The Administration for Community Living has approved the extension of Connecticut’s State Plan on Aging through September 30, 2014.
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Executive Summary

In accordance with the Older Americans Act of 1965 the Connecticut Aging Services Division of the Department of Social Services, as the designated State Unit on Aging (SUA), is mandated to submit a State Plan on Aging to the U.S. Administration on Aging. The State Plan on Aging presents Connecticut’s direction for the next three years. It establishes goals, objectives and strategies and it focuses the needs of the state’s older residents, their families and their caregivers, including long-term care. This plan has been developed through collaborative efforts with state agencies and community service providers and includes input from stakeholders, older residents and caretakers.

Trends identified in the State Plan on Aging:

- Connecticut is an aging state with growing demands on services for older residents.
- People want to stay in the home and community of their choosing as they age.
- On average, most people have not adequately planned for long-term care needs.

Connecticut, like much of the nation, is aging rapidly. It is estimated that by 2015 the number of residents ages 65 and older will increase by nearly twelve (11.9) percent while the number of residents ages 18 through 64 will grow by less than one tenth of one percent (0.10%). This dynamic will result in significant increases in demand for services, particularly long-term care with fewer resources to provide those services. That, coupled with the current economy, will set the stage for several years of challenges facing our aging population as well as our service providers.

These current challenges exist within a long-term care system where 65 percent of Medicaid dollars are spent on institutional care and 35 percent of Medicaid dollars are spent on home and community based services. Currently Medicaid dollars for home and community services provide services for more people than Medicaid dollars for institutional care. This system is maintained with fragmented services among aging, mental health and disability service providers. Many services are separate from one another, each with different access points, processes and providers based upon diagnosis, age or functional status. This has created unnecessary difficulty and frustration for consumers, family members and caregivers when seeking assistance. Fortunately, Connecticut’s aging network has made significant strides within the long-term care system. New programs developed throughout the care continuum have begun to allow seniors and younger people with disabilities to remain in the home and community of their choosing while providing streamlined access to services.

The state remains committed to meeting the needs of today’s older residents and preparing for those of tomorrow. To do so, the State Unit on Aging will focus on providing more consumer choice and control regarding long-term care options; expanding programs to meet the needs of a growing aging population; continuing to advocate for elder rights; and enhancing statewide collaborations to support older residents, their caregivers and families. To that end, Connecticut has adopted the following focus areas:

1. Strengthen and expand the core programs of the Older Americans Act including Title III (i.e. supportive services and nutrition) and Elder Rights Programs (Title VII);
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2. Integrate Connecticut’s Administration on Aging discretionary programs namely, Community Living Programs, Evidence-Based Disease Prevention Program and Aging and Disability Resource Centers into the core programs;
3. Support consumer control and choice across the spectrum of Connecticut’s long-term care services, including home, community and institutional settings.

These actions to improve the state’s long-term care system will provide older residents, their families and their caregivers easier access to information and assistance. These actions will continue to move Connecticut towards a rebalancing of the Medicaid dollars spent on long-term care. Finally these improvements will afford seniors more options when seeking long-term care services and more control in how and where those services are delivered.

Throughout the three years of this State Plan on Aging, Connecticut will closely monitor its efforts to make quality improvements to the services provided to the state’s older residents, their families and their caregivers. To do so, Connecticut has chosen the following goals for its three-year state plan:

1. Empower Connecticut’s older residents, their families, and other consumers to make informed decisions about existing health and long-term care options and enable these groups to access these options more easily.
   Objectives include:
   ▪ Educate the public to prepare for their long-term care needs.
   ▪ Educate the aging services network about the resources available to the public regarding long-term care options.

2. Enable seniors to remain in their own homes and maintain a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers.
   Objectives include:
   ▪ Provide older adults the opportunity to remain in a setting of their choice by making available an array of services and supports.
   ▪ Ensure Connecticut’s caregivers and older adults have access to information and flexible service options that allow them to direct how and when services are delivered.

3. Empower older people to stay active and healthy through services under the Older Americans Act and the new prevention benefits under Medicare.
   Objectives include:
   ▪ Promote Health and Wellness Programs.
   ▪ Enhance awareness of information and programs designed to promote the healthy aging of Connecticut’s older residents.
   ▪ Promote awareness of prevention benefits available to older adults through
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Medicare.
4. Ensure the rights of older people and prevent their abuse, neglect, and exploitation.

Objectives include:
- Improve access to quality legal advice, representation and referral for older persons, particularly those with the greatest social and economic needs and advocate on behalf of older people who are frail or have a disability to improve responsiveness to their needs.
- Develop a unified system of elder abuse prevention in Connecticut that strengthens the efforts of protective services, reduces criminal victimizations of older persons and facilitates the delivery of law enforcement services to our aging populations.
- Empower seniors to know and exercise their rights, make informed decisions about planning for long-term needs and promote opportunities for self-advocacy.

Connecticut can be proud of its many accomplishments in its services for older residents. In 2009 - 85,629 seniors received services. Also during that year 2,177,777 meals were provided and 140,924 units of service were provided for health insurance counseling, information and assistance through the CHOICES program.

Connecticut’s State Unit on Aging continues to support opportunities for our communities throughout the state. For example, five (5) CHOICES trainings are held each year for new volunteers. Once trained, volunteers educate seniors about available health insurance options. In addition, five (5) forums are held by the Connecticut Partnership for Long-Term Care to educate residents on the importance of long-term care insurance. These forums are in addition to numerous other presentations provided by the Partnership throughout the state. Other events supported by the state’s aging network have included the annual National Health Care Decisions Day and 2009’s Getting Ready for Work for participants of the Senior Community Service Employment Program. Connecticut can also include the opening of two Independent Transportation Network (ITNAmerica®) affiliates and the availability of $750,000 in special state funding in 2008 for 168 senior centers and municipal agents among its many successes over recent years.

In combination with these services, the State Unit on Aging began significant new initiatives with new grant funding during the previous State Plan on Aging. In 2007, the Model Approach to Statewide Legal Assistance for Elders Grant was awarded to expand collaborations and legal services to educate and serve vulnerable seniors. Connecticut also received the first Community Living Program grant and developed the Choices at Home Cash and Counseling program as well as the state’s first Aging and Disability Resource Center (ADRC). In 2008, the state received an Evidence-Based Health Program grant to assist people with a chronic illness gain confidence in their ability to control their symptoms and to recognize how their health problems affect their lives as well as a second Community Living Program grant which opened a second ADRC. In 2009, an ADRC grant was awarded to open a third Aging and Disability Resource Center in the state. Finally, in 2009 and 2010, Connecticut received $1,817,139 through the American Recovery and Reinvestment Act to
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expand existing services of nutrition, employment and evidence-based disease prevention programs for older residents statewide. With this State Plan on Aging, Connecticut has mapped out its goals and objectives to address the issues facing the state’s current and future older residents. With a focus on strong services and consumer directed care the State Unit on Aging, in partnership with the aging network, will provide older adults, their families and their caregivers easier access to information and assistance as well as long-term care services with fewer barriers and challenges.
Vision and Purpose

The Connecticut Aging Services Division of the Department of Social Services, as the designated State Unit on Aging (SUA) is pleased to present its three-year State Plan on Aging as a roadmap for serving the state’s older population. The plan for Federal Fiscal Years 2011 -2013 provides the priorities by which Connecticut will ensure elders have access to the supportive services necessary to live with dignity, security and independence.

The State Unit on Aging (SUA) is responsible for planning, developing and administering a comprehensive service delivery system. To accomplish this, the division conducts needs assessments, surveys methods of service administration, evaluates and monitors such services, maintains information and referral services, and develops, coordinates, and/or collaborates with other appropriate agencies to provide services to the state’s elders. More specifically, the division administers Older Americans Act programs for supportive services, in-home services, and congregate and home-delivered meals. It also administers programs that provide senior community employment, health insurance counseling, and respite care for caregivers.

This State Plan on Aging will be the primary resource for the state as it strives to meet the needs of an aging population. Over the next 15 years Connecticut’s total population is projected to increase by 3 percent, growing by 113,526 people. Although this increase is modest, there are two extraordinary trends. The number of adults between 18 and 64 will decrease by 107,092 (5 percent) and the number of individuals, ages 65 and older will increase by 207,705 or 40 percent, because of the aging Baby Boom generation. These changes coupled with the challenges of a struggling economy will make the goals and strategies outlined in this plan an important tool to navigate the coming years.

Mission and Purpose

The Connecticut Department of Social Services maintains a vision of people working together to support individuals and families to reach their full potential and live better lives. In that spirit, the agency’s mission is to provide a continuum of core services to:

- Meet basic needs of food, shelter, economic support and healthcare;
- Promote and support the choice to live with dignity in one’s own home and community; and
- Promote and support the achievement of economic viability in the workforce.

With these guiding principles, the SUA has worked with its partners in the aging network to develop a State Plan which supports the priorities of the Administration on Aging to ensure aging residents maintain independence and dignity in the home and community of their choosing for as long as possible.

The purpose of this plan is to provide a road map for the state’s long-term care systems for older adults; a translation of activities, data and outcomes of services and a way of building capacity for services throughout the state.
In 2009, the Connecticut State Unit on Aging (SUA) received more than $18 million in federal funding, including Older Americans Act funding and almost $8 million in state funding to provide services to older adults and their caregivers. With these funds, the SUA provided 2,177,777 congregate and home delivered meals; supplied 211,943 trips for elders to doctor’s appointments, shopping and recreational activities; funded 116,973 hours of adult day care services and provided 140,924 units of service for health insurance counseling, information and assistance.

Previously, Connecticut’s State Plan on Aging allowed the state to expand services, foster changes in ideology and to identify opportunities for new partnerships. The state can be proud of what it has accomplished during the last three years. There have been successes with the receipt of Community Living Program funding, the opening of three Aging and Disability Resource Centers and the securing of the Evidenced Based Disease Prevention Program funding to address Chronic Disease Self-Management and Fall Prevention. The state continues to face challenges, both old and new, that have shaped the delivery of services and the needs of our aging population.

The economy continues to be a challenge that impacts all of the state’s efforts in both how services are delivered and who is receiving those services. As budgets continue to be stretched, our state has an uncertain economic future. On a local level, senior centers are facing reductions in funding and local food banks are seeing increases in demand by over 30 percent in some communities. Despite our budget uncertainties Connecticut continues to provide services to our growing number of older residents in need.

Through these successes and challenges, Connecticut has diligently developed its new State Plan on Aging with a full understanding of the population that it is serving, the needs of our state residents and the availability of resources.

The People Served by the Plan

In Connecticut, as across the nation, the age of our population is changing. Though a small state, it is ranked 29th in population size. It is also quickly becoming one of the oldest states in the union. In Attachment C Connecticut’s Demographics contains information regarding population race and ethnicity, location, poverty, aging and disability, education and employment and the Elderly Economic Security Standard Index.
Given this information, projections can be made regarding how Connecticut will age as a state. The US Census Bureau anticipates the following to occur between 2010 and 2015: the number of residents between 18 and 64 years of age will increase by only one tenth (0.10) percent while the number of residents aged 65 and older will increase by nearly twelve (11.9) percent.3

The issues that accompany this dynamic will include an increased demand for medical care, an amplified need for accessible and safe housing, an increased demand for reliable transportation options, a greater need for employment and a significant expansion in services to meet the growing need for assistance.

Physical and Mental Health

National Information

Demographic changes across the nation, as well as in Connecticut, have important implications for service delivery to our older adults. As the number of aging residents grows and life expectancy increases for men and women, issues of physical and mental health become a major focus of what services are needed and how they are delivered.

The following data on older adults has been obtained from “The Profile of Older Americans” [Administration on Aging, 2009] and the chartbook “Older Americans 2008: Key Indicators of Well-Being” [Federal Interagency Forum of Aging, 2008] to illustrate important health indicators for older adults.

Nationwide 38.9 million people were age 65 and older in 2008. Of this, 19.6 percent were minorities – 8.3 percent African-American and 6.8 percent Hispanic. There were 16.5 million more women than men during that year. Of those older residents ages 65 and older not living in institutional settings, 31 percent lived alone, however, half of the women ages 75 and older live alone. Also during 2008, 3.7 million residents nationwide lived below the poverty level ($10,400 annually for an individual).4

Nationwide, 39.1 percent of non-institutionalized older adults in 2008 assessed their own health as excellent or very good. This finding was relatively consistent between men and women; however there were significant differences across ethnicity. Only 25.1 percent of African-Americans, 23.2 percent of Native Americans and 28 percent of Hispanic individuals described their health as excellent or very good.

Also in 2008, 38 percent of older adults nationwide reported having a disability (sensory, physical, and mental). This finding increases with age, with 56 percent of individuals over the age of 80 reporting that they have a severe disability and 29 percent of that age group reported needing assistance. Of interest and concern is that disability was associated with poor report of health status and lower income status and levels of educational attainment.5

In 2007, heart disease and cancer were the leading causes of death for individuals age 65 and
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older irrespective of gender and ethnicity. Other major causes of death, in order of incidence included: stroke, chronic lower respiratory diseases, Alzheimer’s disease, diabetes and influenza and pneumonia.6

Forty-two (42) percent of individuals age 65 and older reported having a functional limitation. A functional limitation is defined as a limitation on an activity of daily living (ADL) or a limitation with an instrumental activity of daily living (IADL). Women are found to have higher incidence of functional limitations than men, with 47 percent of women having difficulty with daily living activities as compared to 35 percent of men.8

Depression is more common in people who have other illnesses or whose functioning has become limited.9 Older women are more likely than older men to report “clinically-relevant depressive symptoms”. In 2004, 17 percent of women ages 65 and older reported symptoms of depression as opposed to 11 percent of men.10 Regrettably, it can also be mistaken for a reaction to illness or life changes associated with aging.11

Connecticut Specific Data

The Connecticut Long-Term Care Needs Assessment completed by the University of Connecticut Health Center in 2007 has provided the state with various indicators of the health status throughout the state. This comprehensive study also gathered information on long-term care needs. The indicators of health status are the incidence of disability, prevalence of use of preventative health screenings, falls, unintended loss or gain of weight, hospitalizations and report of depression. The following information is based on the results of the 6,268 surveys that were returned. These surveys were completed by phone, mail and online. These surveys targeted people born in 1964 or earlier and all people with disabilities, regardless of age.

Although 78 percent of all respondents described their health as good or excellent, 22 percent reported fair or poor health. Of particular note is that health status varies across income and ethnicity. While 86 percent of those in top three income categories rated their health as excellent or good, 45 percent of low-income group rate their health as fair or poor. Among respondents, 45 percent of Latinos and 32 percent of Blacks rated their health as fair or poor, almost twice the rate at which Whites did so.

