their caregivers, the ability of health professionals to appropriately assess the physical and social needs of older patients and to enhance the ability of health professionals to link their patients with appropriate community resources.

- DSS Aging and Social Work Services Divisions, in collaboration with the Alzheimer’s Association, the Capitol Region Conference of Churches, and the North Central and Western Connecticut Area Agencies on Aging began a new collaborative project intended to enhance the quality of life for people with Alzheimer’s disease and related dementias. The project, titled *REACT (Reaching and Empowering Alzheimer’s Clients Together)*, has two components. The first provides education and culturally sensitive information about Alzheimer’s disease and other dementias to populations that are traditionally underserved, including but not limited to, Latinos, West Indians and African Americans. The project is working with members of the faith-based community, through the Capitol Region Conference of Churches, to reach those who seek help through the church. Faith-based leaders are being trained on issues affecting those with memory loss including how to recognize early signs of dementia.

The second component of the REACT project provides clinical services to people with Alzheimer’s disease or other dementias and their caregivers. The clinical services team is comprised of three clinical social workers and a nurse practitioner. The team provides in-home assessments as well as case management, referral and counseling services. REACT services are provided free of charge to clients under funding by AoA. Currently, the project is providing these services in the North Central and Western regions but services will be expanded to other regions of the state in the future.

- In recognition of Older Americans Month Aging Services, during this period, honored all the state’s centenarians at a ceremony held at the State Capitol. Ten centenarians were commemorated with their life stories illustrated and displayed on posters at the entrance of the House chamber. Individuals who had lived through two millennia and three centuries had their names read into the House record by Representatives Tallarita, Villano, Floren and D’Amelio. Each member of the House of Representatives was given copies of the ten life stories, names of those who lived through two millennia and three centuries and a calendar of events recognizing Older Americans Month.
- During the 2002 – 2005 State Plan period, the Agency on Aging of South Central Connecticut annually celebrated the lives of centenarians for its region. Centenarians were invited to a luncheon and honored with certificates.
- The Southwestern Connecticut Agency on Aging annually collaborates with Fairfield School of Nursing to sponsor educational forums. In 2005 the forum’s topic was “Serving the Young Old – Plan NOW to Meet the Challenge.” The first half of the forum focused on the demographics and challenges of the baby boomers, their impact on society and services, and the importance of starting now to integrate this population into service planning. The second half described a primary prevention model that supports service planning.

Transportation

- Aging Services, Senior Resources (the Eastern regional Area Agency on Aging) and the Department of Transportation collaborated to hold a transportation forum in Eastern Connecticut. Participants included elders, service providers and policymakers. U.S. Representative Rob Simmons, State Senator Edith Prague, Assistant Secretary of Health and Human Services Administration on Aging, Josefina Carbonell, then Director of Elderly Services, Christine Lewis, and several local transportation providers gave presentations. Booths were available where local and state agencies supplied information on transportation and elderly-related services. The afternoon session gave participants an opportunity to work in small groups to identify transportation issues in Eastern Connecticut and to identify strategies for addressing them. Nearly 100 people participated in the forum.
- A transportation forum was also held in Western Connecticut that was sponsored by Aging Services, the Western Connecticut Area Agency on Aging and the Connecticut Department of Transportation. The purpose of the forum was to give transportation providers and municipal officials information about state and federal transportation resources and to provide them with an opportunity to collaborate with each other to enhance transportation services for elderly individuals. Participants broke into small groups to discuss how they might work together to avoid duplicate trips, to provide more rides and to use resources that are idle at certain times. Attendees came up with several ideas for collaboration; one group in particular set a time to meet again to further examine their proposal. This proposal was especially exciting because it was developed among providers of a region that is known for challenges in communication.
- Aging Services staff attended a conference sponsored by the Transportation Institute on PATHS (Plan for the Achievement of Transportation Coordination in Human Services) to address the future of human services transportation in Connecticut. Included was an overview of the PATHS project, an introduction to United We Ride, other Connecticut Department of Transportation initiatives, an explanation of existing systems and priorities for action. One of the goals is to enhance access to transportation for people with disabilities and to recognize that a responsive, comprehensive, coordinated community transportation system is essential for persons with disabilities, persons with low incomes and older adults who rely on such services to participate in their communities.
- Advocacy efforts were successful in promoting transportation-based legislation. Legislation initially provided \$100,000 and subsequently added an additional \$100,000 in funding to DSS to provide grants to four municipalities with populations of 25,000 or more. These grants will be used to develop and plan financially self-sustaining, community-based regional

transportation systems utilizing to the extent possible the ITN America model.

Aging Services held a transportation informational forum at the Connecticut Legislative Office Building (LOB) in response to this legislation at which the President and Executive Director of ITN America, Katherine Freund, presented on the model and how it can work in Connecticut. DSS presented on the Request for Proposal (FRP) process. Nearly 50 people attended the forum, including legislators. Connecticut Television Network (CTN) televised the forum.

Information and Assistance

- CHOICES (Connecticut's programs for Health Insurance Assistance, Outreach, Information and referral, Counseling, and Eligibility Screening) is the state's name for all information and assistance programs for the elderly. Managed and coordinated by Aging Services and operated through the Agencies on Aging, consumers have one-stop shopping for aging services through the use of one toll-free number; namely, 1-800-994-9422.
- With a grant from the Centers for Medicare and Medicaid Services (CMS), CHOICES surveyed and evaluated the quality and accuracy of information Medicare beneficiaries receive when insurance companies are contacted for information about their Medigap policies. The goal of the Medigap Demonstration Project was to improve the information that consumers receive on Medigap options so that they can make informed decisions about their health insurance and to improve Medicare beneficiaries' access to Medigap policies. To accomplish this goal, CHOICES adapted a method originally implemented by the North Carolina Department of Insurance State Health Insurance Assistance Program (SHIP). Volunteers made calls to insurance companies that market Medigap plans in Connecticut and asked a series of scripted questions regarding their policies. Answers were recorded on a standard survey form and analyzed.
- The Aging Services CHOICES coordinator and staff worked with the Southwestern Connecticut Agency on Aging and AARP to develop a plan for launching the national Benefits Outreach Project statewide in order to increase older adults' and caregivers' access to resources and services that may benefit them. Tailored for Connecticut residents, the project was initially piloted in three cities in Southwestern Connecticut where approximately 30 AARP volunteers received training on how to use the National Council on Aging's online eligibility screening tool. Volunteers were also trained to speak to groups about the tool, to assist individuals using the tool and to inform people about available programs. The statewide initiative was then launched in the North Central region; and subsequently in the remaining three regions. More than 400 people have already been connected to programs that may benefit them.

- The North Central region piloted a program to reach non-English speaking persons. The Agency on Aging collaborated with local agencies that serve Polish, Russian and Vietnamese communities. CHOICES translated its general brochure in each of these languages and trained staff at each of the community agencies serving these groups. Specific numbers were included on the brochure to ensure that persons could access staff that can speak their language. CHOICES staff then worked with these staff members to counsel persons in their native language.
- In 2005, the Agency on Aging of South Central Connecticut met with representatives from 18 community agencies to discuss the status of service provision to elderly Hispanic consumers. Following a discussion of the Agency mission and focus and history of projects designed to serve Hispanic elders, the participants brainstormed the following areas of concern: (1) Gaps in service; (2) Priority service areas; and (3) Opportunities for collaboration with community partners to alleviate gaps in high priority areas. Major areas of concern included need for: appropriate communication methods (translators, bi-lingual and now literacy materials), improved cultural competency, and enhanced trust basis. This project, now known as H.O.P.E. (Hispanic Outreach Project for Elders) meets quarterly to address identified priorities.
- Aging Services invited individuals from agencies and other organizations who work with Latino elders and their caregivers to a Forum to discuss challenges facing the community. Nearly 100 participants prioritized issues as follows: 1) lack of bilingual/bicultural staff in social service agencies and the lack of cultural sensitivity in service delivery; 2) public awareness of programs and services; 3) safe, affordable and accessible housing; 4) health care access to geriatric specialists and dental care; and 5) transportation.
- The biggest challenge for Information and Referral services during this period, however, was addressing the rollout of first the Medicare Rx prescription drug discount card and then Part D. Aging Services organized a Medicare Modernization Act Implementation Workgroup to facilitate the coordination of key players from federal, state and local agencies in the implementation of the Medicare Prescription drug benefit. The group was chaired by the CHOICES Statewide coordinator, and grew from 50 to 84 members, including representation from federal and state agencies, legal assistance, aging and disability advocates, health care, housing Resident Services Coordinators and other agencies and organizations. The group met monthly to receive timely, accurate information on MMA, identify issues and concerns facing Medicare beneficiaries and to coordinate outreach campaigns. A significant result of this group has been the partnership established with Mental Health and Disability organizations.
- CHOICES developed six Question and Answer Guides for beneficiaries, each one written for a specific population of Medicare beneficiaries and a Medicare Rx Enrollment Guide.

- CHOICES collaborated with the Center for Medicare Advocacy to develop and maintain a CHOICES website for staff, volunteers and community partners so that they could have 24 hour access to the most current updates regarding Medicare Rx, training materials followed by a self test that directs users to reading materials on questions answered incorrectly and a discussion section allowing staff, volunteers and community partners to ask questions and talk to each other about challenges and issues.
- CHOICES created a Legislative Desk Guide on the Medicare Modernization Act for Connecticut legislators and their staffs.
- Agencies on Aging increased outreach to Hispanic populations by ensuring that there was at least one bilingual staff person in each office and recruiting other volunteers from the community. They further increased the number of presentations given in Spanish and the availability of appropriate written materials. Additionally, the Agencies on Aging established 15 new counseling sites, which included local pharmacies, mental health facilities and community organizations that served hard to reach populations.
- CHOICES collaborated with the Center for Medicare Advocacy and served on the Medicare Part D Coalition that created legislation, which successfully allowed the State's Pharmaceutical Assistance program to wrap around Medicare Part D.
- Through a federal grant from CMS, DSS purchased a "Medicare Rx" mobile office bus to bring prescription drug enrollment assistance to communities around the state in an effort to provide one-on-one outreach to Medicare beneficiaries. The bus is equipped with a wheelchair lift, a satellite dish, and four computer stations, where CHOICES counselors were able to access the Medicare.gov website to review and enroll Medicare recipients in a prescription drug plan. The bus traveled to over 50 locations that would attract otherwise hard-to-reach beneficiaries. "Host" sites did the advance work with preliminary outreach and scheduling. Once there, counselors assisted almost 1,100 beneficiaries with their Part D options, provided assistance on the online Plan Finder and enrolled beneficiaries in plans. Staff was also able to access the Benefits Check-Up tool to screen beneficiaries for other programs. Plans to continue utilizing the bus for outreach, screening and other aging programs are underway.
- Aging Services updated its Services for Seniors publication, which lists services that are available to Connecticut's elders. Aging Services also worked with AARP to produce a Spanish version of the previously published Resource Guide for Grandparents Raising Grandchildren. The document was produced to meet the growing numbers of Latino kinship families.

- Aging Services published *100 Years Young – Stories of Connecticut’s Centenarians*, honoring Connecticut’s centenarians, and identifying and recognizing 100 centenarians in the state.
- The Connecticut Coalition to Improve End of Life Care and Aging Services partnered to produce an easy-to-read booklet, *Beginning the Conversation about Death, Dying and End-of-Life Care in Connecticut*. It addressed issues including advance directives, talking to health care professionals, pain management, hospice, palliative care, talking to children about death and comforting the dying.
- The Aging Services website <http://www.ct.gov/agingservices> can be accessed either through the DSS website or directly. During the 2005 period, over 97,000 people visited the Aging Services website with over 437,000 successful hits. Popular downloaded publications included the Services for Seniors, Prescription Drug Assistance and Medicare booklets and the Elderly Housing Directory.

Collaboration

Aging Services staff collaborates with numerous government agencies and national, state and regional organizations and associations when working on behalf of older adults. The Director of the State Unit on Aging as well as staff participates in these collaborative efforts.

Director’s Collaborative Efforts

The Director of the State Unit on Aging participated in the following groups during the 2002-2005 State Plan period:

National Association of State Unit on Aging (NASUA):

The State Unit on Aging is an organizational member of NASUA which is a non-profit association representing the nation’s 56 officially designated state and territorial agencies on aging. The purpose of the Association is to advance social, health, and economical policies responsive to the needs of a diverse population and to enhance the capacity of its membership to advocate for older persons, adults with disabilities and their families.

National Council on Aging (NCOA):

The State Unit on Aging is an organizational member of NCOA, which was founded in 1950 to improve the health and independence of older persons and increase their continuing contributions to communities, society, and future generations.

Connecticut Coalition on Aging (CCOA):

The State Unit on Aging is an organizational member of the Coalition, which was founded in 1974 to improve the quality of life for all elders, especially those most vulnerable. This purpose is accomplished through study, education, communication and advocacy. Coalition activities include: (1) Convening the Annual Harold Carlson Forum; an event to discuss major initiatives on Aging. This past year the topic was “Keeping Advocacy Alive” and included a panel discussion on the White House Conference on Aging (WHCOA); (2) Conducting an annual statewide survey to identify major concerns effecting older people; (3) Establishing priorities for the annual Connecticut Legislative Session based upon the survey results; (4) Working for legislation beneficial to Connecticut's elders including taking positions on bills, testifying at hearings and reporting to members on the status of legislation and needed action; and (5) Educating Members about significant issues, as well as on the legislative process and how and when to contact their legislators.

Connecticut Commission on Aging (COA):

The Commission on Aging is an independent state agency devoted to enhancing the lives of the state’s older adults and preparing for their secure future. The Commission’s role is to assist in leading public/private sector efforts to promote and improve public policy on issues including health care, long-term care, transportation, financial security, housing, employment, legal assistance and many others. The State Unit on Aging Director participates in the Commission as an ex-officio board member appointed by the Commissioner of DSS. The Commission’s mission is to advocate on behalf of elderly persons in Connecticut by regularly monitoring their status, assessing the impact of current and proposed initiatives, and conducting activities that promote the interest of these individuals. The Commission reports its findings to the Governor and the Legislature.

Connecticut Council for Persons with Disabilities (CCPWD):

The State Unit on Aging Director sits on this Council in her capacity as the Director of the Bureau of Aging, Community and Social Work Services. The Social Work Division administers two Medicaid Home and Community Based Services (HCBS) Waiver programs that are critical to the quality of life for numerous consumers with disabilities. The Council is advisory in nature to DSS. The Council provides input and direction from consumers, their family members and various advocacy groups on how to best design, advertise and provide services to this population. In this last legislative session due to the recommendations made and supported by this Council, both of these waivers were expanded to include those over the age of 64.

Connecticut Elder Action Network (CEAN):

The State Unit on Aging Director acts as an ex-officio member of this group. The goal of this working advocacy group (stakeholders throughout Connecticut) is to speak with a common voice for older adults and their advocates in developing

and pursuing a well supported short list of legislative priorities. Executive Committee members include: the Connecticut Commission on Aging, AARP-Connecticut, the Center for Medicare Advocacy, The Connecticut Association of Area Agencies on Aging, the Connecticut Coalition on Aging, The Connecticut Association of Municipal Agents for the Elderly, the Connecticut Association of Senior Center Personnel, Connecticut Community Care, Inc. and Connecticut Legal Services organizations. The three legislative priorities for this past legislative session were: (1) Medicare Part D Wrap-around; (2) Funding for a Comprehensive Long-Term Care Needs Assessment; and (3) Support for Elderly Nutrition Programs.

Long-Term Care Planning Committee (LTCPC):

The State Unit on Aging Director serves on this committee to represent the needs of the aging population from the perspective of a policymaker and provider/developer of services. The Long-Term Care Planning Committee, chaired by of the Office of Policy and Management, is composed of representatives from ten executive state agencies and the Co-Chairs and Ranking Members of the Legislative Committees of Aging, Human Services, and Public Health. The Planning Committee's responsibility is to exchange information on long-term care issues, to coordinate long-term care policy development, and to establish a statewide plan for persons of all ages in need of long-term care that is reviewed and revised every three years.

Long-Term Care Needs Assessment:

The long-term care needs assessment is an undertaking by the Connecticut General Assembly in consultation with the Commission on Aging, the Long-Term Care Advisory Council, and the Long-Term Care Planning Committee. The needs assessment will address consumer need as well as the structure and capacity of the long-term care system. Results and recommendations from the assessment will be reported by January 1, 2007.

Low Income Energy Advisory Board (LIEAB):

This is a statutorily mandated Advisory Board established to advise and assist the Office of Policy and Management and DSS in the planning, development, implementation and coordination of energy assistance related programs and policies and low-income weatherization assistance programs and policies. The Board makes recommendations to the General Assembly regarding legislation to ensure affordable access to residential heating services to low-income state residents. The State Unit Director participates in this Board as a designee of the Commissioner of DSS in her capacity as the State Unit on Aging Director as well as the Director for the Energy Assistance Program in Connecticut.

Mental Health Transformation Grant:

The Director of the State Unit on Aging participates on this "alleviating stigma and suicide prevention" workgroup under the Transformation Grant.

Connecticut's Transformation Grant exceeds \$13 million in funding, includes 15 state agencies in the planning, focuses on the New Freedom goal areas, has a life span approach and has a cross-system orientation to reduce fragmentation. The goal for the State Unit Director on this workgroup is to remind participants of the needs of the older population and to ensure that whatever is developed addresses the older consumer's reluctance to acknowledge and seek treatment for mental health issues.

Nursing Facility Transition Grant Steering Committee (NFT):

For the past three years, this project has assisted Connecticut residents with disabilities who choose to leave nursing home placements, to transition to integrated community settings appropriate for their individual support requirements and personal priorities and preference, consistent with the Americans with Disabilities Act. Known as "My Community Choices" and administered through DSS, this project has facilitated community transitions for over 115 individuals with disabilities and supported them in achieving and maintaining a quality of life that is not possible in a nursing home. The State Unit on Aging Director sits on the steering committee of this program to assist with negotiating the state bureaucracy, accessing services, ensuring that Department staff are utilized on subcommittee efforts and providing advice regarding funding and consumer issues.

Staff's Collaborative Efforts

Aging Services' staff also represents Aging Services as members of or advisors to the following organizations and committees:

Association of State and Territorial Chronic Disease Program Directors Healthy Aging Council:

The Council addresses the unique health needs of older adults, the impact of chronic disease on older adults and advocates for preventative policies and programs.

Alzheimer's Association's Education Conference Planning Committee:

This yearly conference educates over 300 caregivers and professionals on Alzheimer's disease, research and treatments, and supports for families living with the disease.

Connecticut Lifespan Respite Coalition:

This non-profit coalition is dedicated to establishing quality, coordinated respite services in Connecticut for individuals across the lifespan. This coalition is represented by a broad spectrum of state agencies, non-profit providers, caregivers and organizations that address the needs of children, adults and elders as well as the families caring for them.

Commission on Grandparents Raising Grandchildren, City of Hartford:

The first commission of its type in the state, this group meets monthly to discuss and advocate for issues pertaining to grandparents and relative caregivers raising children. Staff have an advisory role on the Commission. Members include grandparents and staff from city and area agencies.

Connecticut Association of Municipal Agents to the Elderly (CAMAEL):

DSS is responsible for assuring that each of Connecticut's 169 municipalities appoints a municipal agent for the elderly. Aging Services is responsible also for disseminating guidelines to municipalities that describe the role and duties of municipal agents. The Department is mandated to provide municipal agents with training at least once per year and to collect statewide data on the work performed by municipal agents. An annual Municipal Agent Report is produced and forwarded to municipalities, the aging network and State legislators.

Connecticut Association of Resident Services Coordinators in Housing:

This is a professional association of Resident Services Coordinators in Connecticut. It provides members with opportunities to network, to receive educational and resource development, to troubleshoot common problems that are faced with residents and to market service coordination.

Connecticut Bar Association - Elder Law Section:

The purpose of the Elder Law Section is to discuss and consider issues in elder law, promote the continuing education of CBA members and the general community, monitor and develop positions with respect to proposed legislation and regulatory action involving the elderly, and to foster relationships between attorneys and private, public, and governmental organizations dealing with the elderly.

Connecticut Coalition to Improve End-of-Life Care:

Founded in 1998 to develop a comprehensive approach to improving the care and support of dying patients and their families during the end of life and bereavement periods, the Coalition includes over 50 members including government agencies, community groups, schools of nursing, medical schools, long-term care providers, home health care and hospice providers and individuals committed to realizing the Coalition's mission. The Coalition is actively sponsored by Aging Services and the Departments of Public Health and Mental Health and Addiction Services. The mission is to improve the care of people who are dying and their families in the state and to ensure that every individual has information about and access to compassionate, quality end-of-life care. The Coalition's primary objectives in fulfilling its mission are to: (1) Identify, disseminate and promote education on end-of-life care for health care professionals, the general public and policy makers; (2) Encourage the translation of research in end-of-life care into practice; and (3) Promote effective end-of-life care through public policy.

Connecticut Department of Public Health Injury Planning Group:

The Department of Public Health, as a recipient of a core capacity grant from the Connecticut Development Commission, develops a comprehensive injury prevention plan addressing intentional and unintentional injuries across the lifespan (i.e. falls among the elderly and medication mismanagement).

Connecticut Flu Coalition:

The Coalition meets prior to flu season to discuss dissemination of vaccine for the coming flu season and to address current issues (Avian Flu) related to flu viruses.

Connecticut Medicare Beneficiary Education & Training Coalition (CMBETC):

Chaired by the CHOICES statewide coordinator, the coalition consists of partners from the regional office of the Centers for Medicare and Medicaid Services, Qualidigm (the Connecticut Peer Review Organization), First Coastal Service Options (a Medicare Part B carrier), and Empire (a Medicare Part A intermediary), and the Agencies on Aging. The Coalition meets to address issues faced by state Medicare and dual-eligible beneficiaries.