Low-income individuals were more likely to report disability than those in the top three income tiers, including physical (55%), intellectual (31%) and psychiatric (29%) disabilities. Incidence of disability ranges across ethnicity. Latino respondents reported the highest incidence of intellectual disability (20%), mental illness (22%) and the second highest incidence of physical disability (40%). Black respondents reported the highest incidence of physical disability (42%) and the second highest incidence of intellectual disability (15%) and mental illness (16%).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Women (%)</th>
<th>Men (%)</th>
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<tr>
<td>Hypertension</td>
<td>54%</td>
<td>52%</td>
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<tr>
<td>Arthritis</td>
<td>54%</td>
<td>43%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>26%</td>
<td>43%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>17%</td>
<td>19%</td>
</tr>
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54% of women and 52% of men reported hypertension
54% of women and 43% of men reported arthritis
26% of women and 43% of men reported heart disease
17% of women and 19% of men reported diabetes

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Low-income respondents were less likely to have received preventative health screenings. Generally, Black and Latino respondents had fewer wellness checks than Whites, with 54 percent of Blacks and 47 percent of Latinos reporting that they had not received one in the past two years as compared to only 38 percent of Whites. Across age tiers, those ages sixty-one through seventy-four reported either the highest or one of the highest rates of screenings in all areas, with the exception of wellness exams. Of note is that only about one third of those sixty-one through eighty-four have had a bone density or sigmoid/colonoscopy in the past two years. Further, while 75 percent of respondents age seventy-five and older had received the flu vaccine, the pneumonia vaccine had been much less utilized by any age.

Twenty-three percent of respondents experienced a fall within the twelve months preceding the survey. It is significant to note that 40 percent of those 85 and older reported falling in the last year.

Among other health indicators, of respondents Connecticut Long-Term Care Needs Assessment results show that 37 percent had been admitted to and stayed overnight in the hospital in the last year and 11 percent reported three or more admissions to the hospital in that time period. It is important to also note that 49 percent had at least one emergency room visit in the last year.

Generally, there was a high rate of mental health needs among respondents with 27 percent reporting that they often felt down, depressed or hopeless and 23 percent reporting little interest or pleasure in doing things. Forty-eight percent of the low-income group reported that they had experienced feelings of depression or hopelessness in the month prior to completing the survey. This compared to 17 percent of those in the top three income categories. This key indicator of mental health status ranged across ethnicity with 43 percent of Latinos reporting feeling down, depressed or hopeless in the last month as compared with 33 percent of Blacks and 25 percent of Whites.

Connecticut’s Long-Term Care

The Connecticut Long-Term Care Services and Supports website, www.ct.gov/longtermcare, defines long-term care as a wide range of consumer directed assistance, services or devices provided over an extended period of time and designed to meet medical, personal and social needs in a variety of settings or locations to enable a person to live as independently as possible.

Long-term care services and supports are needed to help people with activities of daily living (ADLs), including bathing, dressing, or eating, or the instrumental activities of daily living (IADLs) including meal preparation, housework, shopping, or managing money. These needs are met in many settings, including at home, another site in the community, in a managed residential care setting, or an institutional setting.

The Connecticut Long-Term Care Planning Committee completed the “Long Term Care Plan: A Report to the General Assembly January 2010” which addresses the long-term care
needs of Connecticut residents. In the 2010 Plan, it states that it is Connecticut’s goal to “establish a long term care system that offers individuals the services and supports of their choice in the least restrictive and most enhanced setting.” The 2010 Plan seeks to balance the long-term care system in terms of the ratio of home and community-based and institutional care and the ratio of public and private resources. This tool will be instrumental in coordinating services, addressing rebalancing and meeting the long-term care needs of the state’s residents.

In June 2007, The University of Connecticut Health Center also gathered information directly from the state’s residents about their current and future plans, what community based services they use now, what the unmet service needs are, how prepared they are to obtain these services, what their preferences and expectations for care are, what type of care they provided to family members and how they describe their physical and mental health status.

Of the more than 6,000 surveys returned, 80 percent reported a strong desire to remain in their own homes with home care services and supports, such as home health or homemaker services and modifications to the home. The least preferred choices were a move to an institution or congregate living center or moving in with an adult child.

- When asked how they will pay for Long-Term Care:
  - 38% plan on Medicare funding to pay for at least part;
  - 46% age 60 and older think Medicare will pay for all of their care and;
  - 25% of the baby boomers surveyed expect to rely on Medicaid.

- How much they think they can afford to pay in Long-Term Care each year:
  - 40% indicate they cannot afford to pay anything;
  - 25% believe they can pay less than $10,000 per year and;
  - Less than 20% are able to pay $25,000 or more per year.

Between July 1, 2008 and June 30, 2009 Connecticut spent $4.7 billion on Medicaid. Of that, over $2.5 billion was spent on long-term care services which encompasses both institutional (65%) and home and community-based services (35%).

The Connecticut Long-Term Care Needs Assessment also identified how residents and service providers recognize that there are many gaps in services with regard to long-term care. These gaps are:

1. Transportation
2. Supportive Housing
3. Community-Based Programs and Services
4. Mental Health
5. Dental Care
6. Other Health Issues

Connecticut’s long-term care system includes a multitude of services, both public and private. From informal caregivers to institutionalized medical services, this system involves a number of state agencies; however, with regard to older residents, the Department of Social
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Services is the lead. The Department of Social Services administers the Medicaid program for the state. It also houses the Money Follows the Person grant, traditional Home and Community Based Services (i.e. the Connecticut Home Care Program for Elders), Medicaid waivers, the Long Term Care Ombudsman and the State Unit on Aging. In this system, the State Unit on Aging provides a number of programs and initiatives to address the state’s long-term care needs including Congregate and Home Delivered Meals, Aging and Disability Resource Centers, Caregiver Support, Respite, Elder Abuse Prevention and the Long-Term Care Partnership (in collaboration with the Office of Policy and Management).

With changes in demographics, ongoing challenges in healthcare and dynamic socioeconomic issues throughout the state, Connecticut is dedicated to rebalancing its approach to long-term care from an institutional focus to a community based approach. Inherent in achieving this balance is the promotion of independence and choice for all individuals seeking supports and services.

Connecticut’s Aging Network

The State of Connecticut has a strong and diverse aging services network headed by the Aging Services Division. An array of services is provided in rural and urban settings, throughout different cultures and socioeconomic statuses and in large and small agencies. This network is made up of four core components.

The Aging Services Division: As Connecticut’s State Unit on Aging, the Aging Services Division of the Department of Social Services examines the conditions and needs of older individuals including but not limited to nutrition, transportation, home care, housing, income, employment, health, recreation and elder rights. As a part of the Department of Social Services, it works collaboratively with federal, state and local agencies to fulfill its responsibilities for providing an integrated social delivery system to aging residents.

In its capacity as the State Unit on Aging, this division is primarily responsible for the coordination of activities that impact the quality of life for older state residents. It coordinates those efforts directly and through contracts with service providers. The SUA also serves as an advocate for older persons and provides technical assistance to various agencies, organizations and individuals that address the needs of our residents.

To ensure federal and state funding are utilized to meet local demands, the State Unit on Aging works collaboratively with regionally based planning organizations, Connecticut’s five Area Agencies on Aging.

Agencies on Aging: In accordance with a 1973 amendment to the Older Americans Act the State of Connecticut has been divided into five planning and service areas (PSAs). These five PSAs are served by Area Agencies on Aging (AAAs) which are visible focal points to administer services within their region. With funding provided by the Aging Services Division the AAAs are private nonprofit agencies and local representatives in the social services system for aging services. Each Area Agency on Aging provides a wide array of
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services that responds to local needs as identified in an Area Plan. These Area Plans must be submitted to and approved by the State Unit on Aging.

For a complete listing of Connecticut’s AAAs and a map of each region please see Attachment D.

*Commission on Aging:* As an independent state agency located in Connecticut’s General Assembly, the Commission on Aging promotes responsible public policy in preparation for an aging state. Within its efforts to lead the state’s public and private sectors in promoting public policy issues important to the state’s older population, the Commission has provided the aging network with invaluable tools such as the recent “Connecticut Long-Term Care Needs Assessment” and the Elder Economic Security Standard Index.

*Additional Partners:* The rest of the aging network is comprised of local and state non-profit agencies providing day to day services to Connecticut’s older and residents with disabilities. Organizations and agencies such as AARP, Senior Centers, Municipal Agents for the Elderly, Community Action Agencies and non-profits provide a myriad of services including but not limited to, transportation, adult day care, volunteer services, housing, employment, community support, legal assistance and caregiver assistance.

*Developing the State Plan*

In early 2009, Connecticut’s five AAAs held focus groups with consumers, service providers, caregivers and other aging services stakeholders. The input from these groups assisted with the development of the Area Plan for each of the AAAs.

The State Unit on Aging staff used these plans, local, state and national trends and program data to develop specific goals and objectives for services based on federal priorities outlined by the Administration on Aging. Additional comments were collected from service providers in December 2009 and from consumer focus groups at five senior centers across the state.

Once the plan was completed, a draft was made public online. A public hearing was also held to collect input from across the state. This public hearing was held at the United Way of Central and Northeastern Connecticut on May 26, 2010 from 9:30 to 11:30am.

See Attachment F for Public Comments on the State Plan on Aging.

In an effort to provide comprehensive services to its older residents in a way that emphasizes accessibility and consumer choice, Connecticut has adopted the following focus areas:

1. Strengthen and expand the core programs of the Older Americans Act including Title III (i.e. supportive services and nutrition) and Elder Rights Programs (Title VII).

2. Integrate Connecticut’s Administration on Aging discretionary programs namely, Community Living Programs, Evidence-Based Disease Prevention Program and
Connecticut’s Focus Areas

3. Support consumer control and choice across the spectrum of Connecticut’s long-term care services, including home, community and institutional settings.

The Connecticut Aging Services Division of the Department of Social Services as the State Unit on Aging (SUA) plays a leadership role in the development and implementation of comprehensive service systems, including home and community based services for the state’s older individuals and their caregivers. It is important to note that the Aging Services Division does not have any direct administrative responsibility over the traditional home and community-based services (i.e. Home Care for Elders and various Medicaid waivers. However these programs are housed with the same State department with two Medicaid waivers housed within the same Bureau as SUA).

It is the intention of the state to improve coordination between services delivered through Title III and Title VII of the Older Americans Act and its discretionary grants to allow for a more effective delivery system and an increased focus on client centered services.

1. Older Americans Act Core Programs

In Connecticut the supportive, nutritional, health promotion and caregiver services of the Older Americans Act (OAA) Title III Grants for State and Community Programs on Aging are administered through the Area Agencies on Aging (AAAs). The SUA and the AAAs are dedicated to strengthening and expanding these vital services to meet the changing needs of our aging communities. One such example is the nutrition program’s Senior Community Cafes. The state is transitioning the delivery of some congregate meals towards a restaurant type setting to appeal to younger seniors and aging baby boomers by providing meals that are appealing to the aging palette and moving beyond the traditional congregate meal.

Through this State Plan on Aging, Connecticut will also use these core programs to better serve an aging resident as a whole person by including mental health and oral health services in addition to traditional healthcare services. Strategies to do this will include encouraging Area Agencies on Aging to utilize Title III funds to promote the availability of community mental health services and de-stigmatize mental illness and mental health treatment through education. The state will also require the use of Title III funds for the provision of oral health services. Both of these target areas were identified at our public hearings across the State as needed areas of concentration.

To strengthen Connecticut’s Title VII Vulnerable Elder Rights Programs, the state is taking a holistic approach to elder rights advocacy. Through the leadership of the Legal Assistance Developer, the State Unit on Aging will take a proactive role in expanding the state’s comprehensive elder justice system to protect and enhance the basic rights and benefits of vulnerable older people, and empower them to make informed choices that enhance their ability to remain in the community. By fostering collaboration among the Title VII programs, as well as agencies and other legal and aging advocates, the state will be able to address issues of the highest priority for the most vulnerable elders. Further coordination of education, outreach and advocacy will result in enhanced individual and community awareness, thus ensuring that those
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elders encountering legal issues, potential abuse or exploitation are identified and referred to appropriate sources of information and assistance.

2. Connecticut’s Administration on Aging Discretionary Grants

Connecticut received its first long-term care related discretionary grant in 2007. Since 2007, the state has made tremendous progress in bringing this innovative approach of long-term care to fruition. The State Unit on Aging is in the process of integrating its Community Living Program grant efforts into Older Americans Act programs and continues to develop and implement innovative strategies to incorporate all discretionary grant initiatives.

A. Connecticut’s State Unit on Aging (SUA) has received two rounds of Community Living Program (CLP) grant funding to implement a two pronged strategy to target consumers who are at risk of a nursing home placement and Medicaid spend-down through a) the development of the state’s first Aging and Disability Resource Center and b) the implementation of a Cash and Counseling Service Option utilizing the existing Title III-E National Family Caregiver Support Program (NFCSP) and Statewide Alzheimer’s Respite Care program funds. The Cash and Counseling Service Option takes these dollars and transforms them into flexible funds that allow fifty-five (55) clients to hire and receive care by their caregiver of choice.

Separately, the SUA facilitates the development and implementation of the Veteran’s Directed Home and Community Based Services (VDHCBS) option in the south central region of the state. The SUA in partnership with the Agency on Aging of South Central Connecticut and the VA Connecticut Healthcare System is developing a consumer directed home and community based service option for veterans residing in the south central region. Veterans served through this program will have the opportunity to self-direct their own care and receive services in their home by the caregiver of their choice.

Integration with Core Programs (Title III): Connecticut will implement a statewide self-directed care option through the existing Title III-E National Family Caregiver Support and Statewide Alzheimer’s Respite Care programs utilizing the Cash and Counseling model developed through the Community Living Program grant.

- Expected Outcomes:
  - The two existing cash and counseling pilot sites will be transitioned from pilot status to permanent.
  - Connecticut’s Area Agencies on Aging will provide a self-directed care option through these two programs.

B. The burdens of chronic disease continue to take their toll on the quality of life of older adults and the state’s healthcare system. As a response to this, the State Unit on Aging’s three-year initiative to mobilize non-profit aging and public health sectors to disseminate the Chronic Disease Self-Management (CDSMP) or the Live Well Program in the north central region of the state is part of the state’s Evidence-Based Disease Prevention Program which began in 2008. Through this initiative, people with a chronic illness (i.e. arthritis or diabetes) gain self-
Connecticut’s Focus Areas

Confidence in their ability to control their symptoms and how their health problems affect their lives. This discretionary grant is also designed to raise awareness about fall prevention among seniors in two regions of the state.

Integration with Core Programs (Title III): Connecticut has adopted the “2007-2012 Administration on Aging Action Plan” which provides a framework for older adults to stay active and healthy through the increased use of evidence-based disease and disability prevention programs. In embracing this strategy, Connecticut will establish Title III-D (disease prevention and health services) allocation requirements to ensure Area Agencies on Aging provide grantees with a method to provide these programs.

- Expected Outcomes:
  - Outreach efforts will be enhanced to increase awareness about the Live Well and fall prevention programs.
  - 100% of Title III-D funds will be targeted toward evidence-based disease prevention programs.

C. Connecticut’s Aging Services Division has begun implementation of Aging and Disability Resource Centers (ADRCs), also known as “Community Choices”. The ADRC assists individuals ages 18 and older who are seeking services and support, regardless of income or disability, through a coordinated system of information and access. ADRCs are resource hubs of information and assistance including completing benefits applications and planning for long-term care option supports and services. The first ADRC in Connecticut opened in 2008 and a second in 2009. The third opened in May 2010.

Bringing ADRCs to Connecticut is one of the state’s major efforts in combining services for our older population with services for residents with disabilities. While these first small steps have been significant, in comparison to many states across the country, Connecticut is relatively new to the ADRC arena. Connecticut received the 2009 ADRC grant and as part of the implementation process has begun to develop a five-year plan for ADRCs in the state. The plan is in the early stages of development and will be completed in 2011.

Aging and Disability Resource Center core partners include:

Area Agencies on Aging:
- Agency on Aging of South Central Connecticut
- North Central Connecticut Area Agency on Aging
- Western Connecticut Area Agency on Aging

Centers for Independent Living
- Center for Disability Rights
- Independence Northwest
- Independence Unlimited
Connecticut’s Focus Areas

Other Community Partners

• Connecticut Community Care, Inc.

Expected Outcomes include:
  o Connecticut’s existing Information and Assistance/Referral system will be further developed, on a statewide level, to ensure easily accessible supports and resources thus enabling informed decision making by consumers, including older adult family members and caregivers as well as other decision making entities.
  o The flexible use of Title III-B dollars will be implemented to support ADRC activities.

Budget for statewide expansion: The development of Aging and Disability Resource Centers (ADRCs) is a relatively new endeavor in Connecticut’s efforts to provide comprehensive long-term care services to older residents. Discussions regarding statewide expansion have been underway since 2007. A budget will be developed for this initiative over the course of this State Plan. This will not be a simple task given the complexities facing Connecticut in its budgetary process.

Integration with Core Programs (Title III): One of the primary goals of Connecticut’s ADRC efforts is sustainability. In 2009, Connecticut received word from the Administration on Aging that Title III-B funds for Information and Assistance can be used to help sustain ADRC efforts in the existing ADRC regions and to build the foundation for ADRCs in the remaining three regions of the state would be an acceptable use of Title III funds. To do so, the state will work with the Area Agencies on Aging (AAAs) to encourage the use of Title III-B funds to support ADRC activities as outlined in the Older Americans Act Section 307 (a)(8).

• Expected Outcome:
  o A program instruction to the AAAs allowing the utilization of Title III-B funds to support ADRC activities will be issued to Connecticut’s AAAs. The program instruction will contain directives on how much funding can be spent to support ADRC activities.

3. Consumer Control and Choice

The State of Connecticut continues its dedication to providing its older residents with more consumer control and choice regarding their long-term care needs. The state can expect continued progress towards these goals during the period covered by this State Plan on Aging. To do this, the following changes will be made in policy and in the ideology of the services delivered through the State Unit on Aging.

• Implement the self-directed care option statewide through the existing Title III-E National Family Caregiver Support and Statewide Alzheimer’s Respite Care programs.
• Change the regulations governing Title III-E and Connecticut State Respite Care programming to incorporate a permanent self-directed care option.
Connecticut’s Focus Areas

The focus on consumer control will also include elder rights. Connecticut will continue to coordinate services to maximize its residents’ access to appropriate legal services while in home, community and institutional settings. Through its Legal Services Developer, the State Unit on Aging will collaborate with Protective Services for the Elderly to protect those in the community from abuse, neglect and exploitation and the Connecticut Long Term Care Ombudsman Program to assist residents in long-term care facilities. [Note: Neither Protective Services for the Elderly nor the Connecticut Long Term Care Ombudsman Program are under the auspices of the State Unit on Aging in Connecticut.]

• Expected Outcomes:
  o Necessary regulation changes will be made to Title III-E and the Connecticut Statewide Respite Care Program to support a self-directed care option.
  o Awareness and use of advanced directives for healthcare planning in the community and long-term care facilities will be increased.

These changes combined with the expansion of Title III funds and the integration of discretionary grants such as the Community Living Program and the Aging and Disability Resource Centers will allow Connecticut to empower its older residents to take charge of their long-term care planning and to thrive in the home and community setting of their choice.
Strategic Goals

Goal 1: Empower Connecticut’s older residents, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and long-term care options.

Background: Individuals who plan ahead for long-term care needs rather than depend on Medicare and Medicaid to cover long-term care costs have more options and flexibility in how and where they receive care. The Connecticut Long-Term Care Plan for 2010 (CT Long-Term Care Planning Committee) estimates that 69 percent of sixty-five (65) year olds will need long-term care as they age. On average, they will need three years of long-term care.

Connecticut has three programs providing residents with long-term care information and assistance services, the Long-Term Care Partnership, the CHOICES program and the Aging and Disability Resource Centers (ADRC). An additional resource for long-term care information is an existing website at www.ct.gov/longtermcare.

Approximately thirteen (13) percent of Connecticut’s population is foreign born. Forty-one (41) percent are of Latin American descent and 22 percent are of Asian origin. Of the Latin population over 40.6 percent report they speak English less than “very well” and of the Asian and Pacific Islander population 43.7 percent report the same level of English proficiency.

The federal Department of Health and Human Services is establishing the first National Resource Center for Lesbian, Gay, Bisexual and Transgender Communities. It is important that mainstream service providers also become sensitive to the needs of lesbian, gay, bisexual and transgender (LGBT) seniors and caregivers, a population that has been overlooked.

Objective 1.1: Educate the public to prepare for their long-term care needs.

Strategies:

- Educate Connecticut residents through the Connecticut Partnership for Long Term Care Program on the cost of long-term care in Connecticut and the pros and cons of purchasing long-term care insurance.

- Provide information to Connecticut’s residents about the CLASS Act (Community Living Assistance Services and Support Act) through the Connecticut Partnership for Long-Term Care Program, Connecticut’s ADRCs and the Choices Program.

- Provide Long-Term Support options counseling and related materials to older adults and person with disabilities via CT ADRCs and CHOICES.

- Ensure culturally sensitive educational materials are developed for individuals with limited English proficiency.
Strategic Goals

• Promote the development of culturally sensitive materials for lesbian, gay, bisexual and transgender (LGBT) individuals.

Expected Outcomes and Measures:

• Information on the cost of long-term care in Connecticut and the pros and cons of purchasing long-term care insurance will be provided by the State Unit on Aging through the Connecticut Partnership for Long-Term Care to at least 400 residents during each year of this plan. Target Date: 09/30/2013

• Distribute available materials about the CLASS Act through the Connecticut Partnership for Long-Term Care, ADRCs and CHOICES. Target Date: 09/30/2013

• The website for the Aging Services Division as well as the state’s long-term care supports and services/ADRC websites will include up to date information, resources and assistance on topics related to long-term care for aging and residents with disabilities and will be reviewed quarterly. Target Date: 09/30/2012

• Long-Term Support Options Counseling materials will be developed, including a brochure and consumer guidebook. Target Date: 09/30/2012

• The number of culturally sensitive resources available for individuals with limited English proficiency, such as Spanish speaking, will increase. Target Date: 09/30/2013

• The number of education programs and caregiver trainings provided for caregivers with limited English proficiency, such as Spanish speaking, will increase. Target Date: 09/30/2013

• The number of culturally sensitive materials and resources for LGBT individuals will be increased. Target Date: 09/30/2013

Objective 1.2: Educate the aging services network about the resources available to the public regarding long-term care options.

Strategies:

• Further develop Connecticut’s Information and Referral system on a statewide level, ensuring easy consumer accessibility to long-term care information and services.

• Increase collaboration among Connecticut’s aging, disability and mental health networks to maximize resources and more effectively serve consumers.

• Support senior centers in improving information technology services to older residents
Strategic Goals

Expected Outcomes and Measures:

- A five-year statewide ADRC development and implementation plan with a corresponding budget will be created. **Target Date: 09/30/2011**
- A memorandum of agreement between the State Unit on Aging (SUA) and the Bureau of Rehabilitation Services will be signed, supporting their collaboration on the Medicaid Infrastructure Grant through the ADRCs. **Target Date: 12/31/2010**
- The State Unit on Aging (SUA) will utilize its Listserve (e-mail list to the aging network) to provide information regarding disability resources (including mental health services) for purpose of making appropriate consumer referrals. **Target Date: 09/30/2011**
- A SUA staff person will be designated as a mental health network liaison to facilitate collaboration among aging, disability and mental health networks. **Target Dates: Ongoing**
- The State Unit on Aging will continue to designate a staff person as a senior center liaison. **Target Dates: Ongoing**
- The Senior Center Liaison will continue to send electronic notification to senior centers informing them of new initiatives, websites and upcoming events. **Target Date: Ongoing**

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

**Objective 2.1:** Provide older adults the opportunity to remain in a setting of their choice by making available an array of services and supports.

**Background:** The 2007 Long-Term Care Needs Assessment conducted by the University of Connecticut, Center on Aging determined most older residents prefer home and community based services over institutionalized care settings. To meet this preference it would require improvements to the state’s long-term care system, recommendations such as: fostering flexibility in home care delivery; providing true consumer choice and self direction to all long-term care users; and providing supports to informal caregivers.

The state has several services in place to assist its older residents remain in their own homes. These services include the Connecticut Home Care Program for Elders, the Personal Care Assistance Waiver as well as other Medicaid waiver programs. Transitional services include the Congregate Housing Service Program, which is
Strategic Goals

designed to coordinate the provision of supportive services. Additionally, new initiatives, such as the Veterans’ Directed Home and Community Based Services Program give Veterans the opportunity to self-direct their own care. With this, Veterans can receive services in their home by the caregiver of their choice. Also, Choices at Home Cash and Counseling provides a fiscal intermediary for those at risk of nursing home placement and a Medicaid spend-down. This service allows for supports and provides record-keeping and a payment mechanism so consumers and caregivers can recruit, hire/fire and train their worker.

Strategies:

- Promote person-centered care planning for older adults and persons with disabilities.
- Promote the National Family Caregiver Support Program and the CT Statewide Respite Care Program to reduce stress and to assist families providing support at home to older relatives with long-term care needs.
- Strengthen and foster community partnerships to ensure that the needs of older adults in CT are included.
- Support efforts to implement the Veterans Directed Home and Community Based Services Program.
- Support the expansion of community based transportation systems offering services across town lines as well as evening and weekend hours by providing technical assistance to new and existing transportation services.
- Support the accessibility of transportation systems for seniors and seniors with disabilities.
- Promote senior centers as a community resource to support older adults.
- Support cost sharing policies to expand Title III services to older adults, including those who are low income.
- Research viability of a universal application that would be supported by both federal and state agencies. Research would include examining work done by other states.

Expected Outcomes and Measures:

- The State Unit on Aging (SUA) will coordinate with the Area Agencies on Aging in offering multifaceted systems of support to older adults and their caregivers. Target Date: 09/30/2013
- The State Unit on Aging (SUA) with the Aging and Disability Resource Center (ADRC) partners will develop an operational plan to serve the private pay customer in a person-centered planning approach in addition to low income individuals already being served by the ADRC. Target Date: 09/30/2013
Strategic Goals

- The SUA will coordinate with agencies and programs offering federal, state, local and private services and supports, including Money Follows the Person (MFP) groups, disability agencies, health agencies, home and community based service agencies, the federal Administration on Aging and the federal Centers for Medicare and Medicaid Services to insure that the needs of older adults in Connecticut are included. Target Date: 12/31/12

- The Veterans Directed Home and Community Based Services Program will provide services in the South Central CT region. Target Date: 09/30/2011

- The number of community-based regional transportation programs will increase. Target Date: 09/30/2013

- Continue to designate at least 5% of Older Americans Act funding in each region to support Senior Center Initiatives which provide services that enable seniors to remain in their own home. Target Date: 09/30/2013

- A Program Instruction will be completed for cost-sharing in Title III services. Target Date: 09/30/2013

- Research will be completed regarding other states’ universal application use. Target Date: 09/30/2011

Objective 2.2: Ensure Connecticut’s caregivers and older adults have access to information and flexible service options that allow them to direct how and when services are delivered.

Background: The demands faced by caregivers are plentiful and increasingly complex. When accessing services, caregivers are limited by the specific programmatic and financial boundaries established by funding sources, as well as the regional availability of services. According to data from the 2007 Connecticut Long-Term Care Needs Assessment, individuals reported that they were unable to attain all of the services they needed for the following reasons: the high cost of services (53%); the lack of knowledge about services (42%); the inability to find someone to hire (22%); unreliable or poor care (17%); and unavailability of service in the area (5%). These limitations compound the burgeoning amount of stress that a caregiver is facing.

Caregiving also extends to grandparents raising grandchildren due to a myriad of situations. Relative caregivers face added challenges of inadequate housing, lack of health insurance for themselves and/or grandchildren and limited access to financial and other services.

The State Unit on Aging seeks to reduce the stratification of particular groups by offering a centralized database of respite services to address the needs of caregivers caring for those of all ages and disabilities across the lifespan.
Strategic Goals

Strategies:

• Expand service options available to ease caregiver burden by offering more flexibility to caregivers and their families.

• Evaluate and modify existing National Family Caregiver Programs (NFCSP) and CT Statewide Respite Care Program (CSRCP) regulations to incorporate a permanent self-directed care option.

• Strengthen the Grandparents As Parents Support (GAPS) network by increasing the number of participating community organizations.

• Ensure grandparents raising grandchildren and other relative caregivers have access to services and information that support families in their efforts to provide ongoing care for their children.

• Through the implementation of the Administration on Aging’s Lifespan Respite Grant, expand availability and accessibility of respite services.

Expected Outcomes and Measures:

• Fifteen presentations will be conducted to Caregiver Support Group members about available Aging and Disability Resource Center services during the first two years of this plan. Target Date: 09/30/2012

• Caregivers indicate a reduction in stress as measured by Caregiver satisfaction surveys. Target Date: 09/30/2013

• Self-directed care options will be available through the CT National Caregiver Support Program and CT Statewide Alzheimer’s Respite Program statewide. Target Date: 09/30/2013

• The number of community organizations that participate in the Grandparents As Parents Support Network will increase by 5%. Target Date: 09/30/2012

• Families and caregivers will have increased opportunities for choosing a respite provider, including a centralized data base for respite options, as a result of the Lifespan Respite Grant. Target date 9/30/12

Goal 3: Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.

Objective 3.1: Promote Health and Wellness Programs.

Background: Tomorrow’s older adult population will be larger in number than other age groups and this population will be looking for the best services to meet their needs on their terms.
Strategic Goals

Along with these changes come familiar challenges. The burden of chronic disease will continue to take a toll on quality of life. Currently 80 percent of individuals ages sixty-five (65) and older have one chronic condition and 65 percent have multiple conditions. There is also call for mental health services as more than 50 percent of people reporting a mental health disability in the 2007 Connecticut Long-Term Care Needs Assessment indicated they needed more services.

With this significant increase in the demand for services, funding becomes an issue. For example, many of those reporting a mental health disability are not able to afford services. Similarly, oral health services are often not received by older individuals due to cost. Medicare, the primary health insurance of many individuals over the age of sixty-five (65), does not cover routine oral healthcare and only emergency oral health services are covered in very limited circumstances.