Connecticut Triad Advisory Board:

A cooperative effort of the Office of the Attorney General, State of Connecticut; the Connecticut Police Chief's Association; the Office of the Chief State's Attorney; the State's Unit on Aging; and People's Bank, the Advisory Board was formed in 2004 to provide a focal point for implementing, expanding, and operating Connecticut Triad programs. Triads are partnerships of law enforcement personnel, aging network leadership and private sector businesses that agree to work together to reduce the criminal victimization of older citizens and enhance the delivery of law enforcement services to this population.

Consumer Law Project for Elders - Advisory Board:

A collaborative partnership of state and community organizations, the Advisory Board assists Connecticut Legal Services, Inc. with the development, implementation and expansion of the statewide Consumer Law Project for Elders (CLPE). The Project provides free advice, representation and referrals to seniors 60 and older with such consumer problems as credit card debt, medical debt, abusive and harassing collection practices and identity theft.

Health Disparities Committee Subcommittee of Cancer Care Partnership:

This Subcommittee addresses the disparities of how health care is delivered to various minority populations.

Health Education Committee of the Connecticut Public Health Association:

This networking committee meets quarterly to discuss issues related to health education and communication of health related issues. Each meeting includes an educational speaker related to specific health issues across the lifespan.

Hospice Veteran Partnership of Connecticut:

Consisting of representation from approximately 50 organizations throughout the state, the Partnership is dedicated to ensuring that Connecticut veterans have quality hospice and palliative care at the time and place of need.

Insurance Subcommittee of the Connecticut Partnership for Long-Term Care:

The purpose of this Subcommittee is to discuss issues, developments and trends in long-term care insurance generally and in the Connecticut Partnership specifically. Staff also serves on ad hoc and other Subcommittees including Policy, Steering, and Partnership Advisory.

Medicare Modernization Act Workgroup (MMA Workgroup):

In order to address the issues to be faced by Medicare beneficiaries during the implementation of MMA, including the Part D Prescription Drug Benefit, the State Unit established this workgroup to bring together the many key players of concern from federal, state, and local agencies including community based organizations and advocacy groups representing populations of underserved populations. The goals of the workgroup, which includes over 80 members, include the following: (1) To introduce and explain the roles of key players in the implementation of MMA in the state; (2) To ensure that stakeholders have timely accurate information on MMA implementation efforts taking place nationally and across the state; (3) To identify issues and concerns facing Medicare beneficiaries, their family members, caregivers and the professionals who serve them and develop solutions; and (4) To coordinate messages and outreach campaigns targeting all segments of Connecticut's Medicare beneficiary population.

Muriel Banquer Gerontology Lecture Committee:

The committee representing the State Unit on Aging, Agency on Aging of South Central, the Consultation Center and Muriel Banquer was established in 2001. The annual lecture series was created to recognize the work of Muriel Banquer, an advocate for older adults and grandparents raising grandchildren. Annually, experts in the field of aging are invited to lecture on aging and current trends.

North Central Regional Leadership Advisory Council for the Northern Connecticut Chapter of the Alzheimer's Association:

This group assists the Chapter Board in assessing community needs, development, and public policy. It also advises and supports program delivery for the Alzheimer's Association.

Collaborative Efforts within the Department of Social Services

Aging Services also collaborates with a number of units within its own Department, the Connecticut Department of Social Services (DSS). The Department serves families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self reliance and independent living. In order to accomplish this mission, the Department provides a broad

range of services to the elderly, persons with disabilities, families, and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. In so doing, it administers over 90 legislatively authorized programs and one-third of the state budget. Headed by a Commissioner with two deputy commissioners for the Administration and Programs Divisions, the agency is managed from a central office but administers most of its programs through offices located in five regions throughout the state.

Administration Division:

Within the Division, Medical Administration Operations has cognizance over:

- Alternate Care Unit, which is responsible for the development, operation and monitoring of the Connecticut Home Care Program for Elders (CHCPE), operated regionally by three contractors. The CHCPE is a state and federally funded comprehensive home care program designed to enable elders who are at risk of institutionalization to receive the services they need to remain living in the community. The ACU is also responsible for administering and performing a portion of the pre-admission screening required by the Omnibus Budget Reconciliation Act (OBRA) Nursing Home reform Act; and
- The Pharmacy Program Team, which includes ConnPACE (Pharmaceutical Assistance Contract to the Elderly and Disabled), which is the state-funded pharmaceutical assistance program which helps eligible elderly and disabled individuals pay for most prescription drugs, insulin, insulin syringes and needles.

Program Division:

Within the Division the following Bureaus plan, create, implement and deliver programs, services and resources that support optimal functioning for all Department consumers/clients:

Bureau of Rehabilitation Services (BRS), which operates programs that provide opportunities for individuals with disabilities to work and live in an independent setting. The three components to BRS include: The Vocational Rehab Program which assists individuals with significant physical and mental disabilities to prepare for, obtain and maintain employment; Disability Determination Services which determines eligibility for Social Security Disability Insurance (SSDI) and Supplemental Security Insurance (SSI) Programs; and the Connecticut Tech Act Project which makes assistive technology across the lifespan more accessible to persons with disabilities living in Connecticut. This Bureau is working with Aging Services to develop a viable proposal for funding of Aging and Disability Resource Centers through AoA. It is envisioned that they will serve older adults, younger individuals with disabilities, family caregivers and persons planning for future long-term support needs as well as being a resource for health and long-term support professionals and others who provide services to older adults and to people with disabilities;

Bureau of Assistance Programs: Among other responsibilities, this Bureau is responsible for administering programs related to financial and medical support of elderly persons including the Food Stamp Program, Adult Medicaid (Aged, Blind & Disabled), State Supplement, Medicare Savings Programs (QMB, SLMB, ALMB) and Medicare Part D, and Housing Services; and

Bureau of Aging, Community and Social Work Services: Besides Aging Services, this Bureau also has cognizance over the following:

- Energy/Weatherization/Refugee Division is responsible for administration of the Refugee Assistance and Services Programs, Connecticut Energy Assistance Program (CEAP), the State Appropriated Fuel Assistance Program (SAFA), and the Low Income Weatherization Assistance Program (WAP) and ensures coordination with other energy and conservation assistance programs.
- Social Work Services Division has primary responsibility for the Conservator of Estate (COE) and Person (COPP) programs, Long-Term Care Investigations and Interventions, as well the Protective Services for the Elderly (PSE) program. PSE is designed to safeguard people 60 years and older from physical, mental and emotional abuse, neglect and abandonment and/or financial abuse and exploitation. PSE is operated regionally by social workers who respond to reports of alleged situations, investigate, and if warranted, devise a plan of care aimed at assuring an elder safety while preserving the person's right of self-determination. Staff may help the person remain in the living situation he or she prefers, safeguard legal rights, prevent bodily injury or harm, determine service needs and then mobilize resources to provide necessary services.

Collaborative Efforts with Other State Agencies

Collaborations with other state agencies include the following:

Department of Mental Health and Addiction Services (DMHAS) whose mission is to improve the quality of life of the people of Connecticut by providing an integrated network of comprehensive, effective and efficient mental health & addiction services that foster self-sufficiency, dignity and respect. This Department's primary focus is centered on the idea of "recovery oriented services in the areas of mental health treatment and substance abuse". Mandated to serve adults over the age of 18 with psychiatric and/or substance abuse issues who do not have the financial means to seek help on their own, DMHAS seeks to serve all of Connecticut's adult as well as its aging population through programs and grant initiatives. Through the Department's Senior Outreach and Senior Service Program older adults with substance abuse problems are targeted for services either through direct contact or through the mediation/referral of other agencies that serve senior populations. Through a five-year \$15 million federal Mental Health Transformation State Incentive Grant DMHAS is increasing its scope of senior services that build upon and further

develop a recovery-oriented system of mental health care across the lifespan, providing an array of accessible services and recovery supports from which they will be able to choose to address their particular mental health condition or combination of conditions. DMHAS will also be collaborating with Hartford area service providers focusing on the identification of effective screening/ assessment/ referral/ and treatment services for older adults.

Department of Labor (DOL) focuses on the protection and the promotion of the interests of Connecticut workers. The DOL is committed to achieving this by assisting workers and employers in becoming competitive in the global economy and taking a comprehensive approach to meeting the needs of workers, employers and other agencies that serve them. DOL and DSS have had a long history in collaboration in serving the needs of Connecticut's older workers as DOL has been key in meeting the training needs of the clients participating in the federal Title V Senior Community Service Employment Program (SCSEP) through the federal Workforce Investment Act (WIA). The DOL has continued to be very supportive and aggressive in maintaining effective communication and integration between WIA and SCSEP. DOL staff participate quarterly in SCSEP meetings and provide updates concerning DOL policies and procedures in relation to the Workforce Investment Boards (WIB). Also, both agencies are members of the Connecticut Employment and Training Commission (CETC) that is responsible for establishing and promoting workforce policy and are part of a newly expanded JOBS Cabinet consisting of the state agencies that make up the core of Connecticut's workforce development, educational and economic development system.

Department of Public Health (DPH) works to protect the health and safety of Connecticut residents. DPH is responsible for monitoring the needs of Connecticut's frail elder nursing home population and regulating Connecticut's nursing homes, and this Department's Injury Prevention Program provides funding to local health departments to address the risk factors for falls among older adults. Such strategies have included home safety assessments to identify and correct injury hazards, provision of safety supplies, fall prevention seminars, medication safety reviews and service provider training. DPH also addresses elder needs through the Northeast Injury Prevention Network and the Connecticut Arthritis Action Plan: A Public Health Strategy. A key player in addressing the health care workforce shortage, specifically as it is related to home health workers and certified nurse's aides, DPH will be monitoring the Connecticut Nursing Incentive Program established in 2005 under Public Act 04-253 and administered by the Department of Higher Education.

Department of Mental Retardation (DMR) is committed to providing Connecticut citizens with flexible and person directed supports through self-determination initiatives, and services that enable all people with mental retardation to participate fully in Connecticut life. DMR takes a collaborative approach through a decision-making process that is inclusive of diverse groups. Some of these initiatives include: the Self-Determination Initiative, Core Indicators Project,

Waiting List Focus Team, and the Advisory Commission on Services and supports for persons with disabilities. DMR and DSS were awarded an “Individual and Family Support Medicaid Waiver” by the Centers for Medicare and Medicaid Services. This waiver strengthens supports to families.

Department of Veteran’s Affairs (DVA) is primarily responsible for the following aspects of veteran services in Connecticut: 3 state veterans cemeteries; the Veteran’s Home Health Care Facility, which provides long-term care to veterans with chronic and disabling medical conditions including, but not limited to heart and lung disease, stroke, Parkinson’s, Alzheimer’s and other dementias, Hospice care, Palliative care and Respite care; The Veterans Recovery Center (VRC), which provides a variety of substance abuse services to eligible veterans who have chosen to be clean and sober and whose long term desire is to reintegrate back into the community; and information concerning a variety of other general veteran matters. A subdivision of this Department is the Office of Advocacy and Assistance, which provides advice, and assistance to the state’s 339,000 veterans and their dependents in obtaining comprehensive rights, benefits and privileges to which they may be entitled under law. Aging Services has collaborated with CVA in providing information and assistance at Veteran’s Stand Downs and serving on the Hospice Veteran Partnership of Connecticut and will be taking a more active role with the Office of Advocacy and Assistance in providing benefit screening.

“Grow old with me! The best is yet to be, the last of life, for which the first was made.” Robert Browning

Section III

Developing Coordinated Service Systems

Local Level: Area Agencies on Aging:

At the federal level, the OAA provides the legislative context for Area Agencies on Aging to carry out their systems development role. Systems development is defined as the set of activities and processes used by the Area Agency and other organizations to envision, plan, manage, coordinate, integrate, evaluate, refine and improve the quality of a community's constellation of services. Systems development seeks to address four major problems associated with delivering community services. These problems include:

- Difficulty in accessing or using services, especially if multiple services are required;
- Fragmentation of services;
- Duplication of services; and
- Gaps in services.

Systems development does not take place in a vacuum. Rather, it is created within the context of laws, regulations, organizational arrangements and expectations created and shaped at the federal, state and local levels. Four sections of the federal OAA outline how Area Agencies on Aging are to carry out their systems development role:

1. Part A of Title III, Grants for State and Community Programs on Aging, identifies the ultimate goal of Area Agencies' systems development efforts to provide an opportunity for older persons to remain independent in their homes and community as long as possible;
2. The definition section of Title III Part A outlines the purpose of a comprehensive and coordinated system, making it clear that systems development efforts are to extend beyond Title III funded services to include all supportive services provided by both public and private entities. This section also emphasizes the need for efficiency in the organization of the service delivery system;
3. The Rules and Regulations Subpart C, "Area Agency Responsibilities" set forth the mission of the Area Agencies on Aging and mandate them to carry out a proactive leadership role in system development in each community in the PSA; and
4. Subpart C also describes the characteristics of the comprehensive and coordinated system, processes to be used and criteria for evaluating the performance of the system.

Barriers to systems development are numerous. Programs are often categorical in terms of their financing, eligibility criteria and administrative requirements, making coordination quite challenging. Agencies can have different allegiances and values, which guide their approaches to serving older adults. In short, basic differences in operations and philosophy may make organizations feel threatened or challenged by collaborative efforts and may make it difficult to create a shared "vision" of what a system of care should accomplish.

Area Agencies on Aging often do not have the authority to “require” other agencies or organizations to participate in their systems of development efforts. Other organizations in the system of care may not even be aware of the Area Agency’s system development role.

Even if local agencies do conceptually have a shared vision, systems development requires a commitment of time and resources from all parties involved. In times of budget and staffing reductions, allocating resources for these efforts can be even more challenging. Strong leadership in times of fiscal austerity can also create the impetus for collaborating and sharing resources to help compensate, to some degree, for reduced funding.

Finally, systems development is an ongoing process that is never complete. Simply having services, structures and processes in place does not guarantee that a system will work smoothly. Dedicated leadership, careful listening and observation, and active hands-on management are needed to help ensure that the system continues to be responsive to the needs of older persons and their families.

While the obstacles noted above are not insurmountable, they underscore the challenges involved in the Area Agency’s system development mandate and the need for careful planning efforts.

State Level: Connecticut State Unit on Aging:

Just as the OAA provides the overarching mandate for Area Agencies on Aging to become actively engaged in systems development efforts, state-level policies and structures also define the Area Agency’s systems development role. Particularly important are policies, which determine legislative mandates for systems development.

The OAA makes it clear that as the State Unit on Aging, Aging Services is expected to play an important role in helping Area Agencies on Aging and their local communities develop systems of care. As with Area Agencies on Aging, Aging Services often does not have the authority to “require” other agencies or organizations to participate in systems development efforts. Needed services may not be under the State Unit’s or the local Agency on Aging’s administrative or budgetary authority.

Aging Services assists Area Agencies on Aging and communities by:

1. Working with other State departments and agencies, Area Agencies on Aging and other local entities to define roles and responsibilities at both the State and local levels;
2. Providing Area Plan guidance that encourages and supports systems development;

3. Working to remove State-level barriers. SUA works with sister agencies to resolve implementation issues;
4. Developing common program standards including services unit definition and reporting requirements;
5. Fostering the development and implementation of common intake, screening and assessment instruments;
6. Actively supporting local efforts;
7. Helping to improve access to information assistance to individuals and organizations at the local level as needed;
8. Providing training and technical assistance to individuals and organizations at the local level as needed;
9. Sharing promising practices; and
10. Refining data collection and reporting to improve the information available to decision makers in developing policies that effect older adults.

“A man ninety years old was asked to what he attributed to his longevity. I reckon, he said, with a twinkle in this eye, it is because most nights I went to bed and slept when I should have sat up and worried.” Dorothea Kent

Section IV

**Key Issues and
Promising Practices**

This 2007 –2009 State Plan was developed with input gathered from local planning processes. The Area Agencies on Aging followed a planning process for coordinated systems development as they prepared their area plans. The Aging Services Division replicated this process to the greatest extent possible to reflect and support local and State level efforts. The Agencies' input was collected through each agency's regional needs assessment and area plans. (See Appendix ... for the Area Agencies on Aging Needs Assessment Survey.)

Four critical issues regarding current service needs, unmet needs and projected needs emerged from these sources. They are:

- Access to needed services (Outreach and Information)
- Maintaining and Improving Mental and Physical Health
- Financial Security
- Transportation

Access to Needed Services: (AoA Priority #1 and #3)

As Connecticut prepares for a rapid growth in its aging population, the State must identify, test and implement effective means of providing outreach and information to a more diverse and rapidly growing number of older adults, family caregivers, and multidisciplinary professionals (as well as young people exploring career options) who seek:

- Information on healthy aging and preventive health options;
- Help with understanding and finding the full range of in-home and community options available to support continued independence and quality of life; and
- Training and professional growth opportunities for those serving older and disabled adults.

AAA Findings:

During the next four years of the Area Plans, the agencies on aging plan to increase the number of older people and their caregivers who have access to an integrated array of health and social supports. Connecticut's Area Agencies on Aging' needs assessments indicated that older adults do not know how to access available services and that information on what services exist and how to access them is one of the most pressing needs.

Strategies the Area Agencies on Aging identified in their area plans to increase outreach and education in their communities include:

- Translate materials, develop cultural competence of staff through in-service training, and make presentations to the community in partnership with representatives of people-of-color communities;
- Explore the feasibility of linking with Infoline's 2-1-1 service to permit direct transfer of calls from Infoline staff to the Agency on Aging;

- Seek funding for bulk printing of “A Senior’s and Caregiver’s Guide to Services, Programs and Benefits,” and in conjunction with the Connecticut Medical Association, disseminate to doctors’ offices throughout the South Central region;
- Expand the agency’s cable TV shows to cover the region’s 41 towns and continue the live call in radio show in the Western region;
- Expand the agency’s website by adding a caregiver’s corner and health related information;
- Develop outreach programming in the North Central region and multi-lingual materials targeted to non-English speaking older adults, specifically Spanish, Russian, Polish, and Vietnamese elders;
- Develop partnerships with at least one local service provider to identify and address the special needs of immigrants and refugee older adults in the North Central region;
- Continue to be an active member of regional and local Senior Services Councils to relay information on aging issues and services;
- Continue to work closely with libraries in order to enhance their ability to disseminate information on aging issues and services;
- Expand the scope of the agency’s Women of Color Network to no fewer than three representatives from each of the agency’s sub-regions;
- Network with statewide advocacy groups such as Health Care for All, the Connecticut Coalition on Aging, Inc., Connecticut Concerned Citizens on Nursing Home Reform; and
- Sponsor a *Feeling Fabulous!* program for older women on topics such as personal finances, health, mental health, elder abuse and healthy relationships.

Maintaining and Improving Mental and Physical Health: (AoA Priority #2)

During the four years of the Area Plans, the agencies on aging plan to increase the number of older people who stay active and healthy. In recent decades, there has been a growing appreciation for the fact that while old age may be a time of greater risk for declines in health and daily functions, it need not inevitably be associated with such negative outcomes. Indeed, there has been an increased awareness that considerable numbers of older adults continue to enjoy relatively high levels of physical and cognitive functioning and remain actively engaged in various life pursuits well into their 70’s, 80’s and even 90’s. Although considerable and needed attention is devoted to health and functioning problems that are most commonly experienced by older adults, aging is not uniformly associated with significant disease and disability.

Health promotion activities consisting of exercise, nutritional guidance and regular preventive physician visits must be greatly expanded if they are to have any meaningful and long term positive impact upon both health maintenance and

cost containment of health care. Policymakers need to consider ways to invest in disease prevention as a way to promote wellness in our older population.

AAA Findings:

- Increased health insurance premiums, elimination/reduction of retiree health plan benefits, loss of managed care plans, limited or no dental coverage and increased Medicare premiums and co-payments are contributing to a health care crisis;
- Many older and disabled adults cannot afford needed prescription drugs;
- More education is needed so older adults understand what services Medicare covers and the available options that exist when Medicare does not cover a service;
- Congregate nutrition program needs to be redesigned to better meet changing needs;
- Respite care was identified as important to older adults and their families in preventing the health problems associated with caregiver responsibilities;
- More education on medication management for older and disabled adults is needed; and
- A personal safety program should be developed and implemented with particular emphasis on fall prevention.

Strategies the Area Agencies on Aging identified in area plans to increase health access, wellness, and chronic disease self management in their communities include:

- Collaborate with staff from an area hospital, including an emergency department nurse, social worker and discharge planner, to sponsor a forum for older women on advocating for oneself in the hospital setting. The forum plans to address the following topics: 1) how to prepare to enter the hospital; 2) the admission process and insurance issues; and 3) patients' rights such as treatment options, advance directives and discharge;
- Promote food security through food stamp outreach and dissemination of the Connecticut Food Bank's guide to food pantries and soup kitchens through the Aging Resource Center and in collaboration with End Hunger Connecticut;
- Develop partnerships with at least three local organizations, including but not limited to senior centers, to develop and/or enhance health promotion activities and programs, related to topics, including but not limited to medication management, injury and fall prevention and physical activity;
- Co-sponsor educational seminars, health fairs, forums or conferences on health related issues for older adults, their families, and/or service providers;

- Establish a partnership with grocery stores such as Stop & Shop, Shaw's and the Elderly Nutrition programs to develop a healthy cooking/eating series and demonstration for older adults, especially men;
- Expand the state-funded health/dental screening/disease prevention program in the 41 towns with a special focus on low- to moderate-income housing communities in the Western region;
- Partner with the Mental Health Action Team to produce a community education program for older adults, family members and caregivers on understanding and addressing the stigmas attached to mental illness, treatment options and resources for older adults diagnosed with mental illness;
- Disseminate five in-briefs to 2,500 older adults on health factors such as nutrition, prevention measures, health screenings, mental health, oral health, disability, poor health habits (such as smoking and overeating) and vaccinations; and
- Promote the usage of programs such as AoA's "You Can!" campaign on healthy aging to entities such as senior centers and municipal agents.