Strategies:

- Establish and promote the utilization of evidence-based disease prevention programs statewide.
- Improve access to mental health and oral healthcare for older adults.
- Encourage Elderly Nutrition Providers (ENPs) to share nutrition education services with older adults who access facilities where meals are served.
- Identify opportunities to increase the effectiveness of the Elderly Nutrition Program and implement appropriate improvements.
- Review the Health Care Reform Law to promote understanding and access by Connecticut’s older residents

Expected Outcomes and Measures:

- At least one evidence-based health promotion program will be operational in each Area Agency on Aging (AAA) region. **Target Date: 9/30/13**
- At least one mental health program will be operational in each AAA region annually. **Target Date: 09/30/2011, 09/30/2012, 09/30/2013**
- At least one mental health outreach initiative will be conducted annually in each AAA region. **Target Date: 09/30/2011, 09/30/2012, 09/30/2013**
- At least one oral health program will be operational in each AAA region annually. **Target Date: 09/30/2011, 09/30/2012, 09/30/2013**
- In addition to older adults who receive meals through the congregate meal sites (Senior Community Cafes), the SUA will support the efforts of the Area Agencies on Aging/Elderly Nutrition Providers (AAAs/ENPs) in providing nutrition education services to any older adult at the facilities. **Target Date: 09/30/2013**
Strategic Goals

- The State Unit on Aging (SUA) nutritionist will provide technical assistance to the AAAs/ENPs to support changes in meal delivery services to entice baby boomers.  *Target Date: 09/30/2013*

- Coordination will be enhanced between the SUA’s Elderly Nutrition Program and other nutrition programs that serve older adults such as the Supplemental Nutrition Assistance Program (SNAP).

**Objective 3.2:  Enhance awareness of information and programs designed to promote the healthy aging of Connecticut’s older residents.**

**Background:** Healthy aging is the cornerstone of all aging services. Connecticut’s demographics are changing. The number of older residents is on the rise as is the number of seniors from diverse backgrounds. Providing supports that address injury and assist older adults in staying active will improve quality of life for the state’s older residents and their caregivers.

**Strategies:**

- Ensure information and resources on healthy aging and prevention are available to all older residents and their caregivers to enhance their ability to obtain and maintain optimal health for themselves and their family members.

- Promote a healthy lifestyle through education and consumer choice in conjunction with home delivered and congregate meal programs.

- Promote awareness and increase implementation of evidence-based health programs of Chronic Disease Self-Management and Fall Prevention among Connecticut’s older residents.

- Increase the statewide volunteer base for the Chronic Disease Self-Management Program (CDSMP).

- Encourage an active lifestyle through volunteer and employment programs to allow older adults remain active and involved in their communities.

- Expand efforts of collaboration among the State Unit on Aging, Connecticut Department of Labor, The Bureau of Rehabilitation Services Connect to Work Program and other older worker resources to address the needs of older workers and workforce issues.

**Expected Outcomes and Measures:**

- A CDSMP/healthy aging webpage will be developed for community partners at the state and AAA level as a resource for CDSMP network and other evidence-based programs.  *Target Date: 9/30/11*

- Embed evidence-based CDSMP in the five AAA regions utilizing Aging and Disability Resource Center and Medicaid networks for information and referral.  *Target Date: 09/30/2013*
Strategic Goals

- Nutrition education will be made available to each participant in the Home Delivered Meal Program at least once a year. \textit{Target Date: 09/30/2013}

- Nutrition education will be made available to each participant in the Congregate Meal Program at least once per quarter. \textit{Target Date: 09/30/2013}

- Nutrition assessment and counseling will be provided to both Congregate and Home Delivered meal participants. \textit{Target Date: 09/30/2013}

- A Memorandum of Agreement with the State Department of Public Health for the creation of a statewide fall prevention coalition will be established. \textit{Target Date: 9/30/11}

- A CDSMP statewide delivery system to maintain program sustainability and fidelity will be established. \textit{Target Date: 9/30/12}

- Annually expand and maintain the database of CDSMP lay leader volunteers at the state level in to Connecticut Area Agency on Aging regions. \textit{Target Date: 09/30/2013}

- Information about volunteer and employment services, including the Retired and Senior Volunteer Program and the Senior Community Service Employment Program will be distributed to the Aging Network, the State Department of Labor and the Bureau of Rehabilitation Services, Connect to Work Program. \textit{Target Date: 09/30/2011}

- The State Unit on Aging will become an active partner with the network of older worker resources. \textit{Target Date: 09/30/2013}

Objective 3.3: Promote awareness of prevention benefits available to older adults through Medicare.

\textbf{Background:} Medicare’s preventive benefits can help individuals keep ahead of certain chronic diseases and serious illnesses such as diabetes, heart disease and cancer. Making residents aware of the available tests, screenings and inoculations offered under Medicare will help older adults to stay active and healthy.

\textbf{Strategies:}

- Work in partnership with the aging network to promote the preventive benefits available to Medicare beneficiaries.

- Encourage Medicare beneficiaries to access online resources for benefits information such as the Aging Services Division and www.mymedicare.gov.

\textbf{Expected Outcomes and Measures:}

- Outreach to older residents will continue through the mailing of Medicare related information packets, presentations and health fairs. \textit{Target Date: 09/30/2011}
Strategic Goals

- Health, wellness and preventative information will be available on the Aging Services Division website. *Target Date: 09/30/2011*

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**Goal 4: Ensure the rights of older people and prevent their abuse, neglect and exploitation**

**Objective 4.1:** Improve access to quality legal advice, representation and referral for older persons, particularly those with the greatest social and economic needs and advocate on behalf of older people who are frail or have a disability to improve responsiveness to their needs.

**Background:** Many older adults have limited knowledge about the availability of legal services. Specifically, those older adults are unaware of their rights and the services available to protect their rights. To address these issues, a number of elder rights programs in the state are available to provide important information to protect older adults against threats to their independence, well being and financial security.

**Strategies:**

- Continue to support the initiatives of the Model Approaches to Statewide Legal Assistance Project, including the Consumer Law Project for Elders
- Utilize the findings of the Model Approaches to Statewide Legal Assistance Project – Legal Needs Study (LNS), work with Area Agencies on Aging, Aging and Disability Resource Centers and legal service providers to coordinate the services that address the needs of older adults as well as resources available to support these services.
- Support public policy initiatives and network forums to address gaps identified through the LNS that impact quality of life and the ability of older people to obtain services.
- Promote networking opportunities among public and private entities for elder rights initiatives through traditional and nontraditional organizations.

**Expected Outcomes and Measures:**

- As a result of the LNS, legal services resources will be utilized to meet the needs of older adults. *Target Date: 09/30/2013*
- The State Unit on Aging Legal Services Developer will participate in legal service network forums as these forums become available. *Target Date: 09/30/2013*
- Networking among legal service providers will increase access for older adults to legal services. *Target Date: 09/30/2013*
Objective 4.2: Develop a unified system of elder abuse prevention in Connecticut that strengthens the efforts of protective services, reduces criminal victimizations of older persons and facilitates the delivery of law enforcement services to our aging populations.

Background: As a group, older people can be a powerful and active force but as individuals they can be vulnerable and in need of help. This susceptibility requires innovative state and community wide approaches to prevent the criminal victimizations of older adults.

Strategies:

- Collaborate with Protective Services for the Elderly to develop an operational statewide Elder Abuse Collaborative Council (EACC) that addresses public awareness about issues of elder abuse, neglect and exploitation.
- Promote TRIAD SALT Council development to share safety information and resources with community responders and social service providers.
- Facilitate the involvement of law enforcement agencies through TRIAD to address crime-related issues that impact seniors.
- Expand the reach and availability of the State Unit on Aging’s Elder Rights Protection Program Alerts.

Expected Outcomes and Measures:

- Once formed, the Elder Abuse Collaborative Council will promote educational activities. Target Date: 09/30/2013
- Through TRIAD SALT Councils, community responders and social service providers will be able to address senior specific issues and make appropriate referrals for assistance. Target Date: 09/30/2013
- Community responders will be aware of how to respond to complaints in various long-term care settings and residents will report increased satisfaction when responders are involved. Target Date: 09/30/2013
- Through TRIAD SALT Councils, law enforcement will address crime related issues that affect seniors. Target Date: 09/30/2013
- Continue to distribute the State Unit on Aging’s Elder Rights Protection Program Alerts by e-mail and increase the number of recipients of these alerts. Target Date: 09/30/2013
Objective 4.3: Empower seniors to know and exercise their rights, make informed decisions about planning for long-term needs and promote opportunities for self-advocacy.

Background: As the population ages and lives longer, increasing numbers of older people are at risk of an infringement of their rights or abuse, neglect and/or exploitation. There is an increasing need for strong advocacy – from caregivers, family and the seniors themselves – to protect and enhance the basic rights and benefits of vulnerable older adults both in the community and long-term care facilities.

Strategies:

- Alert older adults to healthcare and other frauds, scams, victimization and risk factors that threaten their financial and personal security, through Senior Medicare Patrol (SMP).
- Conduct annual VOICES Forum developed and delivered by the Long Term Care Ombudsman Program for skilled nursing facility residents with focus on education about rights and quality of life issues and ways in which these can be strengthened through changes to policy and legislation along with ongoing education of all stakeholders.
- Provide ongoing training and public information about advance directives for the public and professionals who serve older adults.
- Support statewide initiatives to address specific national and international elder rights activities such as National Health Care Decisions Day and World Elder Abuse Day.
- Support the Coalition to Improve End of Life Care initiatives to ensure that every individual has information about and access to compassionate, quality end of life care.

Expected Outcomes and Measures:

- Community presentations will be conducted for older adults on awareness and prevention of healthcare and other frauds, scams and victimization that threaten their financial and personal security. Target Date: 09/30/2013
- Reporting and resolutions of healthcare fraud will increase as evidenced by SMP reports. Target Date: 09/30/2013
- Update websites and publications addressing consumer law, Senior Medicare Patrol (SMP), Long Term Care Ombudsman and other elder rights issues. Target Date: 09/30/2013
- As a result of their VOICES Forum, residents and the Ombudsman Program will collaborate to form legislative agendas, define public policy issues and develop education programs such as “Fear of Retaliation” for long-term care consumers.
Strategic Goals

and long-term care providers in institutional settings.  

- Awareness and use of Advanced Directives for Health Care Planning in the community and long-term care facilities will increase.  
  Target Date: 09/30/2013

- Consumers and providers will have increased access to end-of-life information and resources.  
  Target Date: 09/30/2012
Attachment A

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

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

ASSURANCES

Sec. 305(a) – (c), ORGANIZATION

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

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

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

(a)(2)(F) The state agency shall provide assurances that the State agency will require the 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 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.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and the 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 aging, or by the State in case of single planning service area states.

Sec. 306(a), AREA PLANS

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

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

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

(C) legal assistance;

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

(4)(A)(i)(I) provide assurances that the area agency on aging will –

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

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

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

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

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

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

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

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

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

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title;
(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as “older Native Americans”), including –
(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;
(B) an assurance that the area agency on aging will, to the maximum extent practical, coordinate the services and 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 related 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 on aging will demonstrate that a loss or diminution in the quantity or quality of 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 of the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.
(15) provide assurances that funds received under this title will be used –
(A) to provide benefits and services to older individuals, giving priority to older
individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations
specifyed in section 212;

Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund
accounting procedures will be adopted as may be necessary to assure proper
disbursement of, and accounting for, Federal funds paid under this title to the State,
including any such funds paid to the recipients for 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 assurances 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
divisions (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 a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and services 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, healthcare, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect and age discrimination.

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

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

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

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

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area –
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English speaking ability in order to assist such older individuals in participating programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will –
(A) identify individuals eligible for assistance under this Act, with special emphasis on –
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.
(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who –
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolong 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 assurances 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 pursues 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 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 advisors 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 and administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not
carried out to implement this title.

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

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

(b)(3)(E) No application by a State under subparagraph 9b)(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 individuals 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 activates aimed and ensuing 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 this chapter.

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

(6) The State plan shall provide an assurance that, with respect to programs for the
prevention of elder abuse, neglect, and exploitation under chapter 3 –
(A) in carrying out such programs the State agency will conduct a program of services
consistent with relevant State law and coordinated with existing State adult protective
service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act
through outreach, conferences, and referral of such individuals to other social service
agencies or sources of assistance if appropriate and if the individuals to be referred
consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if
appropriate;
(B) the State will not permit involuntary or coerced participation in the program of
services described in subparagraph (A) by alleged victims, abusers, or their households;
and
(C) all information gathered in the course of receiving reports and making referrals shall
remain confidential except --
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective
service agency, licensing or certification agency, ombudsman program, or protection or
advocacy system; or
(iii) upon court order.

REQUIRED ACTIVITIES

Sec. 307(a) STATE PLANS

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

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

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for
supportive services (including legal assistance pursuant to 307(a)(11), information and
assistance, and transportation services), nutrition services, and multipurpose senior
centers within the State;

(B) has developed a standardized process to determine the extent to which public or
private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note; “Periodic” (defined in 45CFR part 1321.3) means, at a minimum, once a fiscal year.

(5) The State agency:
(A) affords an opportunity for public hearing upon request, in accordance with published procedures, to any area agency on aging submitted a plan under this title, to any provider or (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

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

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging, in the State unless in the judgment of the State agency --
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;
(ii) such services are directly related to such State agency’s or area agency on aging’s administrative functions; or
(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.
INFORMATION REQUIREMENTS

Section 102(30)

The Connecticut State Unit on Aging (SUA) defines ‘in-home’ services provided through the Older Americans Act funding to include all those services included with the definition of ‘in-home’ services found in Section 102(30)(A) through (G), these being:

- **(A)** services of homemakers and home health aides;
- **(B)** visiting and telephone reassurance;
- **(C)** chore maintenance;
- **(D)** in-home respite care 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 this Act);
- **(F)** personal care services; and
- **(G)** other in-home services defined -
  - (i) by the State agency in the State plan submitted in accordance with section 306.
  - (ii) by the area agency on aging in the area plan submitted in accordance with section 306.

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.

**In-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.

**Skilled Nursing Visits** – Services provided by a licensed nurse (Registered Nurse-RN or a Licensed Practical Nurse-LPN) designed to provide part time, medically necessary and appropriate home health care services under the direction of a licensed physician, dentist or advanced practical nurse (APRN). Services may include preventative, restorative, rehabilitative nursing care, health education and counseling, referral for and coordination of services and delegation of responsibility to, supervision and teaching of non-skilled caregivers.

Due to the addition of personal care services in the Older Americans Act Amendments of 2006, hospice services fit under this category. It is no longer defined separately but these services continue to be provided.
Section 305(a)(2)(E)

The Connecticut State Unit on Aging (SUA) assures that preference will be given to providing services to older adults with the greatest economic need, the greatest social need, with particular attention to low-income older adults and low-income minority older adults with limited English proficiency, and older adults living in rural areas.

The Connecticut State Unit on Aging 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 State Unit on Aging (SUA) requires all Title III service providers to set targets for low-income and minority participation and these targets are used by the SUA and the Area Agencies on Aging (AAA) 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 AAA and their grantees on a monthly basis and is available to these partners 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 State Unit on Aging conducts periodic needs assessments and special studies on various issues related to the status and needs of Connecticut’s elderly. In addition the SUA utilizes needs assessments by other entities such as The University of Connecticut Health Center and the AAAs. The SUA reviews the findings as highlighted, paying particular attention to low income older adults, including low income minority adults, older adults with limited English proficiency and older adults residing in rural areas.

Based on the information gathered, recommendations will be made regarding meeting the needs of older adults and persons requiring long-term care. The SUA 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.

Outreach is particularly important in reaching persons in greatest social and economic need. The State Unit on Aging (SUA) itself conducts extensive outreach efforts to the target population. The SUA delivers training and provides technical assistance to municipal agents, seniors centers and others in the aging network who serve those in greatest economic and social need.

Section 306(a)(17)

The Connecticut State Unit on Aging (SUA) assures that each Area Plan includes information detailing how the Area Agency will coordinate activities and develop long-
range emergency preparedness plan with local and State emergency response agencies.

The SUA, through its Program Instruction, SUA PI 08-1, to the Area Agencies on Aging (AAA) requires that the AAA area plans include their emergency preparedness plan.

Activities outlined in these plans include: identifying local resources, participating in training sessions, providing emergency preparedness information on their website, and participating in local workgroups. The area plan also identifies points of collaboration with local and state emergency response agencies, such as the Department of Emergency Management and Homeland Security (DEMHS) and municipal emergency management personnel. Local and state public health departments as well as local and state relief organizations such as the American Red Cross and United Way are also involved.

Work continues with the AAA to expand their network of resources to serve older adults and people with disabilities for emergency preparedness planning.

**Section 307(a)(2)(C)**

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>16 percent</td>
</tr>
<tr>
<td>In-Home</td>
<td>25 percent</td>
</tr>
<tr>
<td>Legal Services</td>
<td>6 percent</td>
</tr>
</tbody>
</table>

The issue of minimum percentages for Title III-B priority service was the subject of considerable attention within the aging network from 1988 to 1992. During that period the SUA reviewed available data on needs and service utilizations and held two public hearing on the subject. The minimum percentages adopted in 1988 were 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. The minimum percentages that emerged from this process are those listed above. These percentages went into effect on October 1, 1993 and presently remain in effect.

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

The Connecticut SUA assures that 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). Connecticut’s intrastate funding formula has not changed from the intrastate funding formula outlined in Connecticut’s State Plan FFY 2006 through FFY 2010.
The goal of Connecticut’s 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 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 a racial or ethnic minority;
(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; and
(f) Persons age 60 years or older who are both members of racial or ethnic minorities and have incomes below the poverty threshold.

The formula: The Interstate Funding Formula is constructed by weighting the population age 60 or over in each Planning and Service Area (Area Agency on Aging) with the population with each of the characteristics listed above. This is accomplished by adding the population with these characteristics to the total populations, in effect increasing the weight of persons with multiple need characteristics by the number 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 the mathematical notation as follows:

\[
A_A = \left(\frac{\sum A(P_1 \ldots P_6)}{\sum S(P_1 \ldots P_6)}(0.5S) + ((0.5S)/A_N)\right)
\]

Where:
- $A = Area Allocation$
- $P_1 = Total Population 60+$
- $P_2 = Minority Population 60+$
- $P_3 = Low-Income 60+$
- $P_4 = Impaired 60+$
- $P_5 = Rural 60+$
- $P_6 = Low-income Minority 60+$
- $S = State Allocation$
- $A_N = Number of Area Agencies in State$

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.

Baseline funding: Because a minimum level of funding is believed essential to maintain available service programs in any Planning and Service Area, half of the funding available is divided into five equal portions. The remainder of the funding is divided by...
the population characteristics listed above.

In the event that the State Unit on Aging 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 Aging 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 to have a need in their regions. In such cases, the allocation will pass to the next planning and service area in the rotation.

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.

**Carryover:** The Area Agencies on Aging shall not carry more than 15 percent of their allocation over from the preceding fiscal year. Whenever the Director of the Connecticut State Unit on Aging (SUA) 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.

This State Plan on Aging is being submitted using the formula outlined above. During the first year of this Plan, the SUA will review the current needs and service utilization of Connecticut’s 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 the Title III of the Older Americans Act is subject to the approval of the Assistant Secretary.
Connecticut’s Title III Funding Distribution
FORMULA FOR DISTRIBUTING TITLE III FUNDS

<table>
<thead>
<tr>
<th>FUNDING FACTOR</th>
<th>AREA</th>
<th>SW</th>
<th>SC</th>
<th>EC</th>
<th>NC</th>
<th>WC</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL 60+</td>
<td></td>
<td>121,128</td>
<td>117,492</td>
<td>87,546</td>
<td>172,885</td>
<td>96,311</td>
<td>595,362</td>
</tr>
<tr>
<td>MINORITY 60+</td>
<td></td>
<td>10,958</td>
<td>8,015</td>
<td>2,839</td>
<td>12,543</td>
<td>4,089</td>
<td>38,444</td>
</tr>
<tr>
<td>LOW INCOME 60+</td>
<td></td>
<td>7,042</td>
<td>7,837</td>
<td>5,048</td>
<td>11,009</td>
<td>6,058</td>
<td>36,994</td>
</tr>
<tr>
<td>IMPAIRED 60+</td>
<td></td>
<td>17,442</td>
<td>18,721</td>
<td>12,915</td>
<td>26,628</td>
<td>13,972</td>
<td>89,678</td>
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<tr>
<td>RURAL 60+</td>
<td></td>
<td>4,881</td>
<td>2,725</td>
<td>42,474</td>
<td>13,297</td>
<td>28,662</td>
<td>92,039</td>
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<tr>
<td>MINORITY 60+ (POOR)</td>
<td></td>
<td>1,798</td>
<td>1,659</td>
<td>428</td>
<td>2,565</td>
<td>789</td>
<td>7,239</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>163,249</td>
<td>156,449</td>
<td>151,250</td>
<td>238,927</td>
<td>149,881</td>
<td>859,756</td>
</tr>
</tbody>
</table>

| 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 |

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

The Connecticut State Unit on Aging 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)**

This 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). Approximately 84 percent 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.

During the 2009 federal fiscal year, the most utilized services under Title III were congregate meals, home-delivered meals and transportation. In the Eastern and Western regions, the combined expenditures for congregate meals were $1.4 million and the combined expenditures for home-delivered meals were $2.3 million. The transportation expenditure for these regions was $259,000. At a minimum, the funding must remain at these levels in order to continue to provide these services which include services for rural residents.
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)**

*This 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.*

During the last completed federal fiscal year 4,124 service recipients identified themselves as rural residents. This was 11 percent of all service recipients who provided information on their municipalities of residence. Of the 4,124, 89 percent resided in either the Eastern or Western PSA. The services most commonly use by rural residents were congregate meals and home-delivered meals.

**Section 307(a)(8)(B)**

*The Connecticut State Unit on Aging assures that the following agencies are already providing case management services (as of the date of the submission of the plan) under a State program and the SUA specifies that such agencies are allowed to continue to provide case management services.*

These agencies are:

- Agency on Aging of South Central Connecticut
- Eastern Connecticut Area Agency on Aging (dba Senior Resources)
- North Central Connecticut Area Agency on Aging
- Southwestern Connecticut Agency on Aging
- Western Connecticut Area Agency on Aging

These agencies provide case management services through Title III –E, the National Family Caregiver Support Program.

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 State Unit on Aging specifies that the Agency on Aging of South Central Connecticut is allowed 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 State Unit on Aging. The following agencies are authorized for the direct provision of information, assistance and outreach services:

- Agency on Aging of South Central Connecticut
- Eastern Connecticut Area Agency on Aging (dba Senior Resources)
- North Central Connecticut Area Agency on Aging
- Southwestern Connecticut Agency on Aging
- Western Connecticut Area Agency on Aging

Section 307(a)(10)

The Connecticut State Unit on Aging assures that needs of older adults in rural areas will be taken into consideration and describes how needs have been met and how funds have been allocated to meet those needs.

For purposes of this plan the State Unit on Aging has adopted the definition of rural proposed by the Administration on Aging for reporting requirements for Title III and Title VII. In these specifications the Administration on Aging defines rural as “…any area that is not defined as 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”.

Sixty of Connecticut's 169 towns conform to the most recent definition of rural and, in 2000, they were home to 55,029 of Connecticut residents age 60 and above. Under this definition the rural elderly population is 7 percent (601,835) of the state’s total elderly population.

The State Unit on Aging 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 their area plans. A priority area identified in Eastern and Western’s area plans is access which includes transportation. Historically, transportation for a widely dispersed population has been a central concerns expressed in these areas. The funding decision made by these AAAs reflects the special needs of the rural residents.
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)(21)

The Connecticut State Unit on Aging (SUA) states that the SUA will pursue activities to increase access by older adults who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under Title III when applicable.

Area Agencies on Aging (AAAs) shall include information and assurance concerning services to older adults who are Native American in accordance with sec. 306(a)(11) of the Act and specify the ways in which they will implement these activities. The State Unit on Aging monitors the area agencies to assure they are pursuing such activities and includes an assessment of their efforts as part of their end of year evaluation.

The 2000 Census reported that 933 Connecticut residents age 60 or over identified themselves as “American Indian or Alaska Native”. During the 2009 federal fiscal year 212 participants in Older Americans Act (OAA) funded service programs identified themselves as Native American. That was approximately 0.6 percent of all persons who had participated in OAA funded programs during the last fiscal year.

Section 307 (a)(28)

(A) The Connecticut SUA recognizes that in the next ten years there will be a significant increase in the number of older adults in the state, many of whom will need services. The SUA also acknowledges that financial resources are likely to be limited and unable to meet all of those needs.

With this increase in the number of older adults comes a greater demand for long-term care services including access to long-term care information, home care, transportation, affordable and safe housing, as well as the need for public and private resources and long-term care system in place to support these services.

The SUA has been supporting long-term care systems change efforts, working to sustain current efforts of the ADRCs, the evidence-based disease prevention projects, and self-directed care initiatives as well as fostering partnerships in the aging and disability networks.
(i) The number of persons 60 and over is expected to increase nearly 26%, from 717,234 in 2010 to 902,441 in 2020.

(ii) Over the next ten years, there is a projected increase in each of these areas: older adults with low income, older adults with greatest economic need, minority older adults, older adults residing in rural areas, and older adults with limited English proficiency. Two particular noteworthy increases include the minority population with a 65% increase from 99,880 in 2010 to 164,611 in 2020 and the rural population, a 41% increase, from 91,936 in 2010 to 129,341 in 2020.

(iii) The SUA continuously strives to improve its programs, policies, and services. The SUA’s strong partnerships with federal, state, and local agencies including the Area Agencies on Aging, will continue to support these enhancements. ADRC, evidence-based disease prevention, and self-directed care initiatives, once sustained, will improve service delivery.

(iv) The population of 85 and older in Connecticut will increase by almost 13% from 93,698 to 105,584, in the next ten years. With this increase in the number of older adults comes a greater demand for long-term care services and the need for a long-term care system with resources to support these services.

Section 307(a)(29)

Connecticut has developed an extensive emergency preparedness plan to address the needs of its residents statewide. Developed by The Connecticut Department of Emergency Management and Homeland Security (DEMHS), the State of Connecticut Natural Disaster Plan, is the primary resource outlining the response of state agencies during both natural and man-made disasters. This response includes addressing the needs of at risk populations such as frail seniors.

The State of Connecticut Natural Disaster Plan clearly outlines the Department of Social Services’ responsibilities. These include:

1. Staffing the State Emergency Operations Center as requested by DEMHS;
2. Assisting FEMA in the implementation of the Individuals and Households Program (IHP) following Presidentially declared disasters or emergencies for which IHP assistance is authorized by FEMA; and
3. Implementing plans for the receipt and care of evacuees, as directed by the Governor.
4. Protective Services for the Elderly

Providing service delivery programs

The State Unit on Aging has identified several critical programs that will play vital roles in emergency preparedness and response. These services include:
These services have been identified as they are valuable in assuring that the basic needs of older residents are being met, providing information and assistance, and protecting elder rights and preventing abuse and neglect.

As part of the Department of Social Services the State Unit on Aging (SUA) will coordinate their efforts with the aging network to assure these programs are maintained in the event of an emergency. The SUA ensures that notifications received from local, state and federal agencies are distributed to the aging network. These notifications include, but are not limited to, seasonal flu, pandemic influenza and disease, natural and other man-made disasters.

Additional emergency preparedness services available to Connecticut’s older residents include the local Area Agencies on Aging coordination with local health districts to inform elders about the location of services including emergency shelters; and 211, a free statewide information and referral service.

The State of Connecticut Natural Disaster Plan clearly outlines plans which integrate the needs of at risk populations, including frail older residents, at the state level. Emergency preparedness plans at the local and regional level, such as those developed by municipalities, Area Agencies on Aging and health districts, have outlined similar strategies to meet the specific needs of at risk populations as well. These include plans to disseminate information when needed and mapping of senior housing and medically frail individuals. When combined, these local, regional and state plans allow for critical programs and services, (i.e. nutrition and information and assistance) to be fully integrated into the state’s disaster planning.

**Section 307(a)(30)**

Connecticut’s State Unit on Aging continues to support efforts to provide education about individual emergency preparedness for seniors and their caregivers. The aging network regularly coordinates its efforts with local agencies such as the American Red Cross and Senior Centers to assure older residents have the information needed such as how to develop an individual emergency preparedness kit or where to go for help in the event of a natural or man-made disaster.

The Director of the State Unit on Aging continues to participate on the Department of Emergency Management and Homeland Security (DEMHS) and the Department of Public Health (DPH) sponsored mass care and special needs population sheltering committee and project. This is a committee that has been developing the statewide
criteria for the creation of universal access shelters for residents of any age should a disaster be long-term and extensive. This committee has been instrumental in the development and creation of the “Alert 911” system whereby those with disabilities may complete a form to be on file with their local emergency response team regarding communication or mobility issues. Connecticut is continuing to work with other state agencies and local systems of care on the development of enhanced support shelters for residents who need assistance when universal shelters do not provide enough support.

Additional ongoing resources include the Aging Services website devoted to various emergency preparedness events. Topics include how to prepare for winter storms and extreme cold, hurricanes and floods. This website also contains resources from the Department of Emergency Management and Homeland Security (DEMHS), the Department of Public Health (DPH), the Centers for Disease Control (CDC) and the Administration on Aging. Examples of these resources include publications such as FEMA’s Emergency Financial First Aid Kit and Connecticut’s Guide to Emergency Preparedness.

Connecticut’s state and local plans have identified the needs of the state’s at risk populations, including frail seniors. In doing so, the state has outlined the roles each state department will take on in the event of an emergency to meet the immediate and long-term needs of older residents. Particular effort is made for the frail as they are a population who can become increasingly at risk as an emergency situation is prolonged. The State Unit on Aging plays a vital role in these efforts to assure wellness care is maintained for seniors and efforts are coordinated throughout the aging network.