Financial Security:

Today, the notion of living on "fixed" or "guaranteed" retirement income is becoming rapidly obsolete, as many older adults are finding that an increasing portion of their income and assets are dependent upon choices they made in the market economy. There are three important sources of retirement income; namely Social Security, pensions, and public assistance for older adults with low-incomes.

About 92 percent of Connecticut's older adults age 65 and older receive Social Security benefits. According to the Social Security Administration (SS;2001a), older adults receive 38 percent of their total income from Social Security, making it the largest source of income for this population. Today, there is greater use of defined -contribution plans, which have several potential implications for both older adults and baby boomers. These plans are typically portable, but workers often must decide how much and when to contribute. Delaying participation can substantially reduce retirement benefits, and because retirees and workers must choose how to invest the funds, they bear an investment risk. For older women, an important issue involves their rights to benefits from their husband's pension in the event of divorce or his death. Only 26 percent of older adults who are eligible for federally funded food stamps receive this benefit; yet malnutrition remains a serious problem for many elders and it can lead to far greater health issues.

Many older adults also live on low and fixed incomes. Members of minority groups, especially African Americans and Hispanics, may have fewer options to maintain or improve their standard of living. According to the 2000 U.S. Census,

nearly 26,700 older adults in Connecticut live at or below the federal poverty level.

AAA Findings:

- Elderly women are more than twice as likely as their male counterparts to live in poverty. Of elderly persons living below the poverty level, 75 percent are women;
- Social isolation has been associated with low income;
- Older women are more likely to end up in nursing homes;
- Barriers to preventive health care, lack of insurance coverage, poor knowledge of risk factors and inaccessibility to health care can lead to a high incidence of mortality from breast cancer, especially among African-American women.(National Cancer Information Center: Austin, Texas); and
- Without the necessary insurance or financial means, older women over time may face increasing limitations in their daily living activities and require expensive forms of long-term care.
- Middle-aged individuals need to become aware of the importance of planning ahead for their long-term care.

Strategies that the Area Agencies on Aging have identified in their area plans to promote financial independence and to safeguard the economic security of vulnerable older adults include:

- Administer the Money Management Program in affiliation with AARP-Connecticut in the Southwestern region;
- Support lifetime learning initiatives;
- Offer access to information on financial assistance programs through the NCOA BenefitsCheckUp website to diverse populations in collaboration with AARP-Connecticut and the National Council on Aging (NCOA);
- Collaborate with staff of Connecticut Jobs Corps to acquaint them with the special concerns of older women who are transitioning back into the work place, and to urge the Job Corps to target these women to promote greater placement in the workplace;
- Develop a packet of entitlement information (e.g. on Food Stamps, Medicaid) through the Aging Resource Center that is targeted to older female residents of low-income housing and participants of the Senior Companion and Foster Grandparents Programs and provide follow-up assistance in completion of entitlement applications;
- Sponsor an in-service training on agency programs and entitlement for home care providers that serve predominantly African American and Hispanic elders;
- Sponsor an educational program for Human Resource professionals on services available for working caregivers; and
- Sponsor educational sessions for social service and health care providers and community services staff on the needs of older adults in

greatest economic and social needs to access the health and social supports offered by these entities.

Transportation: (AoA Priority #2)

Reliable and dependable transportation is critical to helping community members remain healthy, productive individuals. Older adults rely on the automobile as their primary mode of transportation. More than 80 percent of Connecticut's adults' age 65 and older have active driver's licenses. Many know, however, that at some point changes in vision, hearing, reaction time and other related conditions or illnesses could affect their ability to safely drive. Transportation is important in helping many older adults make crucial connections, but in many locations especially in rural regions it is often lacking or even nonexistent.

AAA Findings:

- There is a need for affordable transportation, giving particular attention to low-income and older adults of color;
- There is a need for assisted (escort) transportation as well as a need to collaborate with churches and other organizations that have available vehicles;
- There is fragmentation in the current transportation system which encourages transportation entities to work independently rather than collaboratively;
- Transportation should be tailored to fit personal needs and to be reliable, flexible, timely and local; and
- There is a lack of weekend and inter-regional transportation as well as limited social transportation.

Strategies that the Area Agencies on Aging identified in their area plans to address transportation include:

- Support and advocate for the development of effective transportation systems that meet the special needs of older adults and adults with disabilities;
- Continue to support the Transportation Coalition in the Eastern Region and conduct an educational program on best practices, government funding, and local resources;
- Research the potential for shared transportation services;
- Continue to update the Transportation Resource Guide;
- Explore the concept of a discounted on call transportation service, day or night; and
- Support the development and expansion of volunteer transportation services to supplement existing formal transportation systems.

"The quality, not the longevity, of one's life is what is important."

Martin Luther King

Section V

**Priorities for
Federal Fiscal Years
2007 to 2009**

As the State Unit on Aging the Aging Services Division plans to build upon issues raised in the Agencies on Aging's needs assessment, Aging Services' forums, feedback from older adults, persons with disabilities, caregivers and providers to respond to the needs, challenges and opportunities presented by Connecticut's growing population of older adults and adults with disabilities by focusing its activities and resources in five key areas during Federal Fiscal Years 2007-2009, namely:

- Ensure access to services through effective education and outreach;
- Promote optimal physical, mental and social well-being among older adults and their informal caregivers;
- Protect the quality of life and rights of elders through education, legal services and coordination with law enforcement;
- Promote senior-friendly communities; and
- Strengthen quality and accountability in Aging Services' programs.

Following approval of the Plan, Aging Services will undertake the process of establishing a timeline for the accomplishment of Plan Objectives over the three-year Plan period.

As noted in Section III, the Older Americans Act broadly charges the State Unit on Aging and Area Agencies on Aging to advocate on behalf of older adults for services they may need, even if the majority of the funding for those services or programs are not under either entity's administrative or funding authority. Examples include physical health, mental health, housing, and transportation services.

Topic A: Ensure Access to Services through Effective Education and Outreach (AoA Priority #1)

Current and Future Concerns:

- ✓ A more effective outreach, information and assistance infrastructure must be developed to reach a growing and more diverse population;
- ✓ The process individuals go through for service screening, assessment and intake must be streamlined so that customers do not have to "jump through so many hoops," and services are received in a timely manner;
- ✓ Responding to the needs of a very diverse older adult population requires additional expertise and resources; and
- ✓ Federal grants help test innovations and reforms, but they are not typically designed to sustain or expand these efforts for the long term.

Objective 1: Improve the Information and Assistance (I&A) system statewide to ensure that older adults, family caregivers and service providers have easy access to needed information and services.

Background:

Traditionally, older persons and adults with disabilities turn to family, friends, doctors and clergy when they need advice. Today, older persons and their caregivers face a complicated array of choices and decisions about their health care, pensions, insurance, housing, transportation, financial management and long-term care needs. Depending upon individual circumstances, needed assistance and support can be as simple as providing factual information or be more involved by providing advocacy and interventions on behalf of individuals who are frail and vulnerable.

Based on the 2000 U.S. Census, Connecticut ranks twelfth among states in the nation having the largest percentage of residents age 60 and older; it ranks tenth for having the largest percentage of residents who are at least 75 years of age. Connecticut is both urban and suburban, yet it is also very rural. In the coming three years, we must find effective ways to better reach the state's culturally diverse population who are in need of aging and disability services (This was confirmed by participants in the Latino Forum).

Connecticut is one of seven states that do not have an Aging and Disability Resource Center (ADRC). The state plans to explore new strategies to implement an ADRC in 2007 to expand information and assistance services, provide outreach to diverse populations and streamline the translation from information and assistance to program referral, assessment and intake.

Aging Services has an AoA Alzheimer's Demonstration grant, which focuses on increasing education on Alzheimer's disease and related disorders to family caregivers and links Hispanic and Haitian families to needed services. This grant provides the state with valuable information for addressing the information and assistance needs of diverse and often hard-to-reach populations.

Aging Services also funds the National Family Caregiver Support Program, in which two of the five major program criteria are Information (public education) and Assistance (one-on-one counseling) to caregivers. In addition, Connecticut's Statewide Respite Care Program allocates funding to the Connecticut Chapter of the Alzheimer's Association for outreach and education on Alzheimer's disease.

The Medicare Modernization Act (MMA) of 2003 has greatly expanded the responsibilities of the State Health Insurance Program (SHIP), especially during the implementation of Medicare Part D. In Connecticut, the SHIP program is called CHOICES; it is made up of staff and volunteers at the Area Agency on Aging level. The federal Centers for Medicare and

Medicaid Services (CMS) have turned to SHIP as a key partner in providing objective, fact-based counseling and information to Medicare beneficiaries, the dual eligible population (those eligible for both Medicare and Medicaid), and other hard-to-reach and low-income populations. Given CHOICES' additional role in targeting services to these groups and Connecticut's growing diversity, this expanded role demonstrates a major shift in responsibility and presents complex challenges.

The state of Connecticut plans to apply for the competitive grant "Money Follows the Person" through the Center for Medicare & Medicaid Services (CMS) to help shift Medicaid from its historical emphasis on institutional long-term services to a system that offers more choices for seniors and persons with disabilities. With this program, persons who need long term care and prefer to live in their own home and communities can do so. The state unit on aging is under the Department of Social Services, which is the state Medicaid agency that will apply for the grant. The state unit on aging will participate in the grant writing and decision making activities and also the implementation efforts.

In June 2006, Connecticut received \$21.9 million from the federal government to build a 125-bed health care facility for frail and elderly veterans. One of the most visible of all Veteran Administration benefits is health care. Long-term care is a critical issue for Connecticut's veterans. More than 28, 000 Connecticut veterans age 65 years and older received medical care from the VA in 2005.

Since 2004, DSS has been working with the Community Action Agencies and 2-1-1 Infoline to implement a service delivery model known as Human Services Infrastructure (HSI). The goal is to establish a social service system where customers receive help whether at point of contact or by referral. It is the intent of the system to break down "silos" and to maintain a policy that there is "*no wrong door*" for a customer to receive needed assistance. The customer completes a universal intake that can be transferred to all DSS programs, thus eliminating the need to complete additional intakes. HSI is in its infancy stage, but it is the aim of the Department to partner with the Area Agencies on Aging and other providers in creating a truly "seamless" system of care for Connecticut's families.

Strategies to Accomplish Objective 1:

- √ Incorporate *Vision 2010, the Alliance of Information and Referral Systems (AIRS) Standards*, and the related self-assessment guide into the Area Agency on Aging's contract for Title IIIB programs;
- Ensure that all Area Agencies on Aging receive directions on AIRS standards and that Aging Services includes these

standards in the 2007-2009 Area Agencies on Aging's information and assistance service monitoring process; and

- Work with Area Agencies on Aging to ensure that CHOICES staff are qualified and experienced.
- √ Expand the Aging Services partnership with Infoline, 2-1-1 central information telephone system to ensure that the needs of older adults, persons with disabilities and caregivers are adequately addressed;
- √ Meet with the Department of Veteran's Affairs to discuss how Aging Services can partner with them in serving veterans and their families;
- √ Explore the concept of establishing a partnership between Aging Services, Infoline, Area Agencies on Aging, Independent Living Centers, Community Action Agencies and other state agencies to develop an Aging and Disability Resource Center;
- √ Encourage Aging Services-funded contractors to recruit and employ culturally diverse staff;
- √ Facilitate diversity training for Aging Services-funded contractors' staff and external stakeholders to promote cultural competence and sensitivity in providing services so that ethnic and cultural differences are not barriers to accessing services;
- √ Increase efforts to educate older adults about property tax relief programs, home equity conversion plans, retirement planning, long-term care insurance and other health care issues;
- √ Develop brochures and promotional materials to be available to the public at fairs, training sessions and workshops (both regional and statewide);
- √ Update the "*Aging Services Manual*," which is a resource guide for professionals with information on available aging-related services in the state;
- √ Update "*Services for Seniors*," which is a resource guide for older adults on available services;
- √ Collaborate with the Assistance Program Bureau and End Hunger Connecticut to develop an outreach program to increase enrollment among eligible older adults in the Food Stamp Program during the first fiscal year of the plan;
- √ Expand the use of the DSS Medicare Part D bus, to include eligibility workers who travel on the bus throughout Connecticut to screen older adults and adults with disabilities for services and to access BenefitCheckUp to discover additional resources;
- √ Develop a training plan for a participant of the Senior Community Services Employment Program that trains the person to answer the Aging Services' toll-free line and provide information and referral to Aging Services consumers so that the participant can develop skills to be placed in unsubsidized employment;
- √ Create an outreach staff position at Aging Services with responsibilities for disseminating information and providing support services to senior

- centers, municipal agents, Resident Services Coordinators and the aging network;
- ✓ Expand the List Serve, an e-mail list of aging network providers, to include more aging providers, local commissions on aging as well as providers from the disabilities network;
 - ✓ Redesign the List Serve so that e-mails can be forwarded to specific groups;
 - ✓ Increase the use of the List Serve to inform providers of new and updated information regarding aging-related services and programs;
 - ✓ Redesign the Aging Services website to make it easy to navigate, easy to read and to include more information and links to aging and disability programs and services; and
 - ✓ Educate grandparents raising grandchildren and the providers who serve them about the newly implemented Kinship Navigator Program.

Objective 2: Expand the availability of diverse services to family caregivers so that critical needs are addressed in a comprehensive manner.
(AoA Priority #3)

Background:

The National Family Caregiver Support Program (NFCSP) is a relatively new OAA program. Aging Services is seeking to encourage the Area Agencies on Aging to continue to use this funding in the most effective manner to provide comprehensive support services to families in need. Aging Services must make every effort to reach diverse populations seeking services, such as those who are in civil unions, grandparents raising grandchildren and individuals with disabilities, while still placing special emphasis on those who are in the greatest social and economic need.

Strategies To Accomplish Objective 2:

- ✓ Offer in-service training to Area Agencies on Aging on State Unit on Aging Programs such as the Connecticut Homecare Program for Elders, PCA Waiver, ABI Waiver, Medicaid for the Employed Disabled, other Older Americans Act Services, state-funded programs and other related programs;
- ✓ Coordinate with the Area Agencies on Aging to ensure that caregivers' needs are addressed throughout the continuum of the caregiving experience;
- ✓ Collaborate with the Area Agencies on Aging to expand opportunities for caregivers to utilize "Loan Closets" in their communities which help individuals cope with the added expense of acquiring adaptive equipment such as wheelchairs, walkers, lightweight reachers/grabbers, canes, crutches, shower benches and grab bars. Adults age 60

- and older and caregivers of persons over 60 can borrow equipment for their personal use at home for a period of time;
- ✓ Identify and disseminate promising practices in reaching and serving often hard-to-reach populations, who may not readily identify as “family caregivers,” may not speak English, may be low income and may reside in rural, isolated areas of the state;
 - ✓ Collaborate with the Area Agencies on Aging to utilize the Synergy system to share information to meet the needs of program clients;
 - ✓ Revive the Grandparents As Parents Network and appoint an Aging Services staff person as the coordinator; and
 - ✓ Encourage the replication of the innovative Kennedy Center caregiving program, which provides skills to adult children with disabilities to help them care for their aging parents.

Objective 3: Provide additional Older Americans Act services by developing and implementing a cost-sharing policy for programs not prohibited by federal law.

Background:

The Older Americans Act currently requires that all participants be given the opportunity to contribute toward the cost of services they receive. The purpose of cost sharing is to expand the availability of services by soliciting contributions from service recipients, based on the ability to pay. Revenues collected from the served participants are retained by appropriate regional and/or local providers and used to increase services.

Cost sharing is not allowed for Information and Assistance, Outreach, Case Management, Ombudsman, Elder Abuse Prevention, Legal Assistance or Congregate and Home-Delivered Meals programs.

Strategies to Accomplish Objective 3:

- ✓ Solicit views of older individuals, Area Agencies on Aging, providers and other stakeholders on the implementation of cost sharing in the state;
 - ✓ Establish a sliding scale, based solely on individual income and the cost of delivering services;
 - ✓ Develop plans that are designed to ensure that program participation among older, low-income individuals receiving services do not decrease with the implementation of cost sharing;
 - ✓ Develop simple written materials in various languages to communicate the cost-sharing provisions;
 - ✓ Develop a process to allow Area Agencies on Aging to request a waiver from the state’s cost-sharing policies;
- 3 Expand service provision to private pay and non-elderly clients

Topic B:
**Promote Optimal Physical, Mental and Social Well-being
Among Older Adults and Their Informal Caregivers (AoA
Priority #2)**

Current and Future Concerns:

- ✓ Significant health disparities exist for older ethnic adults;
- ✓ Good health in later years is closely related to educational achievement, income status and access to health care earlier in life. The gap between the “have’s” and the “have not’s” in Connecticut is growing;
- ✓ With a rapidly aging society, effective treatment for chronic conditions has become more critical given its significant impact on quality of life and health care expenditures;
- ✓ Many adults who have disabilities have little or no insurance coverage that pays for needed prescription drugs, dental care, or mental health services; and
- ✓ Health advances and health care coverage is becoming more and more complicated while overall health care literacy is not improving.

Objective 4: Facilitate health promotion and disease prevention services for older adults. (AoA Priority #2)

Background:

Aging Services has increasingly sought to incorporate health promotion and disease prevention education throughout its programs. Aging Services receives approximately \$300,000 in state dollars to fund four elderly health-screening programs statewide. Providers of health-screening services target low-income elders and older adults of color.

Title IIID of the Older Americans Act provides a small amount of funding for a wide range of health promotion and disease prevention activities. Aging Services has begun to look at health promotion programs that keep elders at home and in their community. Programs such as exercise programs, nutrition counseling and education for individuals and primary caregivers, and intergenerational programs. There is a need for programs focusing on chronic conditions (including osteoporosis, arthritis, diabetes and cardiovascular disease), preventing and reducing the effects of alcohol and substance abuse, smoking cessation, weight loss and stress management.

Strategies To Accomplish Objective 4:

- ✓ Create a new unit within Aging Services to include specialists in the areas of nutrition, health promotion and disease prevention;
- ✓ Continue collaboration with the Connecticut Department of Public Health on health initiatives such as coordination of vaccination of

- seniors, particularly for influenza and pneumonia, arthritis, osteoporosis and dental care;
- ✓ Develop and provide additional guidance to Area Agencies on Aging on the broad range of activities that can be funded through Title IIID;
 - ✓ Create opportunities to share promising practices in health promotion and disease prevention with Area Agencies on Aging, state-funded elderly health screening projects and other stakeholders;
 - ✓ Encourage Area Agencies on Aging and other State Unit Aging stakeholders to participate in health promotion efforts, such as the federal AoA's "You Can" campaign;
 - ✓ Collaborate in fall prevention and strength training programs, which serve at-risk older adults, through a coalition that includes Yale University, the University of Connecticut, Area Agencies on Aging, hospitals and health agencies;
 - ✓ Review the state-funded Elderly Health Screening programs and identify ways to move the programs more towards health promotion and disease prevention;
 - ✓ Develop a stronger working relationship between Aging Services and the Bureau of Rehabilitation Services and the Independent Living Centers; and
 - ✓ Reinstate and lead the Connecticut Healthy Aging Coalition.

Objective 5: Identify opportunities to increase the effectiveness of the Elderly Nutrition Program and implement appropriate improvements. (AoA Priority #2)

Background:

The Connecticut Elderly Nutrition Program (ENP) served approximately 25, 000 elders in 2005, providing 3.4 million meals annually at senior community cafés (congregate meal sites) and through the home-delivered meal program. It is Aging Services largest program. Flat funding for the program over the past 10 years, however, has resulted in fewer meals being delivered (an approximately five percent decrease annually) because of the increased cost of food, gasoline and salaries. There is also a sense that tomorrow's older adults, the leading edge of the baby boomers, will not be as interested in congregate meal programs as they exist today. Strategies must be developed to explore alternatives in providing meals.

Strategies To Accomplish Objective 5:

- ✓ Implement the Senior Farmers Market Program in collaboration with DSS Food Stamp Unit and End Hunger Connecticut to educate low-income older adults on the importance of fruits and vegetables in their diets and to increase their access to fresh produce;
- ✓ Evaluate nutrition education and counseling to improve the process for the delivery of these services and agreed-upon improvements will be

- adopted by the Area Agencies on Aging and implemented by the Elderly Nutrition Projects (ENPs);
- √ Evaluate the process of participant donations at congregate meal sites and develop a standard procedure for all Elderly Nutrition Projects to adopt;
 - √ Review participation trends in the congregate meal programs over the past five years by age cohort to determine whether fewer persons age 60 to 70 are attending these programs; and
 - √ Develop recommendations on program options for future congregate meal programs based on current participation patterns and projections for use by the first cohort of Baby Boomers.

Objective 6: Improve oral health care for older adults. (AoA Priority # 2)

Background:

Dental care is problematic for many older adults as noted in the Surgeon General's *Oral Health Care in America* report (2000). Many elders lose their dental insurance when they retire. Medicaid provides coverage to low income individuals but many dentists refuse to accept Medicaid due to the payment structure. Medicare offers limited coverage for dental services related to certain medically necessary medical conditions (or needed for medical treatment). Oral health problems can limit the quality of life for many elders and can have negative consequences for their overall physical health and nutritional status.

The Surgeon General's report also noted that dental care was problematic for residents in long-term care facilities. Residents with dementia may be unwilling or unable to brush their teeth. Currently one of the agencies on aging operates a very successful oral screening program funded by elderly health screening state funds.

Strategies To Accomplish Objective 6:

- √ Identify successful strategies for improving access to dental care and disseminate information on these models;
- √ Add oral health as a component of the state-funded Elderly Health Screening Program;
- √ Identify and disseminate effective information on oral care techniques that caregivers and direct-care staff can use when older adults, particularly those with cognitive impairments, are resistant to brushing their teeth and performing other important routine oral health practices;
- √ Meet with the University of Connecticut Health Center to discuss ways the center can help to provide service to older adults; and
- √ Develop a partnership with the State Ombudsman to provide training to long-term care facilities' staff, residents, and residents' families to increase awareness of the importance of good oral health care.

Objective 7: Improve access to mental health services for older adults.
(AoA Priority #2)

Background:

Almost 20 percent of people over age 55 experience mental disorders that are not a part of “normal aging.” Among adults age 65 and older, an estimated 11 percent suffer from anxiety, 6.4 percent have cognitive impairments and 4.4 percent experience depression and other mood disorders. Suicide rates increase with age, with older white men having six times greater risk for suicide than the general population. Serious mental illness is also a problem for veterans age 60 year and older. Although there is a wide range of services available for veterans in Connecticut, there is a need for an ongoing partnership between Aging Services and the State Veterans Affairs to ensure that our aging veterans receive respectful and compassionate care.

These conditions can severely limit social interaction, quality of life and general health. While the efficacy of mental health treatment is well documented, older adults often do not recognize the need for or availability of treatment, which results in gross underutilization of mental health services.

Connecticut has the opportunity to re-conceptualize how mental health services for older adults and adults with disabilities are organized and delivered and to increase such services for these groups. The Connecticut Department of Mental Health and Addiction Services received over \$13 million for a Mental Health Transformation Grant. Aging Services as well as representatives from the Area Agencies on Aging and their Boards participate in various workgroups that address mental health issues.

Strategies To Accomplish Objective 7:

- √ Meet with staff of the Department of Mental Health and Addiction Services (DMHAS) and the Department of Mental Retardation(DMR) to actively participate in implementation efforts on the state level to assure that mental health needs of older adults and adults with disabilities are well represented in planning and implementation steps;
- √ Convene a meeting with DMHAS, DMR, State Veterans Affairs, Area Agencies on Aging and other aging services providers to learn about the services available to older adults and adults with disabilities;
- √ Develop appropriate media/informational materials to alleviate the stigma of mental health treatment;
- √ Create opportunities for stakeholders to learn about “promising practices” for older adult mental health education and about screening and treatment models in order to disseminate successful interventions;
- √ Support mobile crisis intervention;

- ✓ Add mental health as a component of Elderly Health Screening programs ; and
- ✓ Encourage collaborative efforts between mental health and aging providers.

Objective 8: Collaborate with agencies and coalitions providing geriatric training to current health, social services and mental health professionals as well as those who train these professions to increase the number and improve the skills of those who provide services to Connecticut's older adults and their caregivers. (AoA Priority #3)

Background:

To provide appropriate services to older adults, providers need specialized training on various gerontology and/or disability issues. They also need at least a basic understanding of key programs (e.g., Older Americans Act services, Medicare, Social Security, Connecticut Homecare for the Elderly Program, ConnPace, etc.) that serve elders and adults with disabilities and how to link these individuals to needed services. While Connecticut's aging population is growing, the workforce needed to serve this population is shrinking. In many professions, such as social work, health care and mental health, most of the current workforce lacks geriatric education and experience.

Connecticut's providers must also be sensitive to the needs of a diverse older adult population of African Americans, Hispanics, Asians, other people of color and homosexuals. Because of past practices, older African Americans, in particular, are skeptical of the medical profession. Language is also a barrier for those older adults who do not speak English. In some situations persons in homosexual relationships may have difficulty receiving information about or making decisions for their partners.

To ensure that older adults and persons with disabilities receive the most cost-effective, high quality services, current providers and those in training need to develop skills based on the growing body of evidenced-based research in health, mental health and social service interventions. Significant attention must also be directed to recruiting a diverse group of students into these fields given the growing workforce needs.

Strategies To Accomplish Objective 8:

- ✓ Develop a partnership with the University of Connecticut Center on Aging to participate in an annual seminar series geared towards geriatrics fellows, interns and other health care professionals to provide a basic understanding of services for older adults and develop a services guide to be distributed at the training sessions;

- ✓ Serve on the Connecticut Geriatrics Center Statewide Advisory Committee and support its training initiatives throughout the state to effectively prepare today's and tomorrow's health care, mental health and social service professionals to better serve older adults and persons with disabilities;
- ✓ Seek opportunities for State Unit on Aging staff to learn more about key aging and disability issues; and
- ✓ Speak on aging issues and workforce opportunities to student groups and help link students to local internship opportunities.

Topic C:
Protect the quality of life and rights of elders through education, legal services, and improved coordination with law enforcement (AoA Priority #4)

Current and Future Concerns:

- ✓ Terminal illness, natural aging, accidents and other events that lead to loss are among the hardest issues to discuss and accept. Years ago, people died at home, usually after a short illness, and were attended by family members and the family physician. Now, the dying process is more complex, often preceded by long periods of chronic illness, hospitalization and aggressive treatment. Although we have been able to treat or cure many of the illnesses that were previously fatal, we ultimately cannot prevent death and always face the challenge of our mortality.
- ✓ With older adults living alone, an increasing number of family members do not see the early warning signs that a relative needs help. As a result, interventions that may prevent injuries, abuse or neglect may not occur until a crisis happens, which may make it more difficult for that person to continue living independently. Individuals who are isolated, particularly those who may be developing dementia, are at increased risk of financial abuse, whether by unscrupulous individuals marketing home repairs, refinancing, insurance, and other products or by their own family members, neighbors, chore workers or health care providers.

Objective 9: Educate providers, policy makers and older adults and their families on what is needed to provide the most compassionate, individualized and supportive end-of-life care. (AoA Priority #4)

“Getting older is like riding a bicycle; if you don't keep pedaling, you'll fall.” Claude D. Pepper

Background:

Health care providers, government agencies, community groups and individuals must consider a comprehensive approach to understanding and supporting the needs of dying persons and their families. State Unit on Aging staff has served as board members for the Connecticut Coalition to Improve End of Life Care since it was founded in 1998. It has collaborated with the Coalition on several activities and has been a co-sponsor for three statewide conferences that addressed issues pertaining to end-of-life care. It tries to keep individuals informed about end-of-life issues by presenting on advanced directives at various locations and through the development of a health care planning packet.

Strategies To Accomplish Objective 9:

- ✓ Revise the *Beginning the Conversation about Death, Dying and End-of-Life Care* to include a new state law concerning the topic and to address feedback received from users on suggested changes and additions to the publication;
- ✓ Update Aging Services' Health Care Packet to incorporate a new state law regarding health care decision making; and
- ✓ Educate older adults, communities and providers on the state's new law for making health care decisions.

Objective 10: Increase awareness of and expand collaborations among local law enforcement and the residents of their communities on how to recognize, investigate and prevent elder and dependent adult abuse, neglect and exploitation of those who live in their communities and long-term care facilities. (AoA Priority #4)

Background:

Aging Services and Area Agencies on Aging have done a good job in developing elder abuse training materials for law enforcement personnel and providing training. However, it is important to offer information and training to law enforcement personnel that will allow them to expand and refine their skills in recognizing that when elder and dependent adult abuse occurs in a private home or in a long-term care facility it is a criminal activity.

There are currently 42 local Triad programs in communities throughout Connecticut. Triads are partnerships of law enforcement personnel, Area Agencies on Aging, aging network leadership, banks and other private sector businesses that agree to work together to reduce the criminal victimization of older adults and enhance the delivery of law enforcement services to this population. The Connecticut Triad Advisory Board was founded in 2004 and members include the Office of the Attorney General, the Connecticut Police Chief's Association, Aging Services and People's

Bank. The Board is a focal point for implementing, expanding and operating Connecticut's Triads.

Strategies To Accomplish Objective 10:

- ✓ Facilitate skill building for local law enforcement on interviewing older and dependent adults and understanding the victim's psychological state and needs in the aftermath of potentially abusive situations;
- ✓ Collaborate with the Social Work Division on a joint initiative to bring domestic violence, disability and elder abuse advocates together;
- ✓ Sponsor a conference on domestic violence and elder abuse;
- ✓ Collaborate with Connecticut Triad Advisory Board to expand Triad to an additional 30 communities during the Plan period;
- ✓ Collaborate with the Area Agencies on Aging, Protective Services for the Elderly, other social services and law enforcement agencies to publicize "best practices," address mutual concerns and make it easier for older adults to access legal and other appropriate services to insure that they are protected from physical, emotional and fiduciary abuse; and
- ✓ Revise, maintain and disseminate the *Law Enforcement Response to the Needs of Connecticut's Elderly: Training and Resource Field Guide*.

Objective 11: Increase education of older adults and their families about health care and other consumer fraud, scams and deceptive practices.
(AoA Priority #4)

Background:

Consumer fraud that targets older adults is a growing problem not just in Connecticut but nationally. According to the Federal Trade Commission and the United States Postal Service, money lost by older Americans to Internet fraud increased 375 percent from 2002 to 2003 alone. Identity theft has cost businesses and financial institutions nearly \$48 billion, in addition to the reported \$5 billion in out-of pocket expenses incurred by consumer fraud victims. Not surprisingly, therefore, 37 percent of older Americans ranked fear of fraud ahead of concern for health crises and terrorism according to a study conducted by Harris Interactive. Even though health care fraud is widely under-reported, estimates range that it accounts for five to 10 percent of all health care expenses, which is between \$80 and \$160 billion based on 2002 expenditures of \$1.6 trillion.

The fast growth of businesses that use telemarketing has accelerated the proliferation of telemarketing operations. It is estimated that over 140,000 telemarketing firms are in operation in the U.S., with 10 percent of them believed to operate as illegal "boiler rooms," stealing annually from consumers an estimated \$10 to \$40 billion nationwide.

While these telemarketers prey on people of all ages, older adults are one of their most vulnerable targets. The frauds include identity theft, home repair frauds and deceptive sales, contests and sweepstakes. Unscrupulous

contractors offer “super bargains” on home improvements or repairs; after taking the consumer’s money, they leave the job unfinished or improperly done. Some companies use high-pressure sales tactics to sell older consumers expensive products that are of little or no benefit.

In response to the rapid growth of consumer fraud that targets elders, Aging Services has, for the past four years, received federal funds to ensure that older adults are empowered to address issues of health care fraud, errors, abuse and other health care-related scams. Through the Medi\$ave program, staff and volunteers of the Area Agencies on Aging provide one-on-one counseling and assistance to elders and provide presentations to groups of older adults, caregivers and other concerned citizens. In addition, the Division’s collaboration with Connecticut Legal Services has established the Connecticut Law Project for Elders, which has proven beneficial to older consumers with fraud issues, especially those who are homebound and have language barriers.

Strategies To Accomplish Objective 11:

- ✓ Collaborate with Connecticut Legal Services and established networks including community, faith-based, and government agencies to promote the Connecticut Law Project for Elders;
- ✓ Fully integrate the Medi\$ave Project under the CHOICES umbrella of programs in order to maximize targeted outreach activities and utilization of trained staff and volunteers to educate and counsel persons on how to understand and exercise their rights, receive benefits to which they are entitled and make informed decisions about quality of life concerns;
- ✓ Increase accessibility, quantity and effectiveness of information available to help targeted populations from being victimized by fraud, abuse and scams through a statewide awareness campaign; and
- ✓ Utilize established networks including community, faith-based and government agencies to disseminate consumer alerts and tips to prevent, address and further combat instances of suspected fraud and abuse.

Objective 12: Improve the quality and quantity of legal services provided to older adults. (AoA Priority #4)

Background:

As a result of the rapid increase of Connecticut’s older adult population, an increased number of elders are at risk of exploitation and abuse by relatives, dishonest care providers, discriminatory employers, unscrupulous merchants and predatory lenders.

In the coming three years, Aging Services will take a more active role to improve legal services for elders.

Strategies To Accomplish Objective 12:

- √ Request assistance from the Center for Social Gerontology and others, as appropriate, in order to develop a process to assess the legal needs of older adults, including their cultural and linguistic needs and formulate strategies to address them;
- √ Convene a statewide Legal Assistance and Elder Rights Summit to identify key elder rights issues, actions and program initiatives that can and should be pursued in the coming plan period and develop a framework for enhanced communication and collaboration among the legal, elder rights and broader aging communities;
- √ Collaborate with the Connecticut Bar Association, the Probate Court Administration and other appropriate partners to develop curriculum and pilot programming to educate current and potential conservators, both public and private, on their duties and responsibilities;
- √ Collaborate with the Area Agencies on Aging and Title IIIB legal services providers (as appropriate) to develop statewide uniform reporting standards, prioritize Older Americans Act priorities on a regional basis and establish a system for contracting, which includes core elements and measurable outcomes for legal services providers to ensure consistency in the quality among services statewide;
- √ Collaborate with the elder rights network to organize and sponsor annual statewide training conferences to enhance legal service providers' knowledge of specific topics, which include elder abuse, predatory lending, access to benefits and bankruptcy; and
- √ Provide technical assistance to the Area Agencies on Aging' program staff to ensure uniform periodic monitoring and evaluation of legal services providers.

Topic D:

Promote Senior-Friendly Communities (AoA Priority #1-4)

Current and Future Concerns:

- √ Substantial investment is needed to develop creative transportation options for all citizens, especially elders and adults with disabilities statewide;
- √ Many low-income older adults cannot afford adequate housing;
- √ Expansion and management of volunteer opportunities require adequate support;
- √ When developing senior-friendly communities, they must be culturally sensitive to diverse populations;
- √ Social and economic employment opportunities must be available to all individuals, without regard of age;
- √ Funds for senior centers have been reduced, which diminishes their capacity to help build senior-friendly communities; and
- √ Building senior-friendly communities will require commitment, time and resources.

Objective 13: Support Senior-Friendly Communities for Connecticut’s 169 towns. (AoA Priority #3)

Background:

Each of the five priorities identified in this state plan is important to meet the long-term care needs of older adults, adults with disabilities and caregivers, but there is a very important role for communities to ensure that all elders have a choice of where they want to live and how they want to live.

While American society has a history of assisting older adults in important ways, including Social Security and public medical insurance, it has fallen short in other areas. Today’s communities are not adequately equipped and “aging sensitive,” to enable older people to remain in their communities with independence and choice. As their needs change, older adults must frequently either move out of their communities or make less than desirable adaptations.

The National Governors Association (NGA 2001) acknowledged that a combination of public, private and philanthropic investment in communities is essential in preparing for the transformation that aging baby boomers will bring as they begin to retire toward the end of this decade. The NGA launched an initiative specifically designed to help states create policies and programs to aid the nation’s communities in meeting this challenge.

Aging Services, as the State Unit on Aging, realizes that the future health, wealth and social integration of seniors depend largely on what happens locally as well as with state and national developments.

While nearly every community in Connecticut will see greater numbers of older adults in the future, many may not readily or easily see the effect of this increase nor respond proactively by tapping resources to meet the needs of their older residents. A senior-friendly community is not only a desirable goal, but also a necessity for the interests of older adults, their families and their communities.

Aging Services is responsible for administering programs under the Older Americans Act, and is charged with helping “older people to secure equal opportunity to the full and free enjoyment” of the many objectives articulated under the Older Americans Act. While achievement of these objectives requires significant federal and state support, their realization ultimately requires the development of communities that:

Senior-friendly communities are those that respect and work toward achieving these objectives. They enable senior households to remain an integral part of their communities regardless of they chose to define them.

A senior-friendly community is not a term bound by any jurisdiction established for administrative purposes by government agencies. At the center of each senior community stands a neighborhood with older residents. The focus of senior-friendly community initiatives is individuals, neighborhoods, agencies, organizations and public and private programs that collaborate to remove barriers to services and opportunities and that improve the quality of life for older adults wherever they live.

Because nearly every aspect of society is affected by the aging of its population, the tasks of becoming senior-friendly are enormous. Advocacy and evaluation are essential activities for helping the state and communities become aware of the changes inherent in an aging society. These are two of nine areas discussed in this chapter that are considered key to building senior-friendly communities in ways that are consistent with the missions of Aging Services and Area Agencies on Aging under the Older American Act and state statute. The other seven areas are senior centers, information and assistance, family caregiver support, volunteer coordination, nutrition, housing, transportation and disaster preparedness. Progress in all eleven of these areas should strengthen the preparedness of Connecticut's communities to become "senior-friendly."

Strategies To Accomplish Objective 13:

- ✓ Convene a task force to develop a blueprint for designing senior-friendly communities;
- ✓ Understand and accommodate for the special needs of elders, especially the most vulnerable, and adults with disabilities;
- ✓ Advocate for social and economic opportunities without regard to age in employment and in volunteer and community service;
- ✓ Advocate for adults to receive respect and opportunity to live in the community without prejudice because of race, ethnicity and sexual orientation;
- ✓ Facilitate independence through responsive transportation services and such physical considerations as easy-to-read street signs and well-lighted and accessible sidewalks;
- ✓ Advocate for suitable and affordable housing;
- ✓ Encourage meaningful activity with a wide range of civic, cultural, educational, spiritual and recreational opportunities;
- ✓ Support access to well-coordinated supportive services; and
- ✓ Support people's independence and the free exercise of individual initiatives in planning and managing their own lives.

Objective 14: Continue to Support Statewide Advocacy Efforts.

Background:

For Connecticut and its communities to be senior-friendly there must be entities that can focus attention on the needs and interests of seniors, individually and as a group. The Older Americans Act authorizes state agencies on aging to serve as effective and visible advocates for older adults. Aging Services has embraced this charge and is involved in numerous advocacy efforts on behalf of Connecticut's older adults, ranging from those that pertain to a single individual to those that affect large numbers of elderly persons. In this advocacy, Aging Services works with a wide range of public and private partners.

Connecticut is fortunate to have numerous advisory and advocacy groups including the Commission on Aging, which is authorized by state legislation to advocate for older adults, the Connecticut Elder Action Network (CEAN) that develops legislative priorities and the Area Agencies on Aging that provide ongoing grass-roots advocacy.

Another important component of advocacy is the state Long-Term Ombudsman program administered by DSS. It is designed to advocate for older adults individually and, at the same time, address overall systemic issues. Regional Ombudsmen work on behalf of residents in nursing homes, residential care homes and in assisted living communities. Other state agencies such as the Department of Public Health, Department of Mental Retardation and Department of Mental Health and Addiction Services and other state programs also have important roles in promoting the interest of seniors. These interests are especially met by the DSS' administration of Protective Services for the Elderly and Conservator of Person and Estate Programs.

Strategies To Accomplish Objective 14:

- ✓ Continue to advocate for older adults through presentations and the production of reports on aging issues;
- ✓ Support the Commission on Aging, local Commissions on Aging and other advocacy groups; and
- ✓ Continue to support the Area Agencies on Aging in their advocacy efforts.

Objective 15: Collaborate with senior centers and identify opportunities to increase their effectiveness. (AoA Priority #1, #3)

Background:

All people need places that offer them identity, opportunities and assistance. For some, these are places of employment, education or worship. Others find what they need in their civic or fraternal affiliations.

For many older adults, senior centers help serve this function. Senior centers also serve a vital role in the community by providing a focal point for services to promote independence and wellness for older adults. While senior centers in Connecticut are primarily locally financed, they are included in the Older Americans Act as essential focal points for older adults.

Beginning in 2007, Aging Services plans to begin an important step in strengthening the capacity and role of senior centers. Aging Services will achieve this goal by supporting the accreditation process of senior centers and providing leadership and career development training for senior center personnel. The accreditation process recognizes senior centers that meet specific criteria to be considered a “senior center.”

Given the current and future composition of the aging population, especially driven by baby boomers, Aging Services will convene a work group to develop a model of the “Center of the Future.” Some of the challenges that centers and communities face is preparing to meet the needs and interests of baby boomers. These include growing numbers of participants and increasing expectations for centers whose facilities, staffing and funding are inadequate.

Strategies To Accomplish Objective 15:

- ✓ Work with senior center personnel to identify and sponsor appropriate leadership training;
- ✓ Advocate for the accreditation of senior centers and provide technical assistance and financial support toward the accreditation process to at least two senior centers each year of the plan;
- ✓ Convene a meeting of senior center personnel and others in the aging network to discuss the future of senior centers; and
- ✓ Initiate development of the “Center of the Future” model for senior centers that responds to the needs and interests of baby boomers.

Objective 16: Promote the enhancement of Information and Assistance services that help to increase older consumers’ abilities to locate and access needed services through a no-wrong-door policy whereby consumers can receive information and referrals concerning aging-related services regardless of the agency they contact. (AoA Priority #1)

Background:

A major frustration for many people is that they do not know whom to call when there is a question or problem. Their frustration is made worse when they are referred from one organization to another without success. For seniors and their caregivers, such experiences create a very unfriendly community, sometimes with consequences that are personally devastating.

Helping older adults make informed choices, whether they are planning for retirement, facing changes of later life or seeking immediate help is an important role of the Area Agencies on Aging. They administer the CHOICES Program, which is information and assistance program that is staffed by paid personnel and volunteers, specifically designed for the aging population. Through CHOICES, the Area Agencies on Aging provide information and assistance for a variety of topics including health insurance, transportation, housing and financial assistance.

The Area Agencies on Aging collaborate with Connecticut's Infoline (2-1-1), which has also played an essential role in ensuring that older adults and their caregivers have access to information about services. Infoline recognizes the Area Agencies on Aging as an important link for older adults and makes referrals to these agencies for further assistance.

The Connecticut Long-Term Care website is a new, dynamic information source available for those in need of services and supports. It utilizes many of the resources provided by CHOICES and Infoline. This website, www.ct.gov/longtermcare, is a collaboration among the Long-Term Care Advisory Council, the Connecticut Commission on Aging and the Office of Policy and Management. The goal of this state website is to provide easy access to comprehensive information on private and public long-term care services and supports in Connecticut.

The Connecticut Long-Term Care Plan endorses the importance of information and assistance as one of the core services that should be available for all citizens. In 2006 State legislators committed \$200,000 for a long-term care needs assessment..