Section 705 (a)(7), ADDITIONAL STATE PLAN REQUIREMENTS

(1) In accordance with Chapter 2 of this section in the Older Americans Act, the Ombudsman Program provides services as described below for older adults.

The Ombudsman Program investigates complaints made by or on behalf of nursing home residents, managed residential community residents and residents of residential care homes. The Program provides information and consultation on long-term care issues and empowers residents and families to discuss issues and address concerns with nursing home staff. The Program educates and informs residents and families on residents’ rights as well as state and federal mandates.

The Connecticut Ombudsman Program promotes and supports Resident and Family Councils in a variety of ways, including its Annual Voices Forum, a recently developed Family Council web based training program and a quarterly newsletter for nursing home residents. The Program organized and continues to support a statewide Coalition of Presidents of Resident Councils. The Executive Board of Presidents of Resident Councils meets regularly, helps set legislative agenda and helps develop the agenda and program for the Voices Forum. Both the statewide Coalition and the Executive Board members collaborate to identify systems and systemic issues and trends.
The State and Regional Ombudsmen also provide community education and disseminate information and resources. The Program collaborated with Connecticut Legal Services to develop an outreach program to residential care home residents about their rights as residents and about consumer protection issues. Statewide forums for assisted living residents have been held to disseminate education about their rights about consumer issues and other issues. Other public meetings on crucial long-term care issues are held as needed.

The State Ombudsman represents the interest of nursing home residents at hearings, court proceedings and legislative committees and task forces and advocates for as well as proposes statutory amendments and changes. The State Ombudsman and Regional Ombudsmen serve on a variety of statewide committees, including the Long Term Care Advisory Committee, the Money Follows the Person Steering Committee, the Connecticut Cultural Change Steering Committee and other advocacy organizations and groups.

The Ombudsman Program recruits, trains and supervises the Volunteer Resident Advocate Program and holds statewide conferences for volunteers as well as monthly regional training sessions. The Program continues to maintain partnerships with organizations and agencies in the long-term care field and holds memberships with state and national organizations in the aging network.

The Ombudsman Program contracted with University of Connecticut researchers to do in depth interviews and research on the topic of Fear of Retaliation and the Program is developing a web-based training video for residents, families and staff to promote understanding of the issue and develop strategies to combat retaliation in the nursing home setting. A Family Council web-based training program was developed in collaboration with the University of Connecticut Organizational and Skill Develop Unit at the Department of Social Services.

In accordance with Chapter 3 of this section the State Unit on Aging has a two tier collaborative approach using both statewide and regional initiatives to implement the provisions.

**Statewide**

The proposed statewide Elder Abuse Collaborative Council brings together stakeholders, including the regional Area Agencies on Aging, to identify state and regional needs, enhance development of multidisciplinary responses and public awareness strategies to elder abuse, neglect and exploitation, and target services to underserved populations. The Connecticut Triad Advisory Council, which promotes collaboration of law enforcement, seniors, and community organizations, assists in the development of local councils, supportive programming and training to address crime-related issues that impact seniors. The State Unit on Aging produces Elder Rights Protection Program Alerts which are
posted on the Website and forwarded via email to vulnerable older persons, organizations, caregivers and providers that serve populations of seniors and people with disabilities. Other statewide initiatives include support of the Connecticut Chapter of National Healthcare Decisions Day, World Elder Abuse Day and the Connecticut Coalition to Improve End of Life Care.

Regionally

Through grants to each of the Area Agencies on Aging, regional implementation of priorities is possible through a comprehensive community based program of information, education and outreach. Such programs support the development and continued operation of multidisciplinary elder justice activities in the region including: (1) Multidisciplinary programs and services involving social services, health care, public safety, and legal disciplines; (2) Community Triads SALT Councils consisting of Seniors and the aging network, Law Enforcement and Public Safety personnel, and business and community groups; (3) Appropriate programs and services ensure that the region will effectively address the special problems of elder abuse, neglect, and exploitation of underserved populations; and (4) Public education, training and outreach to promote the identification and prevention of elder abuse, neglect and exploitation, specifically including identity theft and financial exploitation, for individuals, including caregivers, professionals, and paraprofessionals, and community organizations.

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

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 uses the same two-tier approach to solicit input regarding programs carried out under this subtitle. The Director of the State Unit on Aging (SUA) together with her staff visit locations throughout the state to discuss aging issues and gather input from seniors about needs and programming. The SUA also utilizes its netserve to gather information from service providers and aging network organizations. In addition, the Connecticut Commission on Aging, and independent state agency devoted to enhancing the lives of older adults conducts numerous hearings and studies of elder’s needs and issues which are shared with the State Unit on Aging. Area Agencies on Aging conduct their own
hearings and meetings to gather information to formulate their area plans for development of appropriate programs and services to meet the needs of seniors.

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

(4) The Connecticut State Unit on Aging assures 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 this chapter.

(5) 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 process, 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 nine Regional Ombudsmen and intake staff out-posted in regional offices throughout the state.

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3 – (A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective services 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.

The Connecticut State Unit on Aging (SUA) provides the assurance that, with respect to programs for the prevention of elder abuse, neglect and exploitation under chapter 3. The SUA will conduct a program of services consistent with relevant State law and coordinate with State Protective Services for the Elderly 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.

(A) In Connecticut, direct protective services are provided by the Protective Services for the Elderly (PSE) program of the Social Worker Division of the Bureau of Aging, Community and Social Work Services of the Department of Social Services. The Department is divided into three service delivery areas within the state, with social workers on staff in twelve (12) regional offices and a Central Office that provide services designed to safeguard people sixty (60) years and older from physical, mental and
emotional abuse, neglect and abandonment and/or financial abuse and exploitation.
Close collaboration of the Aging and Social Work Services Divisions within the Bureau, and the Area Agencies on Aging and the regional offices ensures that services are consistent with state law and coordinated to prevent duplication. Public education, advocacy, outreach and coordination of activities with local social service providers are handled through the statewide Elder Abuse Coordinator in State Unit on Aging or by the Area Agency on Aging. Established protocol directs reports of suspected abuse, neglect or exploitation to the applicable PSE office for investigation, referral to law enforcement when required and ongoing social and material support. PSE, therefore, collects the specific data on the number and types of cases handled. This data is periodically made available to the State Unit on Aging for further distribution to enhance public education on the nature and prevalence of elder abuse. As to the particulars of specific cases and reporters, state law governing the operation of PSE requires strict enforcement of confidentiality.

(B) the Connecticut State Unit on Aging (SUA) assures that the SUA 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) the Connecticut State Unit on Aging assures that 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.

Signature and Title of Authorized Official
Michael P. Starkowski, Commissioner

Date 6/16/12

**It is important to note that neither the Long Term Care Ombudsman Program nor Protective Services for the Elderly is under the auspices of Connecticut’s State Unit on Aging.**
Attachment B

State Unit on Aging
Organizational Chart
Attachment C

Connecticut’s Demographics
In 2008, over thirteen percent (13.7%) of Connecticut’s population was aged 65 years or older, ranking the state fifteenth (15) in the nation according to the U. S. Census Bureau. The following is an overview of the state’s demographics. The state’s older population is an illustration reflecting a diversity that can be seen throughout Connecticut’s people and landscape.

**Projections in Connecticut’s population of residents ages 60 and older:**

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<thead>
<tr>
<th></th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>717,234</td>
<td>902,441</td>
</tr>
</tbody>
</table>

*Data from the Connecticut Statewide 2000-2030 Projections Connecticut State Data Center, 2007 University of Connecticut

**Projections of Connecticut’s residents ages 85 and older:**

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<thead>
<tr>
<th></th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>93,698</td>
<td>105,584</td>
</tr>
</tbody>
</table>

**Race and Ethnicity**

**Projections in Connecticut’s population of residents ages 60 and older by race or ethnicity:**

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<thead>
<tr>
<th>Race</th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>617,354</td>
<td>737,830</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>31,838</td>
<td>57,265</td>
</tr>
<tr>
<td>African American</td>
<td>42,532</td>
<td>58,630</td>
</tr>
<tr>
<td>Other (mostly Mainland Chinese and South Asian Indian)</td>
<td>25,510</td>
<td>48,716</td>
</tr>
</tbody>
</table>

*Data from the Connecticut Statewide 2000-2030 Projections Connecticut State Data Center, 2007 University of Connecticut

**English Speaking Residents Ages 60 and older:**

- Total individuals: 651,854
- Speaking English Only: 83.9%
- Speaking a Language other than English: 16.1%
- Speaking English less than “very well”: 8.5%

*2008 U.S. Census Bureau Data Set

**Location**

concerns that viewing statewide averages such as income, poverty or racial composition, provides a misleading interpretation of the state’s socioeconomic outlook. Although the state is divided into eight counties a regional look at each area would not provide you with an accurate view of the area. For example, Fairfield County holds some of the richest towns but also one of the poorest cities.

To best illustrate Connecticut’s population, the authors developed the “Five Connecticuts”. The following is a snapshot of each group based on 2000 data.16

- **Wealthy**: The eight (8) towns making up this “Connecticut” are characterized as having (1) exceptionally high income, (2) low poverty and (3) moderate population density.

- **Suburban**: Sixty-one (61) municipalities comprise this “Connecticut” and are characterized as (1) above average income, (2) low poverty and (3) moderate population density.

- **Rural**: The sixty-three (63) towns that are defined as this “Connecticut” are (1) have an average income”, (2) have below average poverty and (3) with the lowest population density.

- **Urban Periphery**: The thirty (30) communities that make up this “Connecticut” are considered to be (1) below average income, (2) of average poverty and (3) have high population density.

- **Urban Core**: The seven (7) cities making up this “Connecticut” are characterized as having (1) the lowest income, (2) the highest poverty and (3) the highest population density.

One of Connecticut’s counties can easily contain several of these “Connecticuts”. This information indicates how demographic divisions within the state can lead to significant disparity for residents even when a municipality is a bona fide member of a particular demographic category.

With an understanding of the “Five Connecticuts” it is important to then look at the socioeconomic issues facing the state’s residents, including the aging population. Those issues outlined by The University of Connecticut’s report include:

1. Gains in income are increasingly concentrated with the Wealthy Connecticut. The 2000 Census reports a per capita income in this group at 2.5 times the state average. Furthermore, true income levels for Wealthy Connecticut are higher than what is reported here as the Census does not report capital gains.

2. Rural Connecticut experienced increasing poverty, low income growth and lagging educational attainment.

3. The urban Periphery had the largest growth in population between 1990 and
2000. They have also experienced increasing poverty and mixed income growth.

4. The socioeconomic conditions of the Urban Core were extremely stressed in the 1990s. The population grew by 24 percent and the poverty rate was 19.4 percent as compared to the state wide average of 7.6 percent and the national average of 12.1 percent. The percentage of state’s population living in extreme poverty (defined as having income that is below 50 percent of the poverty threshold) grew from 2.8 percent to 3.7 percent in the 1990’s.

5. The Urban Periphery most closely reflected the typical Connecticut in 1990 and 2000. Mixed socioeconomic trends in these communities could foretell the future of Connecticut.

Households of those residents ages 60 and older:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Individuals</td>
<td>651,854</td>
</tr>
<tr>
<td>Married Couple</td>
<td>42.2%</td>
</tr>
<tr>
<td>Female Household</td>
<td>7.1%</td>
</tr>
<tr>
<td>Non-Family Household</td>
<td>45.6%</td>
</tr>
<tr>
<td>Living Alone</td>
<td>42.9%</td>
</tr>
</tbody>
</table>

*2008 U.S. Census Bureau Data Set

Projections of Connecticut’s population of residents ages 60 and older residing in rural areas:

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>93,936</td>
<td>129,341</td>
</tr>
</tbody>
</table>

*Data from the Connecticut Statewide 2000-2030 Projections
Connecticut State Data Center, 2007
University of Connecticut

Poverty Status of residents ages 60 and older

In 2008, the Federal Poverty Level is $10,400 per year for a one person household and $14,000 per year for a two person household.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Individuals</td>
<td>623,190</td>
</tr>
<tr>
<td>Below 100% of the poverty level</td>
<td>6.6%</td>
</tr>
<tr>
<td>100 – 149% of the poverty level</td>
<td>7.5%</td>
</tr>
<tr>
<td>150% or more above the poverty level</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

*2008 U.S. Census Bureau Data Set
### Aging and Disability

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of individuals responding</td>
<td>182,164</td>
</tr>
<tr>
<td>With 1 type of Disability</td>
<td>35,861</td>
</tr>
<tr>
<td>Sensory Disability</td>
<td>9,364</td>
</tr>
<tr>
<td>Physical Disability</td>
<td>14,922</td>
</tr>
<tr>
<td>Mental Disability</td>
<td>1,583</td>
</tr>
<tr>
<td>Self-Care Disability</td>
<td>194</td>
</tr>
<tr>
<td>“Go Outside Home” Disability</td>
<td>9,798</td>
</tr>
<tr>
<td>With 2 or More Types of Disability</td>
<td>28,432</td>
</tr>
<tr>
<td>Includes Self-Care Disability</td>
<td>11,579</td>
</tr>
<tr>
<td>Number Reporting No Disability</td>
<td>117,871</td>
</tr>
</tbody>
</table>

*2000 US Census Bureau

### Education and Employment

#### Educational Attainment of those ages 60 and older:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a high school graduate</td>
<td>20.6%</td>
</tr>
<tr>
<td>High school graduate or GED</td>
<td>33.2%</td>
</tr>
<tr>
<td>Some college or associate’s degree</td>
<td>19.6%</td>
</tr>
<tr>
<td>Bachelor’s degree or higher</td>
<td>26.6%</td>
</tr>
</tbody>
</table>

*2008 U.S. Census Bureau Data Set

#### Those ages 60 and older in the Labor Force:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the Labor Force</td>
<td>30%</td>
</tr>
<tr>
<td>Those collecting</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

*2008 U.S. Census Bureau Data Set

### Elder Economic Security Standard Index

The Elder Economic Security Standard™ Index is a new measure of income adequacy. This index measures the living expense cost for older adults in today’s economy. It represents how costs of living vary geographically and are based on the characteristics of elder households including household size, homeownership or renter, mode of transportation and health status. The costs are for basic needs of elder households.

The following chart illustrates the Elder Economic Security Standard Index for Connecticut. This chart depicts the annual expenses of a single elder or elder couple depending upon homeownership or renter status. Expenses include housing, food, transportation, health care (Good Health) and miscellaneous expenses.