DSS applied for a \$3 million grant to the Centers for Medicare and Medicaid Services for Systems Transformation. This five-year grant builds on accomplishments from similar grants received over the past four years. The grant intends to strategically transform Connecticut's systems so that persons with disabilities or long-term support needs can remain in the community. Proposed activities are expected to end the institutional bias of Connecticut's systems by improving long-term support services, developing a self-directed service delivery system and developing alternative financing and diversion options to promote community living.

Strategies To Accomplish Objective 16:

- ✓ Promote the enhancement of Information and Assistance services that assist all consumers in locating and accessing needed services; and
- ✓ Diversify outreach to make the process unique to individual communities (faith-based organizations, communities with a large non-speaking population, African-Americans, Hispanics, low-income persons and adults with disabilities).

Objective 17: Increase knowledge of caregiver-related services, including those pertinent to grandparents raising grandchildren to sources outside the aging network, including faith-based organization, physicians' offices, hospitals, utility companies, Chambers of Commerce and schools. (AoA Priority #3)

Background:

Senior-friendly communities are also family-friendly because they sustain the efforts of families to care for their members particularly those with disabilities. The support of family caregivers is crucial to maintain quality long-term care in Connecticut as discussed under Topics A and B in this section.

In establishing the National Family Caregiver Support Program (NFCSP) in 2001, Aging Services envisioned a future when families would enter care giving with the knowledge and assurance that they could call upon the business, faith-based, health and human service communities to assist them with information, counseling, problem solving, respite and formal services. Towards that end, each of the Area Agencies on Aging have a coordinator who are responsible to lead numerous activities designed to increase caregiver support in the following five areas: (1) information about available services; (2) assistance in gaining access to these services; (3) counseling, organization of support groups and caregiver training; (4) respite care; and (5) supplemental services, on a limited basis to complement the care provided by caregivers.

The cornerstone of the development of the NFCSP was the input received from Connecticut's caregivers from a variety of sources. In 2005, Aging Services and AARP-Connecticut cosponsored a caregiver conference, which drew over 300 caregivers. More than one half (177) participants completed a survey that was distributed at the conference. Most respondents were female (82 percent) and cared for a parent (56 percent). Forty percent of caregivers were between the ages of 50 and 59; slightly more than one-third were between the ages of 60 and 69. Eighteen percent were 70 years of age or older. Almost one-half (47 percent) of the caregivers lived with the person for whom they cared. Most were not employed and provided over 40 hours of care weekly. The conference was given during working hours, which may have contributed to the large percentage of caregivers attending who were not employed.

Few respondents were aware of some important resources that could possibly assist them with their responsibilities such as the Personal Care Assistant Program (12 percent), the National Family Caregiver Support Program (10 percent), Municipal Agents (7 percent) and Senior Community Cafes (4 percent). Refer to Table III in Appendix B.

Many respondents feared not being able to do what is expected as a caregiver. Thirty-eight percent sometimes had this feeling, but 30 percent had this feeling often or almost always. Seventy-five percent of respondents at some time also felt anxious. Nearly one-half (49 percent) sometimes felt this way and approximately one-quarter (26 percent) felt this way often or almost always. About one-half (49 percent) are at times overwhelmed with their responsibilities and nearly one-third seldom or never ask for help when they need it. Refer to Table I in Appendix B for a comparison of caregiver needs.

Slightly more than three-quarters of the caregivers agreed to some extent that care giving limited their social life. Nearly one-half (45 percent) to some degree agreed that they had to take considerable time off from work to fulfill their responsibilities as caregivers. A significant proportion of respondents disagreed to some extent, however, that they either knew where to go for help with care giving (43 percent) or that they had a good idea of the services that were available to help them (45 percent). Refer to Table II in Appendix B on how caregivers responded to other issues.

Strategies To Accomplish Objective 17:

- ✓ Establish an Advisory Committee for the NFCSP comprised of Area Agencies on Aging Directors, caregiver staff, community agency staff, as well as key caregivers and leaders from the aging community. It is expected that this Committee can provide guidance for the program's future development by considering the needs of baby boomers and generally bringing about positive changes in support of caregivers;
- ✓ Expand coordination with faith-based organizations, utilities companies, physicians' offices and the Chambers of Commerce to outreach to caregivers; and
- ✓ Continue to co-sponsor with the AARP an annual caregiver conference.

Objective 18: Support the efforts of older adults who volunteer in their community. (AoA Priority #2)

Background:

Community spirit is best seen through the efforts of volunteers who respond to help friends, neighbors and fellow citizens. No group embodies the volunteer spirit more than older adults. Almost 60 percent of adults' age 60 and older volunteer. While not normally seen as a form of volunteerism, grandparents raising grandchildren is yet another example of how older adults contribute to their families and communities. The 2000 Census reports that 18,898 of Connecticut's grandparents raise their grandchildren.

Ageing Services considers volunteerism vital to senior-friendly communities. Every community depends upon volunteers for such crucial

services as home-delivered meals, transportation and home repairs. In fact, Aging Services recognizes the importance of volunteerism in every program it administers. In 2005, the Division funded 11 Retired Senior Volunteer Programs (RSVPs), Breakthrough to the Aging and a Seniors Helping Senior program.

Another aspect of volunteerism is tapping the potential that exists in Connecticut's baby boomers born between 1946 and 1964 who represent one third of the state's total population and who turn 60 beginning this year. The Aging Services Division is collaborating with the Commission on Aging in a fall 2006 statewide forum on baby boomers' participation in civic engagement activities.

Strategies To Accomplish Objective 18:

- ✓ Help promote community needs, including services for vulnerable seniors and children, through the promotion of volunteer activities that enable adults to use their skills, experience and knowledge;
- ✓ Continue to support state-funded volunteer initiatives; and
- ✓ Identify and develop new volunteer programs for baby boomers that may want to volunteer.

Objective 19: Collaborate with Area Agencies on Aging, Elderly Nutrition Projects and the Food Stamp Program to improve older adults' and their caregivers' awareness of nutrition services, including congregate and home-delivered meals, nutrition education and counseling and the Food Stamp Program. (AoA Priority # 1,#3,#4)

Background:

Aging Services receives approximately \$10 million dollars to fund the nutrition program in Connecticut and to provide oversight and administration. The Area Agencies on Aging receive these funds to provide meals to older adults in group settings and individual homes. The former, commonly called "congregate nutrition services" or "senior community cafés," are offered at such places as senior and community centers, churches and schools. The service of delivering meals to individual homes is known as "home-delivered meals" or "meals on wheels." The primary focus of the Senior Nutrition Program remains to serve hot, nutritious meals to older adults; this is especially important because 35 percent of congregate participants and 89 percent of those receiving home-delivered meals are at moderate to high-risk of malnutrition. Additionally, the Older Americans Act envisions these programs as being more than a meal and encourages the provision of related services, including nutrition screening, education and counseling.

"Age should not have its face lifted, but it should rather teach the world to admire wrinkles as the etchings of experience and the firm line of character." Ralph B. Perry

These services help older adults identify their nutritional needs to remain healthy and to manage nutrition-related chronic conditions such as heart disease, hypertension and diabetes.

The congregate meal program offers older adults opportunities for social interaction, mental stimulation and informal support. It allows volunteers who deliver meals an important opportunity to check on the status of homebound older adults and to help the nutrition provider to alert appropriate agencies if additional assistance is needed. The programs also offer active older adults the opportunity for valuable community services. Many home-delivered meal volunteers are themselves older adults. These volunteers perform not only the necessary and time-consuming task of delivering meals individually, but they also enjoy and provide the opportunity for social interaction and companionship.

The program also helps older people connect with other health and supportive services such as transportation, in-home modification and food assistance programs, including Food Stamps. Currently only 20,803 Connecticut's older adults age 60 or older take advantage of this totally federally funded benefit.

Strategies To Accomplish Objective 19:

- ✓ Establish a partnership with the Food Stamp Program administered by DSS to implement a Senior's Farmers Market Nutrition Program;
- ✓ Test different outreach methods to improve Food Stamp participation among older adults (banks, local health departments); and
- ✓ Collaborate with faith-based organizations, health-care providers, Resident Services Coordinators and senior centers to examine that is receiving nutritional services and where possible gaps in services occur.

Objective 20: Identify strategies for addressing issues related to elderly housing including mixed populations and restrictions on grandchildren living with older relatives who live in senior housing. (AoA Priority #1)

Background:

The U.S. Census reports that in 1999 about 11.5 percent of family households headed by an elderly individual had incomes of less than \$15,000 and 47 percent had incomes of \$35,000 or more. Elderly persons living alone or with non-relatives are more likely to have low incomes. The median income for these households was \$14,425 during this period. The primary source of income for older adults is Social Security. Fifty-three percent of renters' age 65 and older who provided information, spent more than 30 percent of their household income on rent.

Grandparents raising grandchildren face additional challenges when they live in senior housing and learn that there are restrictions to having their grandchildren live in their homes. More disturbing news is the number of emergency shelters that report an increase among homeless individuals age 55 and older. There is a need among older adults for safe and affordable housing.

The difficulties many elders and their families face in securing good and affordable housing that meets their needs is a problem at both the state and local levels. On the advocacy front, communities and advocates may want to advocate for legislation to increase property tax relief for low-income elders and adults with disabilities and expand the availability of affordable rental property.

State-funded elderly housing communities and many federal-funded communities offer residency to younger persons with disabilities as well as older adults. Many negative incidents resulting from these two populations living together have been discussed including clashes in lifestyles, fears based on misconceptions about mental illness, disruptive behaviors and criminal activities. Connecticut's Program Review and Investigations Committee submitted a report to the Connecticut General Assembly that provided proposals for addressing these issues through more effective housing management tools and improved support from and collaboration among state agencies.

Strategies To Accomplish Objective 20:

- ✓ Conduct a housing forum with representatives from the Department of Economic and Community Development (DECD), Connecticut Housing Finance Authority (CHFA), U.S. Housing and Urban Development, Housing Authorities, the DSS Housing Unit, Resident Services Coordinators, Area Agencies on Aging and other housing-related entities to discuss how Connecticut can enhance housing services and options for older adults and people with disabilities;
- ✓ Collaborate with the DECD, U.S. Department of Housing and Urban Development and the Connecticut Association of Resident Services Coordinators in Housing (CARSCH) to assist with training Resident Services Coordinators and other housing management staff;
- ✓ Advocate for creative housing options for grandparents raising grandchildren; and
- ✓ Partner with CHFA to increase the awareness in communities of the Reverse Mortgage program.

Objective 21: Encourage the development of innovative transportation options and enhance older adults' driving skills to promote driver safety.

Background:

There are some transportation services in every town in Connecticut. In most, the public transportation system serves both the general public and the customers of human service agencies. In a few areas, there are human service transportation systems that provide services to its consumers. The problem with conventional transportation for older adults is that the services are on fixed routes and door-to-door service usually is not available. Moreover, weekend transportation services may be limited to certain areas of the state.

In rural regions of the state, transportation is critical in helping many older adults make crucial connections. Three out of four older people live in rural areas that lack the density for traditional mass transit. Whether it is making medical appointments, running errands, getting to work or gaining access to vital social services programs, reliable and dependable transportation is critical to helping community members remain healthy, productive individuals. The relocation rates among people over age 65 are the lowest of any age group, and they have been declining for the last 30 years. Most people stay in their current homes as they age which means many will need access to transportation. In communities where transportation services do not exist or where they are insufficient, residents with disabilities, older adults and other public transportation-dependent individuals suffer the most isolation.

Older adults rely upon the automobile as their primary mode of transportation. Many older adults live active lives and are reluctant to give up their freedom and the convenience of driving. Their fears of isolation and lack of independence are warranted. Without adequate transportation systems, older adults may continue to drive beyond the point when it is safe to do so.

In the near future the issue of driver safety will become increasing important as baby boomers age and older drivers are on the road.

This is an important issue for communities, which often are called on to provide alternative means of transportation for elderly residents who can no longer drive. Without acceptable alternatives, many older adults continue to drive themselves, even as their capacity in this regard diminishes. Despite their efforts to self-regulate their driving (e.g. avoiding congested areas, avoiding night driving), their safety remains at risk. Older adults who continue to drive suffer more serious injuries and face the highest fatal accident rate of any age group.

In 2005 State Legislators passed an Act to provide \$100,000 in grants of \$25,000 each to a maximum of four towns with populations of at least 25,000 or to non-profits organizations located within these towns to develop and plan financially self-sustaining, community-based regional

transportation systems. These systems are to provide older adults with transportation and are to be sustained through a combination of private donations and user fees. During the 2006 Legislative session the funds associated with this Act was increased to \$200,000 with each community receiving \$50,000 each. Aging Services submitted a Request for Proposals and is currently waiting for completed applications, which are due on June 23, 2006.

Encouraging drivers to update their skills in courses such as AARP's Driver Safety Program can help to keep older drivers safely on the road longer. The state also must be interested in designing roadways and pedestrian areas with older adults in mind.

Strategies To Accomplish Objective 21:

- ✓ Establish a committee with representatives from the Department of Transportation, Department of Motor Vehicle, State Police, Triads, Area Agencies on Aging, senior centers, Transit Districts and other transportation-related groups to discuss older drivers' safety issues;
 - ✓ Develop an awareness program that enhances older adult drivers' skills;
 - ✓ Convene three regional transportation forums in the Southwestern, South Central and North Central regions to discuss transportation issues related to older adults and adults with disabilities;
 - ✓ Advocate for additional funding to increase opportunities for communities to develop and plan regional-based transportation systems that are financially self-sustaining;
- 3Advocate for the redesign of roadways that are well-lighted and street signs with large print; and
- 3Use AoA transportation toolkit to continue to assess transportation needs among older population and the coordination of transportation services.

Objective 22: Prepare a Statewide Aging Disaster Preparedness Plan for Connecticut, including pandemic flu response.

Background:

The Administration on Aging (AoA) has requested that each State Unit on Aging develop a Statewide Disaster Preparedness Plan and submit it to AoA for approval. During 2007 to 2009, a Statewide Disaster Preparedness Plan will be designed, implemented and evaluated.

After the devastation of Hurricane Katrina in Louisiana in 2005, data became available that many seniors who lost their lives during the hurricane did so because of a flawed evacuation plan.

In June of 2006, the Director of State Unit on Aging participated as the Governor's appointee to an Emergency Preparedness Team in Washington, D.C. to begin planning for Connecticut.

Strategies To Accomplish Objective 22:

- ✓ Collaborate with Department of Emergency Management to convene a forum with community leaders, state agencies, local health departments, senior centers, municipal agents, Area Agencies on Aging, AARP-Connecticut, aging network members, the American Red Cross and others as appropriate to discuss disaster preparedness at the community level; and
- ✓ Develop and submit for approval to AoA the final plan.

Objective 23: Assess whether communities are “senior-friendly” and make recommendations for improvements where necessary.

Background:

This section began with advocacy, because it is the first building block for developing senior-friendly communities; it concludes with evaluation, a vehicle that is necessary to realize the changes and improvements for which we advocate. Planning and evaluation activities increase awareness to help construct and sustain communities that are senior-friendly.

Aging Services will play a leadership role in conducting, planning and evaluating activities for creating senior-friendly communities statewide. Our planning and evaluation activities are guided by three distinct yet interrelated tasks: increasing the focus on results, expanding local capacities and improving collaboration among agencies and programs.

The federal Government Performance and Results Act (GPRA) of 1993 indirectly but clearly drive the focus on results. The GPRA compels federal agencies and programs to set performance-oriented goals and establish mechanisms to measure the degree to which these goals are met. For three years Aging Services participated in the national GPRA-prompted Performance Outcome Measure Project (POMP), designed to develop measures suitable for assessing the performance of community-based aging services. Connecticut’s five Area Agencies on Aging were partners in this project.

Aging Services is interested in expanding local capacity to encourage community ownership and full participation in planning and evaluation activities for creating senior-friendly communities in Connecticut. In supporting communities to become senior-friendly, collaboration among agencies and programs, both public and private, is imperative. In the past several years, DSS and its divisions have implemented several initiatives to strengthen the collaborative approach to planning and evaluation. For example, a joint conference between the Aging and Social Work Divisions on domestic violence was held and a partnership was established between the Aging Services and Medicaid Divisions to implement Medicare Part D.

All the efforts of interagency and cross program collaboration are essential to helping Connecticut energetically and deliberately prepare for the challenges and opportunities that face our residents as they age.

The themes that have guided this Plan can also serve communities as they seek to become more senior-friendly. These communities will draw on the talents and resources of active seniors while enhancing services for those who are vulnerable because of health, economic hardships, social isolation or other health conditions. They will be judged by how well they value diversity and address disparities among their increasingly aging population. They will assure stewardship of formal and informal resources as they respond to the needs of today's seniors while helping aging baby boomers and younger generations prepare for the future.

Strategies To Accomplish Objective 23:

- ✓ Prepare a survey instrument to collect data from communities that will be used to assess their “senior-friendliness;”
- ✓ Develop a standard evaluation tool for assessing senior-friendly communities; and
- ✓ Implement a recognition program for communities that meet the standards of being a “senior-friendly community.”

Topic E:
Strengthen the Quality and Accountability in Connecticut Aging Programs

Current and Future Concerns:

- ✓ More older adults who have complex acute and chronic health and mental health conditions are living longer in their own homes and communities. The increased complexity of their care requires very strong quality assurance mechanisms among service providers, timely coordination between these providers and a well functioning “safety net” in emerging situations; and
- ✓ High turn over in agencies serving older adults and their informal caregivers due to retirement and more frequent job changes, could potentially result in lost expertise and leadership, gaps in program continuity and decreased quality of services.

Objective 24: Provide consistent technical assistance to Area Agencies on Aging and other contractors in the most effective manner.

Background:

Reduced staff at the state level, coupled with increased retirements of long-time employees has created an environment in which new employees who do not have significant expertise in administrating aging programs to

ensure that federal requirements are met and to assure the quality of services provided to older adults and their families is maintained or improved. Aging Services must find efficient and effective options to deliver technical assistance to its contractors, maintaining consumer trust, responsiveness to consumer needs and efficiency of operations and program effectiveness.

Strategies To Accomplish Objective 24:

- ✓ Provide ongoing training to Aging Services staff on contract compliance, Older Americans Act and aging programs administration;
- ✓ Highlight Best Practices discovered through on-site monitoring and post them on the website;
- ✓ Survey contractors to determine what training and technical assistance is needed; and
- ✓ Explore the development of an information and assistance section on Aging Services website.

Objective 25: Develop and maintain program standards and requirements for home and community-based services that are only funded with state funds through Aging Services in a manner consistent with the Older American Act.

Background:

In addition to Older Americans Act programs, Connecticut has historically funded additional services for older adults and adults with disabilities. The programs include volunteer programs, housing, elderly health screening and transportation services. These community-based programs seek to maintain the self-sufficiency and well-being of elderly individuals and adults with disabilities so they remain safely in their own home in the community for as long as possible.

To ensure that these programs continue to receive funding, Aging Services will develop standards, best practices and other guidelines to support the programs' viability.

Strategies To Accomplish Objective 25:

- ✓ Review quality assurance programs in existence for other community-based services/waiver programs;
- ✓ Explore technical assistance from providers with expertise in quality assurance to provide direction for these programs; and
- ✓ Convene a workgroup of state staff and representative providers to discuss and recommend quality assurance procedures.

Objective 26: Develop a management information system that supports the functions of the Older Americans Act programs, including client intake, needs assessment, care plans, utilization and cost.

Background:

In 2006, the Aging Services Division purchased a new National Aging Program Information System (NAPIS). The system will be deployed in 2006 and be able to integrate data across multiple programs and services. The system is web-based, and have the ability to track new data requirements mandated by AoA.

Strategies To Accomplish Objective 26:

- ✓ Monitor the system during the first year to ensure that information is accurate;
- 3 Review system generated reports to determine if data inputted is on the reports; and
- ✓ Meet with the Area Agencies on Aging and other state funded grantees to determine if the system is meeting their needs and to identify any enhancements to the system

Objective 27: Improve and maintain strong financial management practices and enhance accountability of programs administered by Aging Services.

Background:

Fiscal accountability for federal and state funds is a core Aging Services responsibility. Aging Services' goal is to proactively make contractors more aware of program fiscal requirements in order to avoid audit findings.

Strategies To Accomplish Objective 27:

- ✓ Educate Aging Services state funded contractors as needed on the requirements they must meet to comply with federal and state laws, regulations, contract requirements and financial reporting; and
- ✓ Update the Aging Services Financial manual.

Objective 28: Encourage fair competition in awarding contracts (contracts to the area agencies on aging are excluded).

Background:

In 2003, the Aging Service Division began a process to develop standards for awarding contracts for the Elderly Nutrition Services Program. In partnership with the Area Agencies on Aging, statewide standards were developed for the procurement of nutrition services and implemented in 2005. This process serves as an example of how the implementation of standards and uniformity in the Program Request for Proposal (RFP) process can be utilized in other programs. Competition in financing and providing services is an important element that can influence not only the cost of care, but the quality of care.

"The great thing about getting older is that you don't lose all the ages you've been." Madeleine L. Engle

Strategies To Accomplish Objective 28:

- ✓ Develop a plan to open up the award process for all aging-related state-funded contracts, including a timetable for when the programs RFP's will be issued;
- ✓ Ensure that communication on program RFPs is distributed to all groups, especially agencies that serve people of color; and
- ✓ Develop a process to provide technical assistance and training to agencies that have not applied for funding in the past on how to apply for Aging Services funded programs.

Objective 29: Ensure that all Board members of State Unit on Aging contractors are aware and informed of their responsibilities and roles to the agency they serve and to the state and federal governments.

Background:

In 2006 Aging Services, with assistance from the University of Connecticut School of Law's Nonprofit Initiative Connecticut Urban Legal Initiative, piloted a training curriculum for Board members in one region of the state. It is the intent of Aging Services to expand this pilot to other regions of the state and hold continued training sessions in each year of the State Plan.

Strategies To Accomplish Objective 29:

- ✓ Refine the present Board Training Curriculum;
- ✓ Obtain input from the pilot region on improvements to the curriculum; and
- ✓ Expand the training to two more regions in the state in 2007 to 2008.

"When you are younger, you get blamed for crimes you never committed and when you're older you begin to get credit for virtues you never possessed. It evens itself out." I.F. Stone

Section VI
Required Assurances
and
Exhibits

Listing of State Plan Assurances and Required Activities Older Americans Act, As Amended in 2000

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and required activities.

This attachment, along with requirements listed in the State Plan Guidance Program Instruction (PI) and attachment B State Plan Provisions and Information Requirements, make up the package of instructions for development of State Plans.

ASSURANCES

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

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

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

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

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

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

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

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

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

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, outreach, information and assistance, and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i) Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low-income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan.

(4)(A)(ii) Each area agency on aging shall provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will--

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals and older individuals residing in rural areas within the planning and service area.

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

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English-speaking ability; and
(VI) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals);
and inform the older individuals referred to in (A) through (F), and the caretakers of such individuals, of the availability of such assistance.

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

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

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

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

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

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

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

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

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

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an

administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) Each area agency on aging shall provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title.

Sec. 307, STATE PLANS

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

(7)(B) The plan shall provide assurances that--

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

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

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

(11)(A) The plan shall provide assurances that area agencies on aging will--

(i) enter into contracts with providers of legal assistance, which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations

promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

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

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

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

- (A) public education to identify and prevent abuse of older individuals;
- (B) receipt of reports of abuse of older individuals;
- (C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State

leadership in developing legal assistance programs for older individuals throughout the State.

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

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

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

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

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

(16) The plan shall provide assurances that the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

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

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses (A) through (F) and the caretakers of such individuals, of the availability of such assistance.

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

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

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

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

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

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

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

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

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

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

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

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

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

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

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

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

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

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

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

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

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

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv)

of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

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

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

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

(ii) receipt of reports of elder abuse;

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

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

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

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

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

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

(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a), STATE PLANS

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

(B) The State plan is based on such area plans.

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

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(29), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The State agency conducts periodic evaluations of, and public hearings on, activities and projects carried out in the State under titles III and VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas. *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

Signature and Title of Authorized Official

Date

Required Assurances and Exhibits

Section I. Required Assurances

State Plan Provisions from Section 307(a) of the Older Americans Act

(1)(A) The Connecticut Department of Social Services requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

(2) The Connecticut Department of Social Services:

(A) evaluates, using uniform procedures described in section 202(a)(29), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The Connecticut Department of Social Services conducts periodic evaluations of, and public hearings on, activities and projects carried out in the State under titles III and VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities, with particular attention to low-income minority individuals and older individuals residing in rural areas.

(5) The Connecticut Department of Social Services:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under 316.

(6) The Connecticut Department of Social Services will make such reports, in such form, and containing such information, as the Assistant Secretary may

require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the Connecticut Department of Social Services or an area agency on aging in the State, unless, in the judgment of the Department of Social Services—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

State Plan Assurances from Section 307 of the Older Americans Act

(1) The Connecticut Department of Social Services assures that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

((a)(7)(A))

(2) The Connecticut Department of Social Services assures that

(A) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(B) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(C) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act. **((a)(7)(B))**

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

(4) The Connecticut Department of Social Services assures that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs. **((a)(10))**

(5) The Connecticut Department of Social Services assures that area agencies on aging will—

-(A) enter into contracts with providers of legal assistance, which can demonstrate the experience or capacity to deliver legal assistance;

(B) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(C) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis. **((a)(11)(A))**

(6) The Connecticut Department of Social Services assures that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services. **((a)(11)(B))**

(7) The Connecticut Department of Social Services assures that, to the extent practicable, legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; **((a)(11)(D))**.

(8) The Connecticut Department of Social Services assures that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. **((a)(11)(E))**

(9) The Connecticut Department of Social Services assures that any area agency on aging carrying out services for the prevention of abuse of older individuals will

conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

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

(D) referral of complaints to law enforcement or public protective service agencies where appropriate. **((a)(12))**

(10) The Connecticut Department of Social Services assures that it will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State. **((a)(13))**

(11) The Connecticut Department of Social Services assures that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English speaking ability, then the Department will require the area agency on aging for each such planning and service area.

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

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

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

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences. **((a)(14))**

(12) The Connecticut Department of Social Services assures that it will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

(E) older individuals with limited English speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses (A) through (F) and the caretakers of such individuals, of the availability of such assistance.

((a)(16))

(13) The Connecticut Department of Social Services assures that, with respect to the needs of older individuals with severe disabilities, the Department will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities. **((a)(17))**

(14) The Connecticut Department of Social Services assures that area agencies on aging will conduct efforts to facilitate the coordination of community based, long-term care services, pursuant to section 306(a)(7), for older individuals who-

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

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

(C) are patients in long-term care facilities, but who can return to their homes if community based services are provided to them. **((a)(18))**

(15) The Connecticut Department of Social Services assures that special efforts will be made to provide technical assistance to minority providers of services.

((a)(20))

(16) The Connecticut Department of Social Services assures that

(A) it will coordinate programs under this title and programs under title VI, if applicable; and

(B) that it will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities. **((a)(21))**

(17) The Connecticut Department of Social Services assures that, if case management services are offered to provide access to supportive services, it shall ensure compliance with the requirements specified in section 306(a)(8). **((a)(22))**

(18) The Connecticut Department of Social Services assures that demonstrable efforts will be made-

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in childcare, youth day care, educational assistance, at risk youth intervention, juvenile delinquency treatment, and family support programs. **((a)(23))**

(19) The Connecticut Department of Social Services assures that it will work with the appropriate agencies to coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance. **((a)(24))**

(20) The Connecticut Department of Social Services assures that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title. **((a)(25))**

(23) The Connecticut Department of Social Services assures that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title. **((a)(26))**

(24) The Connecticut Department of Social Services assures that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph. **((b)(3)(E))**

Section II. State Plan Information Requirements

Section 102(19)(G)

The Connecticut Department of Social Services defines 'in-home' services provided through Older Americans Act funding to include all those services included with the definition of 'in-home' services found in Section 102(19)(A) through (F), these being:

(A) services of homemakers and home health aides

(B) visiting and telephone reassurance

(C) chore maintenance

(D) in-home respite for families and adult day care as a respite service for families

(E) minor modification of homes that is necessary to facilitate the ability of older individuals to remain at home and that is not available under another program (other than a program carried out under the Older Americans Act).

In addition the following services, which are provided under the Older Americans Act, are considered in-home services:

Personal Emergency Response - In home, twenty-four hour electronic alarm system, which enables a high-risk individual to secure help in a medical, physical, emotional or environmental emergency.

Shopping Services - Service helps participants to obtain food and other basic necessities in the interest of safety and convenience. This service could involve taking the participant shopping if he/she is able to leave home, or doing the shopping for participants who are not able to get out. Deference should be given to the participant's preferred merchants and to convenience.

Personal Assistance Credits - Volunteers provide personal assistance service such as transportation, grocery shopping, respite care and friendly visiting to older persons requiring this assistance to remain in the community. In return these volunteers are given credits, which may be used for similar services should they be required by the volunteers at some time in the future.

Home Mental Health Counseling - This service is designed to provide psychiatric care and counseling in the home to persons in danger of institutionalization or who may have suffered significant losses, dementia, depression, etc. Pharmaceutical therapy is available in addition to counseling when needed.

Hospice - This category refers to family and home oriented palliative care, which focuses on emotional and psychological support for an understanding of the 60+ incurable disease victim. This care includes pharmaceutical services, bereavement counseling, volunteer visits, training and visits by social workers, counselors and ancillary medical personnel.

Section 305(a)(2)(E)

The Connecticut Department of Social Services assures that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income minority individuals and older individuals residing in rural areas and includes proposed methods of carrying out the preference below;

The Connecticut Department of Social Services utilizes a variety of methods to carry out the requirement for giving preference in the provision of services to those in greatest economic or social need. The Title III funding formula is based on several elements including five weighting factors, which pertain to the achievement of this requirement. These are low-income, rural residence, minority status, low-income minority status and functional limitations or disability.

The Department of Social Services requires all Title III service providers to set targets for low-income and minority participation and these targets are used by DSS and the Area Agencies to monitor provider performance. The Title III Management Information System (MIS) also tracks participation by age and impairment level and town of residence. This data is collected by the Area Agencies and their grantees on a monthly basis and is used by all participants in the aging network to assess their success in reaching those in greatest social and economic need. The system includes information on participation by persons who are both low-income and minority group members.

The Department of Social Services conducts periodic needs assessments and special studies on various issues related to the status and needs of Connecticut's elderly. A comprehensive need assessment based on a random probability survey of a thousand interviews that focused on health related matters was completed in 1987. A supplemental study was conducted in 1994. A second major study was completed in 2002. This study focused on transportation, home care, employment and nutrition issues. Data from these studies has been analyzed to identify those problems faced by persons in greatest social and economic need and to recommend solutions. A comprehensive assessment of Connecticut Residents long-term care needs is currently being conducted with a final report due in January 2007. Based on the information gathered, recommendations will be made regarding meeting the needs of older adults and persons requiring long-term care. The Department continues to work closely with other organizations within the state to improve the level of services available to residents in publicly subsidized housing for the elderly.

The Department of Social Services and the Area Agencies on Aging have worked and continue to work with local community organizations to establish meal sites and senior centers in areas with high concentrations of persons in greatest economic and social need. These sites act as focal points of service for these populations and draw them into the aging network. Efforts are made to assist in

the recruitment of staff appropriate to the target population. DSS feels that outreach is particularly important in reaching persons in greatest social and economic need. They are one of the principal targets of its public information effort. DSS encourages each of the state's Area Agencies to spend at least 2% of its Title III allocation on outreach programs for persons in greatest economic and social need. In addition, the Department of Social Services itself conducts extensive outreach efforts to the target population.

DSS includes training on targeting these populations in its network training programs and the training it provides for municipal agents. It also provides technical assistance to organizations interested in serving those in greatest economic and social need.

These efforts have been successful in encouraging significant numbers of low-income, minority, and functionally impaired individuals to participate in Older Americans Act funded programs. Although only 10 percent of Connecticut's older residents were reported as minority group members by the 2000 Census, 15 percent of registered Title III program participants during the 2005 federal fiscal year, 4,420 participants, were reported as being members of minority groups. Similarly, only 6 percent of persons age 65 or over were reported as having incomes below the poverty threshold in 2005. During the 2005 federal fiscal year 6,180 participants, 27 percent of all participants for whom income was recorded, were reported as having incomes below the poverty threshold. An additional 12,786 participants reported incomes between the poverty threshold and 150% of the poverty threshold.

The 1999 Census reported that 89,678 Connecticut residents age 60 or over living in the community suffered from mobility or self care limitations. This was approximately 16% of all persons age 60 or over residing in the community. The 2000 Census classified 162,931 Connecticut residents age 65 and over as having a disability, a broader category than the one used in 1990. Using the 2000 Census standard 37 percent of the state's elderly population would be classified as disabled. The 2000 Census disability standard considered persons 65 or older to be disabled if they had one or more of the following impairments: (a) blindness, deafness, or a severe vision or hearing impairment; (b) a substantial limitation in the ability to perform basic physical activities, such as walking, climbing stairs, reaching, lifting or carrying; (c) difficulty learning, remembering, or concentrating; (d) difficulty dressing, bathing, or getting around the home; (e) difficulty going outside the home alone to shop or visit a doctor's office.

The Lewin Group, a major health and human services consulting firm, has published a web based Home and Community Based Services (HCBS) population tool. The tool generates synthetic estimates of persons with functional limitations for states and specified age groups based on the findings of three national surveys: the 1990 Census Public Use Microdata Sample, the 1996 panel of the Survey of Income and Program Participation, and the Current Population Survey, March Supplement. The definition of functional limitation used to

generate these estimates, based on the ADL and IADL scales, is closest to the definition of disability used by AoA's National Aging Program Information System (NAPIS) reporting standards. The HCBS population tool estimate for functionally limited Connecticut residents age 65 or over in 1990 was 59,184 and 79,520 for 2000. The 2000 estimate is approximately 18 percent of Connecticut's non-institutionalized elderly population. During the 2005 federal fiscal year 12,667 Title III program participants reported functional limitations. This was 41 percent of all participants with at least partially completed functional limitation scales.

The Department of Social Services has adopted the definition of rural proposed by the Administration on Aging for nationwide use under the National Aging Program Information (NAPIS) reporting specifications for Older Americans Act programs. In these specifications the Administration on Aging defines rural as "*...an area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories) with a combined minimum population of 50,000 and (2) and incorporated place or census designated place with 20,000 or more inhabitants*". Zip codes meeting this definition were identified by the National Resource and Policy Center on Rural Long-Term Care under Administration on Aging grant #90-AM-0697 in a publication titled Guidebook for Operationalizing AoA's Definition of Rural and issued in July of 1996. These zip codes have been associated with Connecticut municipalities through the use of Connecticut Office of Policy and Management computer file "Ziptown.WK1" created in April 1994. Municipalities that were entirely covered by rural zip codes were considered rural. Municipalities that included both rural and urban zip codes were considered rural if more than fifty percent of their total population was residing in rural areas on Bureau of the Census' 1990 Census of Population and Housing Summary Tape File 1A. The 2000 Census reported 98,032 persons age 60 or over residing these in rural municipalities. This was 16 percent of all Connecticut Residents age 60 or older. In 2002 10,565 of the participants in Older Americans funded projects identified themselves as residents of rural towns. This was 22 percent of all participants who reported their towns of residence.

Taken together, 32,065 participants had either income below the poverty threshold, functional limitations, were members of minority groups or were residents of rural municipalities; that is, at least one out of three of the principal characteristics, which the Older Americans Act identifies as being indicative of social or economic, need. That was 64 percent of all participants whose records were complete in at least three of four areas and 59 percent of all Title III program participants.

These indicators are not only associated with higher levels of participation, but also more intense use. In 1998 the Department of Social Services under took a serious study of the value of services used by target group members. It found that the average estimated value of Title III funded services received by minority participants during the 1997 federal fiscal year was \$290. This was \$78 more

than the overall average of \$212 and \$93 more than the non-minority average of \$198. The average for low-income participants was lower, \$258, but it was still \$55 higher than the \$203 average for participants reporting incomes above the poverty threshold. Participants reporting at least one functional limitation received an estimated \$246 in Title III funded services. The value of services they received was \$58 higher than the \$188 average estimated for participants not reporting any functional limitations. Collectively participants reported as having at least one of these three target characteristics received an estimated average of \$231 in Title III funded services during the 1997 federal fiscal year. This was \$68 more than the \$163 collective average for participants who were not recorded as having any of these characteristics.

Section 307(a)(2)(C)

The Connecticut Department of Social Services specifies below, a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306(b) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) and listed below (may be listed in dollars, or percentages of titles III and VII allocations):

Access	16 percent
In-Home	25 percent
Legal Services	6 percent

The issue of minimum percentages for the Title IIIB priority services was the subject of considerable attention within the aging network from 1988 to 1992. During that period the Aging Services Division reviewed available data on needs and service utilization and held two public hearings on the subject. The set of minimum percentages adopted in 1988 was eventually modified in response to area agency concerns that it fixed too large a portion of their funds in specific categories and limited their flexibility in addressing local needs and responding to changes in the service environment. The minimum percentages that emerged from this process are those given above. These percentages went into effect on October 1, 1993.

Section 307(a)(3)(A) Intrastate Funding Formula

The plan includes a numerical statement of the intrastate funding formula and a demonstration of the allocation of funds to each planning and service area (PSA).

The goal of the intrastate funding formula is to have the distribution of Older Americans Act funds among the state's area agencies on aging reflect the distribution of the population with social and demographic characteristics known to be associated to the need for assistance in later life.

These characteristics, or "factors" as they are called in the formula, have all been identified in the Older Americans Act itself as defining the target population for community service programs under Title III of the Act. They are:

- a) All persons age 60 years or older
- b) Persons age 60 years or older who are members of racial or ethnic minorities
- c) Persons age 60 years or older with incomes at or below the poverty threshold
- d) Persons age 60 years or older unable to perform basic activities without assistance.
- e) Persons age 60 years or older living in rural communities
- f) Persons age 60 years or older who are both members of racial or ethnic minorities and have incomes below the poverty threshold.

The operational definitions of these factors and the data sources currently being used to enumerate them are described in detail in the notes at the end of this exhibit.

The formula is constructed by weighting the population age 60 or over in each planning and service area (psa) with the population in each of the other categories. This is accomplished by adding the population with these characteristics to the total population, in effect increasing the weight of persons with multiple need characteristics by the number of characteristics they possess. Thus, minority group members have a weight of two, low-income individuals have a weight of two, and low-income minority individuals have a weight of four. The formula can be expressed in mathematical notation as follows:

$$\$_A = ((\sum A_{(P1...P6)} / \sum S_{(P1...P6)})(0.5\$_S)) + ((0.5\$_S) / A_N)$$

Where:

$\$_A$ = Area Allocation

$\$_S$ = State Allocation

A = Area

S = State

A_N = Number of Area Agencies in State

P_1 = Total Population 60+

P_2 = Minority Population 60+

P_3 = Low-Income 60+

P_4 = Impaired 60+

P_5 = Rural 60+

P_6 = Low-income Minority 60+

The underlying assumption is that persons with these characteristics are not distributed in the same pattern as the general population, and that by weighting the general population to reflect these populations in need, funding will be more equitably distributed than if distributed by the general population alone. Because a minimum level of funding is believed essential to maintain a viable service program

in any psa, half of the funding available is divided into five equal portions, and half by the population factors described in the preceding paragraphs.

In the event that the Department of Social Services receives funding awards under Title III of the Older Americans Act from supplemental appropriations or Administration on Aging reallocations that total less than \$10,000, these will be exempt from formula allocation. In the absence of extreme demonstrated need as determined by the Director of Elderly Services, the award of such funds will be made to the area agencies on a rotating basis, beginning with Planning and Service Area (PSA) I, Southwestern Connecticut, with each area agency receiving the full award in successive years. The designated recipient area agency has the option of declining the allocation, should there not be a need in their region. Agencies that are unable to utilize at least 85 percent of their current year's allocation shall be considered to not have a need in their regions. In such cases, the allocation will pass to the next planning and service area in the rotation.

Area Agencies shall not carry more than 15 percent of their allocation over from the preceding fiscal year. Whenever the Director of Aging Services determines that an area agency on aging's carry over will exceed 15 percent of the current year's allocation, the director may make the amount in excess of 15 percent available for reallocation to such other area agencies as can demonstrate a need for the additional funding during the current fiscal year. Funds will be reallocated to those area agencies that request such funding and can demonstrate the need for additional funding in accordance with such procedures and criteria as are developed and promulgated by the Director in the event that the need for such a reallocation should occur. Any reallocation amount made available to an area agency on aging from an appropriation for a fiscal year in accordance with the preceding sentence shall be regarded as the part of that area agency's allocation for the fiscal year in which the reallocation is made and shall remain available only until the end of that fiscal year. Connecticut also funds over 2.1 million in nutrition services through its general fund *to* provide congregate and home delivered meals for older adults. The Aging Services Division will review the current funding formula during the first year of this Plan to determine if a new method should be used to distribute nutrition funds to the Area Agencies on Aging, taking into consideration the need in the individual regions.

The Plan is being submitted using the current formula. During the first year of this Plan, the Aging Services Division will review the current needs and service utilization of Connecticut older adults to determine if current percentages are adequate. If it is recommended that the formula is revised, a public hearing will be held and the Plan will be amended to reflect the revision.

Continued use of this formula for the distribution of funds under Title III of the Older Americans Act is subject to the approval of the Commissioner of the Administration on Aging.

FORMULA FOR DISTRIBUTING TITLE III FUNDS

FUNDING FACTOR	AREA					TOTAL
	SW	SC	EC	NC	WC	
TOTAL 60+	121,128	117,492	87,546	172,885	96,311	595,362
MINORITY 60+	10,958	8,015	2,839	12,543	4,089	38,444
LOW INCOME 60+	7,042	7,837	5,048	11,009	6,058	36,994
IMPAIRED 60+	17,442	18,721	12,915	26,628	13,972	89,678
RURAL 60+	4,881	2,725	42,474	13,297	28,662	92,039
MINORITY 60+ (POOR)	1,798	1,659	428	2,565	789	7,239
TOTAL	163,249	156,449	151,250	238,927	149,881	859,756
POPULATION FACTOR PERCENT	19.0	18.2	17.6	27.8	17.4	100.00
FUNDING FORMULA PERCENT	19.5	19.1	18.8	23.9	18.7	100.00
FUNDING DISTRIBUTION (DOLLARS)	\$2,030,115	\$1,988,472	\$1,957,239	\$2,488,193	\$1,946,829	\$10,410,848

Notes:

1. TOTAL 60+" - The population reported as having reached 60 years of age or older in 1990 in the Bureau of the Census' 1990 Census of Population and Housing Summary Tape File 1A.
2. "MINORITY 60+" - The population reported as having reached 60 years of age or older in 1990 and having identified their race as "Black"; "American Indian, Eskimo or Aleut" or "Asian or Pacific Islander" or answered the question on Hispanic origin in the affirmative. Since "Race" and "Hispanic Origin" were treated as separate variables in the 1990 Census, the overlap between the Hispanic population and the population identified as members of racial minorities was eliminated by subtracting the number of persons age 60 and over identifying themselves as being both Hispanic and members of a racial minority category from the number in that racial minority category. This data was drawn from the Bureau of the Census' 1990 Census of Housing and Population Special Tabulation on Aging,, CD90-AOA1.
3. "LOW INCOME 60+" - The population reported as having reached 60 years of age or older in 1990 and having an income at or below the Bureau of the Census' poverty threshold in 1989. This data was drawn from the Bureau of the Census' 1990 Census of Population and Housing Special Tabulation on Aging, CD90-AOA1.
4. "IMPAIRED 60+" - The population reported as having reached 60 years of age or older, residing in the community and having a mobility or a self-care limitation in 1990. A mobility limitation was defined on the 1990 Census questionnaire as a health condition of 6 months' duration or longer that made it difficult for an individual "to go outside the home alone, for example to shop or go to the doctor." A self-care limitation was defined as a health condition of 6 months' duration or longer that caused an individual "difficulty in taking care of his or her personal care needs such as bathing, dressing or getting around inside the house." This data was drawn from the Bureau of the Census' 1990 Census of Population and Housing Special Tabulation on Aging, CD90-AOA1.
5. "RURAL 60+" - The population reported as having reached 60 years of age or older and living in rural municipalities in 1990. The Administration on Aging defines rural as "...an area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000 and (2) and incorporated place or census designated place with 20,000 or more inhabitants". The National Resource and Policy Center on Rural Long-Term Care under Administration have identified zip codes meeting this definition on Aging grant #90-AM-0697. These zip codes were associated with Connecticut municipalities through the use of Connecticut Office of Policy and Management computer file "Ziptown.WK1". Municipalities that were entirely covered by rural zip codes were considered rural. Municipalities that included both rural and urban zip codes were considered rural if more than fifty percent of their total population was residing in rural areas on Bureau of the Census' 1990 Census of Population and Housing Summary Tape File 1A. Data on the resident municipal population age 60 and over in 1990 was drawn from the Bureau of the Census' 1990 Census of Population and Housing Summary Tape File 1A.
6. "MINORITY 60+ (POOR)" - The population reported as having reached 60 years of age or older in 1990 and reporting themselves as falling into one of the race or Hispanic origin categories described under the note on "Minority 60+" and reporting an income at or below the Bureau of the Census' poverty threshold in 1989. This data

was drawn from the Bureau of the Census' 1990 Census of Population and Housing Special Tabulation on Aging, CD90-AOA1.