<table>
<thead>
<tr>
<th></th>
<th>Single Elder</th>
<th></th>
<th></th>
<th>Elder Couple</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Owner w/o</td>
<td>Renter</td>
<td>Owner w/ Mortgage</td>
<td>Renter</td>
<td>Owner w/ Mortgage</td>
</tr>
<tr>
<td>Total Annual (Index)</td>
<td>$21,383</td>
<td>$24,408</td>
<td>$31,296</td>
<td>$32,039</td>
<td>$35,064</td>
</tr>
<tr>
<td>Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attachment D

Connecticut’s Area Agencies on Aging
Agency on Aging of South Central Connecticut
One Long Wharf Drive, Suite 1L
New Haven, CT 06511
Phone: (203) 785-8533
Fax: (203) 785-8873
www.aoapartnerships.org

Executive Director: Neysa Guerino

North Central Connecticut Area Agency on Aging
151 New Park Avenue, Suite 15
Hartford, CT 06106
Phone: (860) 724-6443
Fax: (203) 251-6107
www.ncaaact.org

Executive Director: Carmen Reyes

Senior Resources (Eastern Connecticut Area Agency on Aging)
4 Broadway, 3rd Floor
Norwich, CT 06360
Phone: (860) 887-3561
Fax: (860) 886-4736
www.seniorresourcesec.org

Executive Director: Joan Wessell

Southwestern Connecticut Agency on Aging
10 Middle Street
Bridgeport, CT 06604
Phone: 9203) 333-9288
Fax: (203) 696-3866
www.swcaa.org

Executive Director: Marie Allen

Western Connecticut Area Agency on Aging
84 Progress Lane
Waterbury, CT 06705
Phone: (203) 757-5449
Fax: (203) 757-4081
www.wcaaa.org

Executive Director: Christina Fishbein
Attachment E

Connecticut’s State Unit on Aging
Programs and Initiatives
Older Americans Act

Title III: Grants for State and Community Programs on Aging – Authorizes funds for supportive and nutrition services, family caregiver support, and disease prevention and health promotion activities. Supportive services programs fund a variety of services to help older residents remain independent in their own homes and communities. These services include but are not limited to access services, home care, legal assistance, case management and activities at senior centers. Nutrition Services provide meals and socialization to older people in congregate settings and meals to frail residents in their homes. Family caregiver support provides grants to develop a variety of services to assist family caregivers. These include information and assistance, individual counseling, organization of support groups, respite services and supplemental services. Disease prevention and health promotion are programs to prevent or delay chronic conditions and promote health among older people.

Title IV: Activities for health, Independence and Longevity – Funds are to be used to expand knowledge about aging and to test innovative ideas on services and programs. Over the years, Title IV has supported a wide range of projects related to income, health, housing and long-term care. Examples include Aging and Disability Resource Centers and evidence-based disease prevention and health promotion efforts.

Title V: Community Service Seniors Opportunities Act - Provides job skills training and job development services to seniors, ages 55 years and older who are at or below 125% of the poverty level. The US Department of Labor contracts with states and national organizations to recruit and enroll workers who are then placed in community service jobs for minimum wage while receiving on the job training.

Title VI: Grants for Services for Native Americans – Used to fund supportive and nutrition services for older Native Americans, Native Alaskans and Native Hawaiians. Connecticut does not receive any Title VI funding.

Title VII: Vulnerable Elder Rights Protection Activities – Authorizes the long-Term Care Ombudsman Program as well as a program to prevent elder abuse, neglect and exploitation. The Long-Term Care Ombudsman Program investigates and resolves complaints of residents in long-term care facilities, board and care facilities and other adult care homes. Other functions include representing the interests of residents before governmental agencies and seeking administrative and legal remedies to protect elder rights. Prevention of elder abuse, neglect and exploitation includes activities to make the public aware of ways to identify and prevent abuse, neglect, and exploitation and to coordinate protective service programs.

Projects and Initiatives

Aging and Disability Resource Centers (ADRCs) / Community Choices – A resource hub of information – a “one-stop shop” or information gateway that offers a range of
information as well as assistance with completing benefits applications. Types of services include counseling, referrals for employment assistance, referrals for care management and planning for the future. Community Choices will assist individuals ages 18 and over who are seeking services and support regardless of disability or income through a coordinated system of information and access. ADRCs are currently available in the North Central, South Central and Western regions of the state.

**Nursing Home Diversion / Choices at Home** – This initiative is designed to divert individuals from long-term care institutions and Medicaid. These efforts include the development and implementation of a cash and counseling option of service delivery, which takes existing program dollars available through the federal Title III-E, National Family Caregiver Support and the Statewide Respite Care Programs and transforms them into flexible funds that allow clients to hire and receive care by the caregiver of choice. Services are available in the South Central and Western regions of the state.

**Fall Prevention Initiative** – This initiative is a partnership with Yale’s Connecticut Collaboration for Fall Prevention designed to decrease the number of falls among older adults. Through this initiative, clinicians receive direct information, training materials and strategies for fall risk assessment and interventions. All are designed to increase clinicians and older adults’ awareness of fall risk factors and appropriate interventions, and to understand that falling is a common health problem with serious morbidity that is preventable through modifiable risk factors.

**Evidence-Based Disease Prevention Programs** - The Chronic Disease Self-Management Program, developed out of Stanford University, is designed to help people gain self-confidence in their ability to control their symptoms and recognize how health problems affect their lives. Small-group highly interactive workshops are generally 6 weeks long, meeting once a week for about 2 hours, and are facilitated by a pair of leaders one or both of whom are non-health professionals with a chronic disease themselves.

**Caregiving**

**Statewide Respite Care Program** - This program offers relief to stressed caregivers by providing information, support, the development of an appropriate plan of care, and respite services for the individual with Alzheimer’s disease or a related dementia. The program is based on income and asset eligibility and participants must pay a co-pay unless it is waived due to financial hardship.

**Grandparents as Parents Support (GAPS)** – This initiative provides assistance in establishing grandparent support groups for grandparents and relatives raising children. This statewide network is designed to encourage and promote the creation of services for relatives who have taken on the responsibility of parenting.

**National Family Caregiver Support Program** – This program supports the efforts to caregivers 60 and older for older relatives. This program provides information, caregiver
counseling, training and support, respite care and supplemental services.

**Health Insurance**

**CHOICES** – The CHOICES Program trains volunteers to work one-on-one with seniors to provide free information and assistance about Medicare choices. Help is also available in navigating the options and technicalities of Medicare benefits. The program also offers assessment and counseling services that can help seniors and their caregivers to address many issues including services for seniors to remain in their home and respite services. Referral sources are also available for a myriad of programs.

**Connecticut Partnership for Long-Term Care** - Works in alliance with the private insurance industry through which Connecticut residents can buy specially designed, state-approved, competitively-sold long-term care insurance that is designed to help seniors pay for long-term care without depleting their assets and impoverishing themselves.

**Health and Wellness**

**Elderly Health Screening** - Health screening tests can include the following services: blood analysis, mental health counseling, blood pressure testing, geriatric assessments and pap, breast and colorectal screenings. Other services offered include stress management, nutrition counseling, vision, podiatry, oral health and physical activity programs. Most services are provided at no cost.

**Housing**

**Homeshare** - Single adults, one of whom must be over age 60, who are having difficulty maintaining their homes and/or don’t want to live alone, may share a home with another single adult who needs affordable housing and is willing to either make a financial contribution or perform services. Housing counseling is also available.

**Congregate Housing Services Program** – This program provides assistance in the form of supportive services for participants in eligible housing projects. The supportive services are provided to frail or temporarily elders with disabilities and non-elders with disabilities for the purpose of promoting independence, preventing unnecessary institutionalization.

**Legal**

**Legal Assistance for Older Americans** – This initiative provides free counseling and representation on many Elder Law issues (including Medicaid and other government programs, patients’ rights, nursing home issues) to those persons age 60 and older who may not be able to afford to hire a private attorney for a civil matter.

**Statewide Legal Assistance for Elders** - Services are aimed at helping seniors, especially homebound seniors and those in rural and minority communities, solve or avoid
consumer law problems that threaten their ability to continue to live independently.

**Senior Medicare Patrol (SMP)** – This project provides seniors with an opportunity to make a difference by becoming involved in the fight against healthcare fraud. As a result, as part of the SMP project outreach and education activities, beneficiaries are taught how to detect Medicare and Medicaid fraud, waste and abuse in an effort to prevent their victimization of fraud and abuse.

**Nutrition**

**Elderly Nutrition Program** – This program serves nutritionally balanced meals to individuals 60 years of age and over and their spouses. Meals are delivered to homebound or otherwise isolated older persons. Meals are also available in congregate settings at Senior Community Cafes.

**Volunteerism**

**Retired and Senior Volunteer Program** – This program provides opportunities to persons 55 years of age and older to participate in their communities by sharing their knowledge and skills through meaningful volunteer experiences.

**Seniors Helping Seniors** – This program provides support for other individuals aged 55+ who are frail or homebound. The support takes the form of transportation to medical appointments, grocery shopping, and minor respite. In return, volunteers receive one credit hour for each hour volunteers that may be redeemed at any time during the program and used for similar services for themselves or other family members.
Attachment F

Public Comments on Connecticut’s State Plan on Aging
On December 2, 2009, The State Unit on Aging requested public comments on the goals it intended to outline for the State Plan on Aging 2010 – 2013. The request was made throughout Connecticut’s aging network and comments were accepted until December 31, 2009.

Upon completion of the plan, The State Unit on Aging opened the plan for public comment. The plan was made available on May 18, 2010 on The State Unit on Aging’s website and e-mailed through several listserves. A public hearing was held on May 26, 2010. The following are the comments received on the plan.

**Oral Comments Received:**

1. **Mag Morelli**  
   **Connecticut Not for Profit Providers for the Aging**

My name is Mag Morelli I am the President of the Connecticut Not for Profit Providers for the Aging or CANPFA. We represent non-profit providers throughout the continuum of long-term care right from affordable senior housing through to skilled nursing care and hospice providers.

I just wanted to… I was coming today just to comment in support of this plan which I think is well thought out and has four great areas and goals to focus on and I just wanted to make two small comments, really, in support of two of the areas. The first is the goal of informed decision making and providing seniors and their caregivers with the options. We find very often that people, you know our push throughout the state to provide consumer choice, consumer directed care and to provide a variety of options but unfortunately very often people need to make decisions very quickly. They are not aware of the options that are out there and I think people fall into maybe inappropriate options or options that beyond the level of care that they need because of not being informed of all of the options that are out there. Not just providers that are, and services but also the financial options and I think people need to be made aware of this as soon as they start receiving care so that they can prepare as they go along for potentially other public programs that might be available to them and not fall into unspectacularly, without meaning to, falling into eligibility issues because they weren’t keeping track of what they were spending on or where their resources went and so I think that’s extremely important. Plus I think that people don’t understand, they can be eligible for services before they actually are completely impoverished or spend down their assets and I think it’s a very good thing to inform caregivers and seniors of that.

The other issue I wanted to bring up and as I said I represent several different types of providers and this is an issue that’s come up I think amongst all of the providers, senior housing providers, community based providers and that is the need to really help with the protected services area and the elder abuse and from my perspective it’s just an area where providers can turn to people they can report suspicions to. They’re not in a position to investigate things or to know things but they certainly are in a position to start
to, to maybe see things or suspect things and raise concerns and that has been a real concern from a lot of providers: where do I turn, particularly if more and more people are being cared for in the home. And, something else, either the role of the ombudsman or maybe even state regulators who aren’t, you know, in the building so, I think that that is a great area, we’d love to work on it with you, offer you, you know, advice or information from the provider perspective and I really want to commend you for including that as such a strong piece of this plan.

Thank you.

2. Marie Allen
   SWCAA

Good Morning. I’m Marie Allen the Executive Director of the Southwestern Connecticut Agency on Aging and I compliment you on all your efforts throughout the plan and we look forward to partnering with you.

I do have a comment regarding the Title III-B diversion of funds into the Aging and Disability Resource Center. I am cautious and somewhat concerned about the fact that Title III-B funds will be diverted from grant programs in the community to develop the ADRC model. My concern it that as we develop the ADRC model, people are calling in need of assistance and typically we refer them to the community programs that we have grant funded so if we’re diverting those funds from the very programs that will provide assistance to our clients calling in we may have a well defined information system but then no place to actually provide services for the clients. So I would just ask that in concert with the directors from the agencies on aging and with other community-based organizations we take a long hard look at making sure that the community safety net is there because there is nothing more frustrating than, as we experienced this year with the closing of the Alzheimer’s Respite and some other programs, nothing more frustrating than having callers call in and then not having anywhere to get them that assistance that they so desperately need.

I also noticed that in the description of the Aging and Disability Resource Center there was no discussion of universal applications or any true integration with the Medicaid eligibility system. As so many other Aging and Disability Resource Centers throughout the nation have stated: you must have the integration with the Medicaid programs to have an effective ADRC. I think that currently what we’re doing with CHOICES provides the overall assistance but where we fall short is in our ability to have one application that properly screens the individual for all eligibility programs and this will actually save the state money because we will prevent duplication, citizens taking part in multiple programs or duplicate programs we will also make sure that we’re getting people help at the beginning of their struggle as opposed to waiting until they’re really at risk or at nursing home level of care. So any assistance to look at possible integration with the medical assistance program, particularly Medicaid and the other waivers would be greatly appreciated.
And finally, regarding the cash and counseling and the PCA options that the plan describes integrating with the National Family Caregiver Support Program and the Alzheimer’s Respite Program, we are very much in favor of bringing those options and true consumer choice into those programs. I think as we begin to plan for coordinating cash and counseling and PCA services we do also have to look, particularly in Alzheimer’s Respite where we’re trying to give the caregiver respite, cash and counseling may not be their first choice because it actually adds an additional burden of hiring, managing the employees that are coming in and out of the program, also keeping in mind that both National Family Caregiver and Alzheimer’s Respite are very limited pots of dollars for the family. By the time they’re able to train the staff, the PCA staff, for their loved ones, their dollars are pretty much running out and that PCA is no longer able to remain connected to the family so I think we have to just be very realistic about the amount of integration we’ll have between the PCA services, cash and counseling and particularly the Alzheimer’s Respite Program.

Thank you very much.

**Written Comments:**

**May 19, 2010**

**Sandra Brown**
Transition Coordinator
Money Follows the Person Program
Agency on Aging of South Central CT

This looks wonderful!

**Catherine Pierce, MSW**
Director, Wilton Social Services

I agree the stated goals but I also think that increasing the affordable housing options for those who cannot afford to stay in their own homes due to high taxes and other costs of maintaining a home should be included.

**Harvey Leon Frydman**
Director
Naugatuck Senior Center

I want to thank and commend the people who wrote the State of CT Aging Plan. Your wording is clear, concise, and caring. You did a great job! Thank you.
May 20, 2010

Sue Bernstein, MSW, LCSW
Town of Manchester

Under goal #2, I would encourage you to consider strong financial support for Adult Day Care Centers. These are terrific resources for family caregivers and bring great enjoyment to seniors. It is also a very economical use of funding. To fund a 8-4 day at only $70-80 including medical and social oversight, meals, activities to build self-esteem, entertainment and socialization is quite a bargain. I work at the Enfield Adult Day Center and see that 90% of the clients would be in Long Term Care Facilities without this facility to support caregivers and clients. Therefore, it is much cheaper for the state to increase financial support for these centers than fund long term care. I would also like to see additional funding for the Early Onset Alzheimer's Clients who were limited to only the Alzheimer's Respite fund to assist them.

May 25, 2010

Brian Capshaw
Resident Council President
East Hartford Health and Rehab

1.) On page 13 it states 63 million of the states 3.852 billion Medicaid dollars is spent on long term care, 1.64%, that seems low.

2.) On page 26 a discussion of increased demand for services and ability to pay services. With all the state programs available, can't the state meet this need?