7. "TOTAL" - The sum of each column. The total represents the population age 60 or older in each area weighted by the number of individuals falling into each need category as defined above.
8. "POPULATION FACTOR PERCENT" - The total in each area divided by the state total. This figure represents the percent of the state's weighted population found in each planning and service area (psa).
9. "FUNDING FORMULA PERCENT" - In order to ensure a minimum level of funding to each psa, half of any allocation distributed by formula is divided equally among the five psas. This figure represents the percent of the allocation that will actually be received by each psa. Mathematically, it is simply the arithmetic mean of the population factor percent and 20 percent.
10. "FUNDING DISTRIBUTION (DOLLARS)" - The formula distribution of Connecticut's Title III allocation of \$10,410,848 for the federal 1998-99 fiscal year between Connecticut's five planning and service areas (psas) is included to illustrate the way funds are allocated under this intrastate funding formula.

Section 307(a)(3)(B)(i)

The Connecticut Department of Social Services assures that it will spend for each fiscal year of the plan, not less than the amount expended for services to residents of rural areas in the 2000 federal fiscal year.

Section 307(a)(3)(B)(ii)

The plan identifies, for each fiscal year to which the plan applies, the projected costs of providing services to rural residents (including the cost of providing access to such services).

During the 2005 federal fiscal year a total of \$1.2 million in funds allocated under Title III of the Older Americans act were used to provide services to the residents of Connecticut's rural municipalities. The four largest categories of service received by rural residents were Congregate Meals (\$362 thousand), Home Delivered Meals (\$312 thousand), Transportation (\$141 thousand) and Home Care and other alternatives to institutionalization (\$192 thousand). Assuming a constant rate of inflation, the costs of providing a similar level of service to Connecticut's rural residents would be approximately \$1.46 million during the 2007 federal fiscal year, \$1.49 million during the 2008 federal fiscal year and \$1.52 during the 2009 federal fiscal year. Connecticut's intrastate funding formula includes a rural factor. The factor has been an element within the state's funding formula since the mid-1970s. The factor was introduced in recognition of the additional costs required to deliver services to the residents of rural municipalities. As the formula is currently computed, approximately five percent of funds available under Title III of the Older Americans Act are allocated according to the distribution of the state's rural elderly population.

Section 307(a)(3)(B)(iii)

The plan describes the methods used to meet the needs for services to rural residents in the fiscal year preceding the first year to which such plan applies.

Approximately three-quarters of all of Connecticut's rural residents reside in two of the state's five planning and service areas. These are the Western Connecticut PSA and the Eastern Connecticut PSA. The area agencies that serve these areas, the Western Connecticut Area Agency on Aging and Senior Resources of Eastern

Connecticut, accommodate the needs of rural residents in their area plans and in their service allocations. The management information systems used by the state's aging network record program participants' municipalities of residence wherever feasible, so area agencies are able to determine their success in providing services to rural residents. During the last completed federal fiscal year 10,210 service recipients identified themselves as rural residents. This was 24 percent of all service recipients who provided information on their municipalities of residence. Of these 9,012, 88 percent, resided in either the Eastern or Western PSAs. The services most commonly used by rural residents were congregate meals, home delivered meals, transportation, home and community based alternatives to institutionalization, health screening and clinics and counseling services. The cost of providing this level of service to rural residents is estimated at \$1.76 million, an increase of 41 percent over the level of service provided in the 2002 federal fiscal year.

Section 307(a)(8)(B)

Regarding case management services, the following agencies are already providing case management services (as of the date of submission of the plan) under a State program, and the State agency specifies that such agencies are allowed to continue to provide case management services:

The South Central Connecticut Area Agency on Aging provides case management services under Title III of the Older Americans Act through its BRIDGE program for persons who are not eligible for case management and home care from other existing programs. The Connecticut Department of Social Services specifies that the South Central Connecticut Area Agency on Aging is allow to continue the provision of case management services for the period of this plan.

Section 307(a)(8)(C)

Regarding information and assistance services and outreach, the State agency specifies that the following agencies may provide these services directly:

All five of Connecticut's area agencies on aging provide information, assistance and outreach as a part of the CHOICES program that also includes health insurance and public benefit awareness and counseling. The program is operated jointly by the area agencies and the Department of Social Services. The following agencies are authorized for the direct provision of information, assistance and outreach services:

Southwestern Connecticut Agency on Aging
South Central Connecticut Agency on Aging
Eastern Connecticut Area Agency on Aging dba Senior Resources
North Central Area Agency on Aging
Western Connecticut Area Agency on Aging

Section 307(a)(10)

The plan provides assurance that the special needs of older individuals residing

in rural areas are taken into consideration and describes how those needs have been met and how funds have been allocated to meet those needs.

For purposes of this plan the Department of Social Services has adopted the definition of rural proposed by the Administration on Aging for nationwide use under the National Aging Program Information (NAPIS) reporting specifications. In these specifications the Administration on Aging defines rural as “...*an area that is not urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories) with a combined minimum population of 50,000 and (2) an incorporated place or census designated place with 20,000 or more inhabitants*”. Zip codes meeting this definition were identified by the National Resource and Policy Center on Rural Long-Term Care under Administration on Aging grant #90-AM-0697 in a publication titled Guidebook for Operationalizing AoA’s Definition of Rural and issued in July of 1996. These zip codes have been associated with Connecticut municipalities through the use of Connecticut Office of Policy and Management computer file “Ziptown.WK1” created in April 1994. Municipalities that were entirely covered by rural zip codes were considered rural. Municipalities that included both rural and urban zip codes were considered rural if more than fifty percent of their total population was residing in rural areas on Bureau of the Census' 1990 Census of Population and Housing Summary Tape File 1A. Prior to this plan the Department of Social Services had defined rural towns in Connecticut for purposes related to the Older Americans Act as those located outside the boundaries of Metropolitan Statistical Areas (MSAs). This earlier definition had been adopted to bring the Department of Social Services' planning process into conformity with regulations issued to implement the 1978 amendments to the Older Americans Act.

Eighty-four of Connecticut's 169 towns conform to the most recent definition of rural and, in 2000, they were home to 98,023 of Connecticut residents age 60 and above. Under this definition the rural elderly population is 16 percent of the state’s total elderly population.

The Department of Social Services uses rural residence as one weighting factor in its funding formula. In effect, all rural residents receive a weighting of two, and an additional weight is given to members of other special groups such as minority, low-income or the frail elderly if they live in rural areas. Most rural residents are served by either the Western Area Agencies on Aging or Senior Resources of Eastern Connecticut. The special needs of rural residents are reflected in the plans and funding decisions of these Area Agencies. Historically, transportation and the relatively high cost of delivering in-home services to a widely dispersed population have been among the central concerns expressed in these areas.

During the past year approximately 19% of all registered Title III service recipients lived in rural towns and 22 percent of those for whom the town of residence was recorded. Congregate meals, home delivered meals,

transportation, benefits counseling, health and dental clinics were among the numerically most important services utilized by these participants. Rural residents constituted high proportions of the participants in a number of service categories including medical visits, telephone reassurance, transportation, benefits counseling, dental clinics and congregate meals.

Section 307(a)(15)

The plan, with respect to the fiscal year preceding the fiscal year for which this plan is prepared (A) identifies the number of low-income minority older individuals in the State.

(B) describes the methods used to satisfy the service needs of such minority older individuals.

In 2000 the Census reported Connecticut had 7,478 minority residents aged 60 years or over with incomes at or below the Federal poverty guidelines. Minority individuals were approximately 18% of all individuals aged 60 years or over with incomes below the poverty guidelines. A further 4,901 are reported to have incomes between poverty and 150% of poverty. The 2000 Census figures show 30,818 Connecticut residents age 65 and over with incomes below the poverty threshold. If the ratio between those 60+ in poverty and those 65+ in poverty in 1990 were the same for 2000, we would expect approximately 38,000 of the state's residents age 60 and over to be in poverty. Assuming the proportion of older minority group members was the same in 2000 and it was in 1990, there would have been approximately 6,900 older low-income minority group members in Connecticut in 2001.

The Connecticut Department of Social Services includes factors on minority status and low-income in its funding formula. It also includes a specific low-income minority factor. Title III providers are required to set yearly targets for minority and low-income participation which are used by DSS and the Area Agencies to monitor provider performance. In 1990 requirements were introduced for low-income minority participation as well. The Department of Social Services provides training and technical assistance on minority programming to current and prospective service providers. The Department has also been instrumental in the establishment of meal sites and senior centers in locations that serve primarily minority clientele and in the recruitment of culturally sensitive and bilingual staff where appropriate.

Needs assessment studies conducted in Connecticut during the 1980s found that lower income minority respondents tended to rate their health lower than other respondents and they reported higher rates of restrictive morbidity. They reported higher levels of stress and lower levels of morale. Their financial concerns were particularly strong in the areas of discretionary spending ("little extras"), utility expenses, medical expenses, and household upkeep. In addition they were more likely to identify housing and transportation as problems than other respondents. In general lower income minority respondents were more likely to report using services than other respondents. However, given their high

rates of poor health and financial concerns it was a little surprising to find that none of the low-income minority respondents reported using adult day care, chore services, friendly visitors or senior job banks.

During the 2005 federal fiscal year, 3,894 Older Americans program participants were recorded as being low-income minority group members. This figure represented 6 percent of all registered Title III program participants and 10 percent of those for whom income information was recorded. This is a relatively high rate of use considering the 2000 Census for Connecticut found only 1.2 percent of the elderly falling into this category. The greatest numbers of low-income minority participants are found using the congregate meals program, home delivered meals, transportation, social work services, senior centers, and outreach. The highest proportions of low-income minority participants are found using companions, senior center, fixed route transportation, employment assistance, legal assistance and counseling. In 1997 a detailed study of Older Americans Act expenditures found that expenditures per low-income minority participant were approximately \$327. This was \$115 above the estimated average per participant expenditure of \$212 and \$125 above the estimated \$202 per participant expenditure for participants who were not low-income minority elderly.

Section 307(a)(21) (B)

The plan specifies the ways in which the State agency intends to implement activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under title III.

The State Unit on Aging has modified its requirements for area plans to include the assurance that they will pursue activities to increase access to Title III services by Native Americans in accordance with sec. 306(a)(19) of the Act and to specify the ways in which they will implement these activities. The State Unit monitors the area agencies to assure they are pursuing such activities and includes an assessment of their efforts as part of their end of the year evaluation. The 2000 Census reported that 879 Connecticut residents age 60 or over identified themselves as Native Americans. The Census also reported that 37 persons age sixty or over was living on Native American reservations or tribal lands in Connecticut. During the 2001 federal fiscal year 310 participants in Older Americans Act funded service programs identified themselves as Native American. That was approximately 1 percent of all persons who had participated in OAA funded programs during the last completed fiscal year.

Section 705(a)(7)

The State Agency includes a description of the manner in which the State agency will carry out Title VII (Vulnerable Elder Rights Protection Activities) in accordance with the assurances described in paragraphs (1) of through (6) of this section. The description must provide the following information:

1- describes the program of services for the ombudsman program and describes the program for the prevention of abuse, neglect, and exploitation.

The Ombudsman Program investigates complaints made by or on behalf of nursing home residents and residents of residential care homes. Provides information and consultation on long term care issues and empowers residents and families on how to discuss and address concerns with nursing home staff. Educates and informs residents and families on residents' rights as well as state and federal mandates. Promotes and supports Resident and Family Councils. Publishes a newsletter for nursing home residents to be informed of issues affecting their care and life. Organized and continues to support (for six years) a statewide Coalition of Presidents of Resident Councils which meets quarterly in the six regions of the program, to identify systems and systemic issues and trends. Provides community education and disseminates information and resources. Holds public meetings on crucial long-term care issues. Represents the interest of nursing home residents at hearings, court proceedings and legislative committees and task forces. Advocates for and proposes statutory amendments and changes. Successfully advocated for the passage of four amendments and/or statutes benefiting nursing home residents in the last five years. Published three research studies; Transfer trauma due to relocation of residents at the time of closures, Non medical transportation trends, Analysis of complaint data in the Connecticut Ombudsman Program as well as a Model Relocation plan for closures. Recruits, trains and supervises the Volunteer Resident Advocate Program and holds three statewide conferences for volunteers. Have developed partnerships with organizations and agencies in the long-term care field. Holds memberships with state and national organizations in the aging network.

Through grants to the local Area Agencies on Aging in each region of the State, the Department of Social Services Aging Services Division has established a comprehensive community based program of information, education and outreach focusing on the prevention of elder abuse and exploitation, expanding public awareness of the rights of the elderly and enhancing partnerships with community agencies serving seniors and their family members or caregivers. The State agency is strengthening outreach efforts to under-served populations such as low income, homebound, rural and minority elders through the creation and dissemination of bilingual printed materials, innovative methods of information distribution and increasing cooperative activities with community agencies such as, domestic violence shelters, law enforcement agencies, Meals on Wheels programs and other local organizations serving seniors. Increased outreach and education efforts targeting caregivers is also occurring through workshops and material dissemination done in cooperation with the AAA components of both the elder abuse and Connecticut National Family Caregiver Support Programs.

The State agency continues to focus on strengthening the knowledge of community service providers in regard to abuse and exploitation of the elderly. The State agency and local AAAs collaborate on methods of developing the

knowledge and skills of traditional and non-traditional senior service providers working in the community. Multi-Disciplinary Teams consisting of social workers, medical professionals, senior center Directors and other such community partners continue to function in many regions of the State to resolve difficult cases, identify gaps in service and address community needs through the development of new programs and cooperative efforts. In addition, through collaboration efforts and a grant from the State agency AAAs continue to provide trainings for senior services providers, law enforcement officers and bank personnel on topics including but not limited to, the causes, warning signs and protocol for responding to cases of financial exploitation, physical abuse and self-neglect.

2- describes how the State uses public hearings and other means to obtain the views of older persons, area agencies on aging, Title VI grantees, and other interested parties.

The Commissioner of the State Department of Social Services co-convenes with the Office of the State Long Term Care Ombudsman an annual statewide conference, the Voices Forum, in which the Statewide Coalition of Presidents of Resident Councils (SCPRC), brings forward directly to policy-makers and legislators their concerns on long-term care issues, specifically those issues affecting the quality of their lives and the quality of their care. The Office of the Long Term Care Ombudsman then makes recommendations for policies and or regulatory changes as well proposes amendments to existing statutes or new laws based on the issues and trends identified at the Voices Forum.

The State agency strives to gain input from all parties involved in elder abuse programming across the State both providers and recipients. The State agency develops all elder abuse programming in conjunction with the Area Agencies on Aging that will receive grant funding from Title VII and other funds to implement many of the programs. Input from the Area Agencies on Aging and other direct service agencies such as regional offices of the Department of Social Services is vital to the development of statewide elder abuse programming. These agencies are able to identify community needs and critical gaps in services and collaborate with the State agency to develop appropriate programming to address these needs.

3- describe how the State will consult with area agencies and will identify and prioritize statewide activities aimed at ensuring that older persons have access to and assistance in securing and maintaining benefits and rights.

The Area Agencies on Aging are a critical component to the successful development and implementation of the State's elder abuse programs. The AAAs work within their communities and respond directly to the target populations. The AAAs share their first hand knowledge of issues facing seniors in Connecticut with the State agency, therefore enabling the agency to develop appropriate elder abuse prevention programming. AAAs are also asked to select and develop their

own elder abuse programs based on need and available funding. All elder abuse programming conducted by the AAAs is done to prevent and respond to cases of elder abuse, exploitation and neglect as well as to educate seniors and the general public as to the rights of and services available to elders throughout the State. The State agency co-develops and monitors the majority of elder abuse programming conducted by the AAAs.

4- describe how the State will ensure that it will not supplant pre-existing funds to carry out each of the vulnerable elder rights protection activities.

Connecticut's Elderly Protective Services' program is funded, primarily, from a combination of state general fund allotments and SSBG funding. Older Americans Act funding is used, primarily, to cover public information, outreach and advocacy activities. Connecticut's commitment to establish and fund a protective services program for older persons in the community predates the establishment of Title VII

5- describe how the State will ensure that it will place no restriction other than those in Section 712(a)(5)(C) on the eligibility of entities for designation of local Ombudsman activities.

The State Ombudsman designates and de-designates volunteers. The State Ombudsman selects regional ombudsmen under the state classified employees policies to carry out their delegated duties in accordance with the established policies and procedures of the Office. The designation and de-designation of Office staff, hiring and termination processes, are the ones for all classified employees of state services. State statutes, CGS Section 17b-400 establishes the Office of the Long-Term Care Ombudsman, with Ombudsman staff out-posted in six regional offices.

6- describe how the State agency will conduct a program of services consistent with State law and coordinated with existing State adult protective services for public education, receipt of reports, active participation of older persons through outreach, conferences, and referral, how referral of complaints to law enforcement or public protective services will be done, how the State will not permit involuntary or coerced participation in the program, and how all information gathered in the course of receiving reports and making referrals shall remain confidential except under prescribed conditions.

In Connecticut direct protective services are provided through the Elderly Protective Services Program within the Department of Social Service's Social Work Division. Public education and advocacy are handled by the state's five area agencies on aging. The investigation of complaints, referral of complaints to law enforcement when required and ongoing social and material support are provided through protective services workers operating in the Department of Social Service's regional offices. Public education, outreach and coordination of activities with local social service providers are among the responsibilities of the area agencies on aging. The Department of Social Service's Aging Services Division works closely with the Social Work Division to facilitate regional

coordination. The regulations governing the operation of the Elderly Protective Services Program require a strict enforcement of confidentiality in all aspects of their operations. Aggregate data on the number and type of cases handled is available on a periodic basis from the Social Work Division and this data is used by the Elderly Services Division and the area agencies to educate the public on the nature and prevalence of elder abuse. Individual records are not handled at the area agency level.

Appendix A
Area Agencies on Aging

North Central Area Agency on Aging

Carmen Reyes, Executive Director
Two Hartford Square West, Suite 101
Hartford, Connecticut 06106
Telephone: 860-724-6443
Fax: 860-251-6107
Website: <http://www.geocities.com/ncaaus>

Towns Served:

Andover	Enfield	Rocky Hill
Avon	Glastonbury	Simsbury
Berlin	Granby	Somers
Bloomfield	Hartford	Southington
Bolton	Hartland	South Windsor
Bristol	Hebron	Stafford
Burlington	Manchester	Suffield
Canton	Marlborough	Tolland
East Granby	New Britain	Vernon
East Hartford	Newington	West Hartford
East Windsor	Plainville	Wethersfield
Ellington	Plymouth	Windsor

Senior Resources – (Eastern Connecticut’s Area Agency on Aging)

Joan Wessell, Executive Director
4 Broadway, 3rd Floor
Norwich, Connecticut 06360
Telephone: 860-887-3561
Fax: 860-886-4736
Website: <http://www.seniorresourcesec.org>

Towns Served:

Ashford	Deep River	Hampton
Bozrah	Durham	Killingly
Brooklyn	Eastford	Killingworth
Canterbury	East Haddam	Lebanon
Chaplin	East Hampton	Ledyard
Chester	East Lyme	Lisbon
Clinton	Essex	Lyme
Colchester	Franklin	Mansfield
Columbia	Griswold	Middlefield
Coventry	Groton	Middletown
Cromwell	Haddam	Montville

New London
North Stonington
Norwich
Old Lyme
Old Saybrook
Plainfield
Pomfret
Portland

Preston
Putnam
Salem
Scotland
Sprague
Sterling
Stonington
Thompson

Union
Voluntown
Waterford
Westbrook
Willington
Windham
Woodstock

Agency on Aging of South Central Connecticut, Inc.

Neysa Guerino, Executive Director
One Long Wharf Drive
New Haven, Connecticut 06511
Telephone: 203-785-8533
Fax: 203-785-8873
Website: <http://www.agencyonaging-scc.org>

Towns Served:

Ansonia
Bethany
Branford
Derby
East Haven
Guilford
Hamden

Madison
Meriden
Milford
New Haven
North Branford
North Haven
Orange

Oxford
Seymour
Shelton
Wallingford
West Haven
Woodbridge

Southwestern Connecticut Agency on Aging

Linda DeLorenzo, Executive Director
10 Middle Street
Bridgeport, Connecticut 06604
Telephone: 203-333-9288
Fax: 203-696-3866
Website: <http://www.swcaa.org>

Towns Served:

Bridgeport
Darien
Easton
Fairfield
Greenwich

Monroe
New Canaan
Norwalk
Stamford
Stratford

Trumbull
Weston
Westport
Wilton

Western Connecticut Area Agency on Aging

Christina Fishbein, Executive Director

84 Progress Lane

Waterbury, Connecticut 06705

Telephone: 203-757-5449

Fax: 203-757-4081

Website: <http://www.wcaaa.org>

Towns Served:

Barkhamsted
Beacon Falls
Bethel
Bethlehem
Bridgewater
Brookfield
Canaan
Colebrook
Cornwall
Danbury
Goshen
Harwinton
Kent
Litchfield

Middlebury
Morris
Naugatuck
New Fairfield
New Hartford
New Milford
Newtown
Norfolk
North Canaan
Prospect
Redding
Ridgefield
Roxbury
Salisbury

Sharon
Sherman
Southbury
Thomaston
Torrington
Warren
Washington
Waterbury
Watertown
Winchester
Winsted
Wolcott
Woodbury

Appendix B
Caregiver Survey

2005 Caregiver Survey

Table I

Caregiver Needs (Total Responses)	Percent of Responses				
	Never	Seldom	Sometimes	Often	Almost Always
I eat a well-balanced diet (162)	1	2	27	38	33
I get help caregiving (155)	18	19	24	16	23
I get enough sleep (162)	4	12	27	38	19
I feel angry as a caregiver (154)	16	31	32	16	4
I feel worthwhile as a caregiver (153)	2	6	29	33	29
I feel anxious (153)	7	18	49	20	6
I fear I will not be able to do what is expected as a caregiver (154)	8	23	38	23	7
I feel blue or depressed (155)	15	28	39	12	6
I exercise (158)	5	21	34	26	15
I maintain contact with my friends (156)	1	9	33	35	21
I ask for help when I need it. (155)	6	25	45	17	7
I feel overwhelmed (154)	6	19	49	18	8
I feel appreciated (154)	4	16	33	29	19
I go regularly to medical/dental appointments (155)	2	10	14	29	46
I feel lonely (154)	19	29	31	12	8
I get support from friends and family (155)	5	12	39	26	18
I attend social events (155)	3	16	45	26	10
I feel guilty (154)	19	23	36	14	8
I enjoy a hobby (154)	5	19	38	23	15
I pursue spiritual interests (154)	12	22	21	21	23
I attend a caregiver support group (146)	69	14	7	4	6

Table II

Statement (Responses)	Percent of Responses					
	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree
Taking care of my loved one limits my social life (149).	16	25	35	7	15	1
I have to give my loved one almost constant attention (150)	11	17	22	14	29	7
There has been a change in my health since being a caregiver (149).	12	21	19	11	26	11
Care assistance costs more than I can afford. (137)	18	23	20	14	17	9
I feel comfortable talking with medical personnel about my loved one's condition. (151)	36	44	15	0	2	3
I have had to take a lot of time off from work to fulfill my caregiver responsibilities. (132)	15	9	21	7	23	24
I know where to go for help with caregiving (150)	6	18	33	21	13	9
When I leave medical appointments with my loved one, I feel satisfied that my questions have been answered (152)	15	28	36	12	7	2
I have all the services I need to help me with caregiving (145)	3	14	32	22	18	11
I have a good idea of the services that are available to help me in my role as caregiver (151)	5	14	37	15	17	13
I have a good understanding of my loved one's illness(es) (146).	22	34	26	9	5	3
I have problems with my employer when I have to take time off because I have caregiver responsibilities. (111)	5	5	14	8	29	39

Table III

**Caregivers' Awareness of Aging-Related Programs
and Organizations**

Name of Agency or Program	Percent of Respondents (N = 177)
Connecticut Department of Social Services	45
AARP	71
National Family Caregiver Support Program	10
Area Agencies on Aging	24
Adult Day Care	40
Connecticut Homecare Program	19
Municipal Agent	7
Senior Center	59
Statewide Alzheimer's Respite Care Program	16
Eldercare Locator	8
Congregate Housing	10
Resident Services Coordinator	6
Assisted Living Community	44
Senior Community Café	4
Alzheimer's Association	31
Personal Care Assistant Program	12
Companion	25
Personal Emergency Response System	21
Homemaker/Home Health Aide	34
Home Delivered Meal	44
Safe Return	9
Visiting Nurse	64
Dial A Ride	45

Connecticut Department of Social Services Aging Services Division, 2005 Caregiver Survey

Appendix C

**AAA's Statewide Needs
Assessment**

Summary of 2005 Area Agency Needs Assessment Findings

Between November 15, 2005 and December 30, 2005 Connecticut's five area agencies on aging conducted an extensive survey of the needs felt by participants in Older Americans funded programs and other older persons. Altogether 1,101 older persons completed survey questionnaires. Respondents included participants in at least 120 service programs for the elderly and residents of at least 124 towns. The questionnaires used in the survey contained 83 separate questions dealing with nine major concerns, 32 separately delineated needs, and a number of demographic and attitudinal characteristics. These questionnaires were based on a questionnaire developed by the Agency on Aging of South Central Connecticut (AASCC) for an earlier study and refined through a series of focus groups conducted by the area agencies during October of 2004. AASCC trained staff in the use of the questionnaires, coordinated data collection efforts and tabulated the results.

The participating area agencies and associated service programs solicited survey respondents. Because the sampling procedure was not random (as would be the case in a national opinion poll for example) it is not clear as to how representative respondents are of any larger population. They were, however, drawn primarily from participants in area agency funded or operated service programs and their responses can be reasonably viewed as reflective of the problems and concerns of the people who regularly use these programs. Table VIII "Comparison of Demographic Characteristics" compares certain of the respondents' demographic characteristics with those of participants in Older Americans Act (OAA) funded programs recorded by the Department of Social Services' management information system. The table also provides a column with comparable percentages from the 2000 census. Respondents were generally similar to survey respondents only a little younger, a little more likely to be women, a little more likely to be African-American or Hispanic, a little less likely to be married, and a bit more likely to have very low incomes. Both groups contained a much high proportion of women, poor people, minority group members, very old individuals, not currently married persons and renters than the general elderly population in Connecticut.

Health and health related concerns completely dominated the needs identified by clients. Health was the most commonly identified concern. Most of the top ranking needs dealt with services that would be useful for persons struggling with difficulties induced or exacerbated by failing health. Even the widespread concern with transportation could be the result of mobility impairments brought on by declining health. A multivariable regression analysis looking at the number and severity of the needs identified by respondents found that a poor health assessment was the best overall predictor of number of needs respondents identified.

Financial concerns were the next most commonly identified by these respondents. This is not surprising given the very low incomes reported by

respondents, yet no specific financial need was identified by more than half of the respondents. The two most commonly identified financial needs, “paying for medications” and “paying for medical care” could be as reflective of the health status of respondents as of their financial concerns. Assistance with financial management, a potentially useful and cost effective program provided by many area agencies, both in Connecticut and elsewhere, seemed to have been of interest to a little less than a third of survey respondents.

Transportation was the third most commonly identified concern and the second most commonly identified need. As noted above, transportation needs are often associated with declining health, a concern well attested to within the respondent population. It has also been documented as a problem of low-income individuals in general, and most respondents reported very low incomes. As anyone who deals with the elderly or other limited mobility populations should be aware, Connecticut has a very fragmented and inconsistent public transportation system. People without access to an automobile are assured of some level of difficulty in getting around and people without resources are most likely to find themselves in this situation. Area agencies and advocates for the elderly have long been aware of this need and have initiated many creative programs to address it. The persistence of the problem is more likely a reflection of the system’s lack of resources rather than any failing of effort or vision. This finding should encourage the elderly services network to persist in its effort to strengthen elderly transportation services.

In past studies, housing needs were highly associated with the overall number of needs expressed. While this relationship was not specifically examined in this data, but the pattern is likely to hold. Apparently changes in one’s life status – the death of a spouse, declining health, changes in household composition or income – encourage people to look for alternatives to their current housing arrangements. Most of these respondents were probably not in the midst of a life altering transition at the time they were surveyed, so the expression of housing concerns was relatively modest compared to other areas. One finding of the multiple variable regression analysis that ought to be noted is that senior housing residence was a negative predictor of the overall number of needs identified. To put it another way, people who had a number of characteristics that predicted a high number of needs but who were elderly housing residents had a lower number of needs than those who were not. This finding suggests that senior housing provides some extra benefit to high-risk individuals.

Older people are notoriously unwilling to admit to emotional or psychological concerns. The relatively high proportion of respondents (around 40 percent) who identified loneliness or emotional well being as needs was unusual in needs studies of the elderly. Since this was not a random probability survey, the interpretation is not certain. However, knowing that mental health is often a neglected area when it comes to elderly services, and that some experts believe that older people suffer from a great deal of undiagnosed depression; this finding provides some support for that position.

Most of the respondents to this study were not living with either spouses or grandchildren, so that needs associated with either spousal care or child or grandchild care were not commonly expressed. Respondents who did, however, express a need for either spousal or child care, were significantly more likely to be male, Hispanic and indicate a general need for some or a lot of help than people who did not.

Information and assistance is a very commonly expressed need in many studies of the older population. The general population is not very familiar with the services available to the elderly and can anticipate that finding these services, when needed, could be a problem. While concern about finding help was not insignificant in this study, most of the respondents to this survey were already receiving some form of benefit from the aging network and had a starting place to seek additional assistance. It is not unreasonable to believe that informational services would probably have had a higher priority among an unaffiliated set of respondents. Taking that into consideration, however, it is interesting to note that Doctors are mentioned more often than any other information source except for friends or neighbors. The level of health concern in this set of respondents may make Doctors or Doctors' offices a particularly important link in their search for assistance.

As mentioned earlier, Part of the analysis of the survey was to look at the relationship that various demographic and psychosocial variables had to the overall number and severity of problems reported by respondents. The purpose was to try and determine if there were subgroups in the population who were particularly vulnerable and in need of additional attention. Multiple regression attempts to predict the number of needs (or some other score) that individuals will have based on correlations between the various independent measures (or variables) and the dependent measure or score (in this case needs). It does this by calculating the amount of the variation between the observed and predicted score that can be attributed to a particular variable. The essence is to find the best predictors of the dependent score. Thirteen variables were examined using this methodology. They were: Gender, Age, Income, Hispanic Identity, African-American Identity, Marital Status, Own House, Private Apartment, Senior Housing, Self Assessed Health, Outlook, General Self View, and Activity Level. The equation that best fit the observed results explained about 23 percent of the variance, which is respectable for social science research. The following variables were included in the final equation in order of their predictive value: Self Assessed Health, Outlook, Income, General Self View, Hispanic Identity, Activity Level, Senior Housing Residence and African-American Identity. This is interesting because, among the elderly, age and income are often associated with measures of vulnerability. In this set of respondents, when self assessed health and psychosocial variables such as general self-view and outlook were known, knowing age and gender did not add to the predictability of the equation. What this means in the real world is, at least for people like these survey respondents, that if you want to know how vulnerable they're likely to be, it's more important

to know their assessment of their health and what they think of their outlook than to know their age or their gender.

The rates of response for individual needs, cross-tabulated by area and social and demographic characteristics can be found in the following eight tables.

Significant associations are marked. Those marked with a ** have about one chance in a hundred of occurring by chance. Those marked with a * have one chance in twenty of occurring by chance. Those marked with a ~ have one chance in ten of occurring by chance. By convention, the first two are considered statistically significant. The third is considered borderline.

	Area					Average	Significance	Total Valid Cases (Not Blank)
	1	2	3	4	5			
Total Questionnaires	174	402	105	324	96			
Concern								
Health	88.9%	85.1%	86.3%	85.5%	88.4%	86.2%		1,075
Fiscal	81.5%	72.1%	66.7%	70.1%	72.2%	72.6%	*	1,042
Spouse's Health	44.7%	35.5%	53.1%	51.2%	52.1%	44.3%	**	592
Children	68.0%	63.0%	65.2%	65.1%	68.2%	64.6%		938
Grandchildren	66.2%	60.0%	57.8%	62.1%	59.0%	61.3%		907
Living Location	52.7%	43.9%	37.1%	43.5%	41.4%	44.4%		1,020
Friends	50.9%	37.2%	25.6%	40.8%	37.5%	39.5%	**	1,021
Transportation	62.4%	57.6%	54.5%	59.1%	47.9%	57.6%		1,062
Rights	59.9%	46.9%	47.3%	47.7%	44.4%	49.0%	*	1,040
Finding Help	65.5%	46.6%	51.1%	47.5%	39.6%	49.8%	**	1,049
Need								
Physical Health	67.6%	69.3%	57.1%	67.8%	45.2%	65.4%	**	1,075
Emotional Well-being	54.8%	43.6%	32.3%	39.5%	28.6%	41.8%	**	1,049
Selfcare	47.0%	49.7%	26.3%	43.2%	23.9%	42.9%	**	1,054
Spousal Care	31.4%	22.3%	17.9%	28.5%	19.6%	25.0%		628
Child Care	20.0%	17.7%	11.0%	14.7%	7.0%	15.7%	~	853
Grandchild Care	25.7%	18.6%	8.2%	16.3%	8.6%	17.4%	*	841
Grief	39.9%	33.3%	36.4%	34.6%	29.3%	34.7%		871
Maintaining Friendships	35.5%	25.1%	28.6%	27.3%	20.0%	27.3%	~	1,052
Intergenerational Contact	22.7%	19.0%	23.7%	25.9%	15.7%	21.8%		1,024
Loneliness	56.3%	43.8%	40.6%	39.5%	25.3%	42.6%	**	1,056
Transportation	59.4%	64.7%	47.9%	58.3%	35.2%	57.9%	*	1,059
Mobility	55.4%	58.7%	46.3%	52.3%	31.9%	52.9%	**	1,052
Safety out of the Home	39.8%	38.9%	24.0%	33.2%	18.7%	34.2%	*	1,049
Safety at Home	53.0%	53.3%	40.6%	47.8%	31.1%	48.5%	**	1,041
Finding Help	52.6%	41.1%	35.1%	43.7%	28.3%	42.1%	**	1,051
Finding a Place to Live	28.2%	28.4%	18.9%	27.1%	19.4%	26.3%		1,038

	Area					Average	Significance	Total Valid Cases (Not Blank)
	1	2	3	4	5			
Paying for Housing	38.6%	34.7%	29.5%	34.2%	18.9%	33.3%	**	1,044
Paying for Utilities	43.1%	36.6%	30.8%	37.1%	33.0%	37.0%		1,041
Taxes	36.0%	23.8%	24.2%	28.6%	19.8%	26.9%	*	990
Chores	54.9%	58.2%	42.1%	47.1%	39.1%	51.2%	**	1,039
Homemaker or Home Health Aid	46.7%	40.4%	24.7%	35.8%	28.6%	37.6%	*	1,043
Trustworthy Helpers	54.4%	42.1%	34.7%	37.8%	23.3%	40.6%	**	1,042
Family Understanding	43.0%	36.5%	30.1%	33.4%	24.7%	35.1%	*	1,028
Meals and Nutritional Advice	30.2%	30.3%	24.1%	29.6%	22.2%	29.1%		1,032
Grocery Shopping	46.5%	56.5%	31.3%	43.3%	31.9%	46.5%	**	1,051
Ordering Finances	39.5%	34.4%	27.4%	32.1%	25.3%	33.1%		1,044
Managing Bills	40.4%	30.9%	27.1%	30.9%	20.9%	31.2%	*	1,044
Understanding Medical Benefits	58.4%	45.5%	38.0%	38.4%	41.3%	44.5%	**	1,054
Medical Costs	53.2%	42.9%	37.5%	37.8%	26.7%	41.2%	**	1,036
Cost of Medications	53.8%	42.5%	35.8%	42.1%	31.1%	42.7%	**	1,036
Finding Helping Agencies	55.9%	45.8%	41.8%	45.0%	41.8%	46.5%	~	1,050
Preventing Illness	46.7%	39.9%	37.9%	39.0%	27.8%	39.5%	~	1,032
Keeping Active	34.9%	33.9%	33.7%	33.3%	20.4%	32.7%		1,047
<u>Count of All Problems Reported</u>							**	1,101
None	4.6%	4.7%	14.3%	6.2%	15.6%	7.0%		
1 to 5	20.1%	18.9%	21.0%	25.0%	30.2%	22.1%		
6 to 10	19.0%	25.9%	27.6%	22.5%	17.7%	23.3%		
11 to 20	30.5%	32.6%	22.9%	26.9%	31.3%	29.5%		
21 or more	25.9%	17.9%	14.3%	19.4%	5.2%	18.2%		
<u>Problem Score</u>							**	1,101
None	4.2%	4.7%	14.3%	6.1%	15.6%	6.9%		
1 to 5	17.6%	15.0%	19.0%	22.6%	27.1%	19.1%		
6 to 15	30.9%	37.7%	38.1%	33.4%	33.4%	31.3%		
15 to 25	21.2%	21.7%	15.2%	17.8%	14.6%	19.2%		
26 or more	26.1%	20.9%	13.3%	20.1%	11.5%	19.9%		

	Area					Average	Significance	Total Valid Cases (Not Blank)
	1	2	3	4	5			
"Very much need help" scored as 2, "Somewhat need help" scored as 1, "Don't really need help" scored as 0								
<u>Social and Demographic Variables</u>								
<u>Gender</u>								1,074
Female	81.5%	80.8%	77.9%	75.9%	76.8%	78.9%		
Male	18.5%	19.2%	22.1%	24.1%	23.2%	21.1%		
<u>Age</u>							**	1,069
Under 65	10.1%	10.8%	23.9%	12.4%	10.5%	12.3%		
65 to 74	34.3%	25.4%	29.3%	32.4%	38.9%	30.4%		
75 to 84	40.2%	46.0%	33.7%	41.0%	31.6%	41.3%		
85 or older	15.4%	17.8%	13.0%	14.3%	18.9%	16.1%		
<u>African-American</u>	27.2%	13.1%	2.0%	14.6%	4.3%	14.0%	**	1,070
<u>Hispanic or Latino</u>	15.6%	11.1%	0.0%	5.8%	1.1%	8.4%	**	1,070
<u>Relative Income</u>							**	1,029
Poor	15.2%	22.1%	12.8%	17.1%	9.4%	17.6%		
Low-income	53.2%	54.5%	37.2%	46.1%	38.5%	49.0%		
Modest or above	19.3%	12.4%	19.2%	20.1%	34.4%	18.4%		
Refused	12.3%	11.1%	30.8%	16.8%	17.7%	15.1%		
<u>Education</u>							~	1,067
Not Highschool Graduate	38.0%	38.0%	43.5%	38.8%	21.1%	37.2%		
Highschool Graduate	38.0%	39.3%	33.7%	36.3%	43.2%	38.1%		
Some College or College Graduate	24.1%	22.7%	22.8%	24.9%	35.8%	24.7%		
<u>Employment</u>							*	1,072
Not Currently Working	67.8%	81.7%	70.3%	81.8%	67.0%	77.2%		
Employed Full-time	4.1%	2.8%	5.5%	2.2%	5.3%	3.3%		
Employed Part-time	14.0%	3.3%	6.6%	6.9%	12.8%	7.2%		
Volunteer	14.0%	12.3%	17.6%	9.1%	14.9%	12.3%		
<u>Current Marital Status</u>							*	1,068

	Area					Average	Significance	Total Valid Cases (Not Blank)
	1	2	3	4	5			
Couple	25.0%	19.2%	28.3%	27.5%	32.6%	24.5%		
Currently Alone	75.0%	80.8%	71.7%	72.5%	67.4%	75.5%		
<u>Family Unit</u>							**	866
One person	59.7%	71.5%	50.0%	61.8%	52.6%	62.9%		
Two people	26.4%	21.4%	31.8%	29.0%	38.5%	27.0%		
Three or more	14.0%	7.1%	18.2%	9.2%	9.0%	10.0%		
<u>Housing</u>							**	1,075
House	42.8%	35.3%	42.4%	37.4%	47.9%	38.9%		
Apartment	19.7%	18.5%	10.1%	18.7%	5.3%	16.8%		
Senior, Congregate or Assisted Housing	31.8%	39.1%	43.4%	40.6%	43.6%	39.2%		
Other	5.8%	7.0%	4.0%	3.2%	3.2%	5.1%		
<u>Self Assessed Health</u>							**	1,099
Good or better	70.1%	66.6%	75.2%	68.5%	91.6%	70.7%		
Not so good	29.9%	33.4%	24.8%	31.5%	8.4%	29.3%		
<u>Self View</u>							**	1,098
Great or Good	79.3%	70.6%	74.3%	77.8%	91.5%	76.2%		
Less than Good	20.7%	29.4%	25.7%	22.2%	8.5%	23.8%		
<u>Outlook</u>							**	1,088
Positive	59.8%	57.9%	51.0%	64.2%	74.0%	60.8%		
Neutral	29.3%	26.9%	35.6%	20.4%	19.8%	25.6%		
Negative	10.9%	15.2%	13.5%	15.3%	6.3%	13.6%		
<u>Independence</u>							*	1,067
Needs a lot of help	10.7%	17.2%	8.8%	11.4%	7.4%	12.8%		
Needs some help	49.4%	49.2%	46.1%	45.1%	44.2%	47.3%		
Needs little or no help	39.9%	33.6%	45.1%	43.5%	48.4%	39.8%		

Concern = Percent very or somewhat concerned

Need = Percent who very much or somewhat need help

Significance:

~ = 0.10 significance level

* = 0.05 significance level

** = 0.01 significance level

Appendix D

Comments on the Plan

References and Acknowledgments

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