3.) On page 54 Section 307 28 item iv changing population 85 and older. An increased need for LTC services, are you referring to the need for nursing home beds? It's my understanding at least 4 nursing homes have closed in the last 2 years due to lack of demand and approximately 2400 beds available statewide today.

Marion Donato
Caregivers Program Coordinator
Senior Resources-Agency on Aging

Overall, a good draft.
In the first few pages there are spelling errors, missed or wrong words.
For the NFCSP, relative caregivers (grandparents) can be age 55 and over. I don’t know if that is something that you may want to add or just leave the age of 60 for all services. Thank you.
Kathy Pontin  
Director of Food Services  
FSW, Inc  

I have read and support the proposed Ct. State Plan on Aging.

Cristina Mejias  
Social Work Supervisor  
Department of Social Services-New Haven  

I'm still in the process of trying to read it all but I can say that the layout and font is easy to read and flows nicely. I just found a few minor errors that I wanted to share.

Page 2 - extra space in third paragraph and fifth.

Page 3-Under section 3 second paragraph from top, first sentence please just add comma after the word families.

Page 4- Second bulleted item under section 4 Objectives grammar errors.

Thank you for being open to feedback.

Jennifer Glick  
Department of Mental Health and Addiction Services  

DMHAS was happy to review this well-written plan. As you know, DMHAS has established an Older Adult Services Unit. So we are most interested in the 2nd bullet under Expected Outcomes and Measures for Objective 3.1: Promote Health and Wellness Programs. More and more, in the past year, we've been collaborating with some AAA's on addressing the mental health needs of community clients. And as you know, DMHAS is part of the planning committee for the Fall C4A conference. Therefore, we would be very interested in extending this collaboration into any programming initiated as a result of this plan.

May 26, 2010

Helen Raisz  

Hi Pam, I don't know how I missed putting the State Plan on my calendar. September 30, 2013! (I'll be only 86!) I'd like to be in on the planning for my future. I am particularly interested in whether the new prevention benefits highlight prevention of osteoporosis in CT I just returned from a meeting of the National Osteoporosis Foundation and am re-committed to that cause.
May 25, 2010

Pam A. Giannini, MSW, Director
Bureau of Aging, Community & Social Work Services
DSS
25 Sigourney St.
Hartford, CT. 06106

Dear Pam:

On behalf of the Western CT. Area Agency on Aging (WCAAA), I am pleased to provide supportive comments on the draft State Plan on Aging, FFY 2011 – 2013. As an overall comment, we are excited about the draft document which was well written with supporting documentation and interesting strategies that reflect national trends. We particularly applaud the intent to focus on evidence based health promotion/disease prevention programming, mental and oral health, implementation of a statewide self-directed care option for Alzheimer’s Respite and NFC services and statewide ADRC development as a regional locale for long term care issues. Also exciting are the opportunities for more partnerships as evidenced by the proposed strengthened relationships with the Bureau of Rehab Services, employment and Medicaid programs as well as exploration of cost sharing policies.

The comments below are meant to strengthen and/or clarify specific sections of the draft State Plan.

1. We recommend clarification of the sections related to nutrition programs. For example, bullet #4 on page 26 appears to add more nutrition education activities that are not financially sustainable. In addition, there are several nutrition strategies in various sections of the proposed plan. It would be helpful to have one section on nutrition rather than having to look throughout the document for reference to nutrition.

2. The proposed additional Title III allocation requirements will mean that Agencies on Aging have less funds to finance new services. Currently, there are DSS requirements for 52% of the Title III B funds. Adding two more required programmatic areas with accompanying percentages will simply add more restrictions to our already complicated RFP process for applicants as well as reviewers and Boards of Directors. If implemented however, DSS might consider some discussion on the type/scope/nature of mental health services to be funded since there are already many state and local groups involved in the complicated state mental health system.

3. We support development of a statewide ADRC system, because we know first hand of the value of ADRCS as a result of the pilot in the western region. We also applaud the potential use of T. III B funds for this purpose. However, we believe that state funds should be sought in partnership with federal funds as opposed to relying on Title III B.
One way to realize some base state funding for ADRCS is to consolidate waivers. While there are many strategies focused on partnerships, we strongly recommend that the SUA assume leadership in waiver consolidation which would likely result in reduction of administrative expenses, faster approvals for clients and much improved public understanding of the state’s LTC system. We recommend that the revised State Plan include such a strategy under SUA leadership.

4. Strategies aimed at targeting of veterans in AAA programs and development of closer service coordination among agencies serving veterans should be a statewide focus rather than limited to one region.

5. We strongly recommend that references to the AOA Lifespan Respite Care pilot be clarified, particularly as policies, procedures and services can be closely coordinated with AAAs. We simply do not understand the proposed strategies that reference the pilot and assumed coordination with the Coalition that will be necessary given the strategies as written.

6. The WCAA supports efforts aimed at uncovering fraud and abuse. To this end, we have historically supported several such pilot efforts in our region and financially supported TRIAD for a large part of our population. While we also support the proposed State Plan strategies, we do not see any strategy aimed at improving coordination among the following groups: Ombudsmen, Protective Services, Medicaid, Agencies on Aging. In fact, little mention is made throughout the State Plan on integration of PSE with other groups & policies.

7. We would appreciate an administrative or developmental objective aimed at consolidation of reports through a refined and centralized MIS system that is able to meet many report requirements. Within this objective should also be a stated strategy of actively seeking funding for service pilots with particular attention on attracting nursing home diversion funds. This would capitalize on and highlight the wonderful grant writing skills of SUA staff.

In closing, we are appreciative of the SUA’s efforts to involve the AAAS, CILS and other agencies as major partners in implementing various LTC strategies as well as the spirit of innovation evidenced by various strategies in the draft State Plan.

Sincerely,

Christina Fishbein, Executive Director
WCAA
May 26, 2010

Pam Giannini, MSW
Director, Bureau of Aging, Community,
and Social Work Services
Department of Social Services
25 Sigourney St.
Hartford CT 06106

Dear Ms. Giannini,

Thank you for the opportunity to review and comment on the draft copy of the Connecticut State Plan on Aging for the period October 2010 – September 2013. I have distributed the draft internally to our Staff members and solicited comments. Given the extremely tight time frame for review and comment, many of the Staff has not had an opportunity to complete this review.

Overall the State Plan is a good framework for the future of aging services in Connecticut. The following comments are made for your consideration:

1. On page 6 the Mission and Purpose statement includes “promote and support the achievement of economic viability in the workforce” however there are no specific objectives or strategies which directly relate to this portion of the mission.

2. On page 22, Goal 2 discusses “several services in place to assist older residents remain in their own homes”. The following suggestion was offered by the Connecticut Association of Area Agencies on Aging in a letter to DSS:

“C4A believes that universal data storage coupled with data imaging will greatly reduce technology redundancies apparent in the State’s waiver, entitlement and financial assistance programs. Universal data storage would provide an opportunity to update information more frequently and accurately while reducing the time and storage requirements of individual programs and projects throughout the State. The cost effective nature of such a project would generate cost savings for the State and its contractors while providing citizens a more streamlined process to access benefits and services. The concept is a great asset to the formation of a Single Point of Entry system where participants can easily be screened and enrolled in numerous assistance programs such as the Low
Income Subsidy and Supplemental Social Security Income. Although harder to quantify, common wisdom dictates that elders supported by community-based programs in the earlier stages of intervention will most likely avoid premature nursing home institutionalization. This recommendation is clearly in line with the intent of the Deficit Reduction Act and the Medicaid Rebalancing Initiatives.

The savings associated with the concept of universal data storage could be bolstered by a uniform or common application for all of the State's entitlement programs. A common application would allow for the issuance of a unique identifier (not a Social Security number) for all residents enrolled in assistance programs. By issuing a unique identifier, the State and its contractors could efficiently and effectively screen program participants to prevent duplication within multiple State programs. A solid example of the screening benefit is the ability to identify clients of the CT Home Care Program for Elders and community-based home delivered and congregate meals.”

I would recommend that these concepts be included in the State Plan and investigated for implementation.

3. On page 23 I am pleased to see that the State Plan includes the development of “an operational plan to serve the private pay customer in a person-centered planning approach to low income individuals already being served by the ADRC”. I look forward to the development of this plan.

4. On page 23, the third bullet under Expected Outcomes and Measures discusses coordination with other agencies and programs but does not identify an expected outcome for this coordination.

5. On page 23, the fifth bullet under Expected Outcomes and Measures states that “the number of community-based regional transportation programs will increase”. This activity will require significant funding. In this very difficult economic time is this realistic?

Again, thank you for the opportunity to comment on the State Plan. The Staff of the Bureau of Aging, Community, and Social Work Services has done an excellent job outlining the plans for the future. As an Agency on Aging we look forward to working with the Department on the implementation of many of these ideas.

Sincerely,

Joan Wessell
Executive Director
Comments on Draft State Plan on Aging

Connecticut Commission on Aging

May 25, 2010

Thank you for this opportunity to comment on the draft State Plan on Aging for the period of October 1, 2010 through September 30, 2013. This draft in broad in scope and represents an ambitious vision for the next three years. It continues to be our pleasure to work in partnership with the State Unit on Aging in setting sound policies for older adults of today and tomorrow.

Two of four goals of the State Plan are based on the Administration on Aging’s strategic goals to rebalance the long-term care system, so that individuals can have true choice about where and how they receive long-term care services and supports. This effort is highly consistent with the U.S. Supreme Court Olmstead Decision and a national movement on behalf of older adults and persons with disabilities. Furthermore, several elements of national health care reform feature unprecedented opportunities for states to place much greater emphasis on home and community based supports. Still, a major challenge in “rebalancing” is that the long-term care infrastructure is highly fragmented with policies and programs based on age and/or specific disability. This fragmentation or “silo” effect is often unintentionally established and perpetuated by the construct of various federal agencies/departments and rigid state plan requirements. The CoA respectfully encourages and hopes that in three years the federal government will expand this plan, especially when emphasizing long-term care reform, to include persons with disabilities as well.

The Connecticut Commission on Aging provides the following observations and suggestions for consideration by the State Unit on Aging:

1) Coordination: The Commission on Aging strongly encourages greater coordination within and across state departments. Specific to the State Unit on Aging, the Commission suggests better coordination with existing and future efforts by other divisions of DSS. For example, ADRCs should be integrated into department-wide efforts at modernizing client services (as discussed in a 5/25/10 legislative briefing). This modernization proposal will provide a more streamlined structure that is easier for consumers to access and achieves economies of scale; it is consistent with recommendations of the legislatively-mandated Long-Term Care Needs Assessment and other national research and Best Practices.

National health care reform will also provide opportunities for maximization of federal funds and coordination with other programs. The Commission advises that the Legislature and executive branch work together to ensure that Connecticut is taking full advantage of these options.
2) economic security: The Connecticut Commission on Aging, the Permanent Commission on the Status of Women and WOW, Inc. published a landmark study on elder economic security, specific to Connecticut. The findings included detailed statistics regarding how much income older adults need in order to be “economically secure” in Connecticut, and which programs are most impactful on their status. The area agencies used this data to develop their area plans. The Commission recommends incorporating some of the findings of this study. Additionally, on page 13, please add “and the Elder Economic Security Index” to the end of the description of the Connecticut Commission on Aging.

3) Long-term care web site: On page 20, second paragraph, please list the Long-Term Care web site as an existing program, in addition to the long-term care partnership, CHOICES and ADRCs:  www.ct.gov/longtermcare

4) Under goal #3, regarding health and wellness, we suggest that the State Unit on Aging enhance coordination among home-delivered and congregate meals, SNAP (formerly Food Stamps) and the Senior WIC program. Attention to coordination of these programs will also help maximize federal funding opportunities for our state.

5) page 24: (minor typo) Please change 2009 Long-Term Care Needs Assessment to 2007 Long-Term Care Needs Assessment.

6) page 22: We suggest adding a goal or integrating into existing goal - Use Senior Center Profile Survey data to inform funding and focus of senior center initiatives.

7) Page 20: We suggest adding that the State Unit on Aging will play a leadership role in educating residents of all ages about the CLASS Act.

8) In general, we suggest using consistent language throughout in describing older adults and using person-first language (e.g., “persons with disabilities” instead of “disabled persons.”).

9) In-line with such efforts as the state’s Results-Based Accountability initiative, we suggest developing a transparent tracking mechanism to help you best meet your goals.

We would be most pleased to work with the State Unit on Aging and other stakeholders on this Plan moving forward. If you have any questions, please do not hesitate to contact the CT Commission on Aging at (860) 240-5200. Thank you for your time and for your consideration of these ideas.
May 25, 2010

Pamela A. Giannini, MSW
Director Bureau of Aging, Community and Social Work Services
30 Laurel Street
Hartford, CT 06106

Dear Ms. Giannini,

Thank You for this opportunity to contribute to the Connecticut State Plan on Aging.

The following are summarized comments submitted by several different faculty from The Center on Aging at the University of Connecticut Health Center based on the draft copy of the Connecticut State Plan on Aging for the period October 1, 2010 – September 30, 2013.

General comments for consideration

- Consider combining the ADRCs into CHOICES over the 3 year period rather than maintaining them as separate programs?
- Consider expanding the “cash and counseling” concept beyond just the respite programs into other programs?
- We are very happy to see the specific focus on mental health and oral health, as well as fall prevention.
- Other critical areas that could be emphasized more in the plan include transportation, employment, and especially workforce issues. Even more explicit descriptions of partnerships with other agencies/groups working on this issue would help.
- The plan mentions education about the new health care reform legislation, which is critical. We suggest specific education around the CLASS Act feature (employer-sponsored LTC insurance savings program), ideally integrated into other LTC planning activities like the Partnership education forums.

Specific comments

- Page 12: It looks as though the $63 million figure (line 2) for the amount spent on LTC services is wrong. That figure has been closer to $2.5 BILLION.
- Also in that paragraph, the 65/35 split cited from the Long Term Care Needs Assessment was for FY06. Since the dollars used are from FY09, would be better to use updated figures for the HCBS/institutional split so they match. It was 63/37 according to the Burwell report for FY2008.
- Page 21: The date for completing the MOA concerning the Medicaid Infrastructure Grant seems too late since that grant ends 12/31/11. Should it be changed to 9/30/10 since the agreement is nearly complete?
- Page 24: “Background” paragraph cites data from the CT Long Term Care Needs Assessment (which should be “2007,” not “2009”), but endnote #8 cites Federal Interagency Forum data. That should be changed to cite the Needs Assessment.
• Page 78: Endnote 14 has an incomplete citation for the Needs Assessment that doesn’t work. It should be http://www.uconn-aging.uchc.edu/res_edu/assessment.html

• The community living program (CLP) should be emphasized more. The efforts to prevent nursing home admissions and promote nursing home discharges are modest and voluntary. There should be a standardized process to ensure that prospective and current (long term) nursing home residents are cared for in a lower level of care, if that is appropriate to meet their needs. Medicaid payment for assisted living is not specifically addressed other than dementia respite.

• References to developing culturally sensitive educational materials are vague, without specific reference to which languages materials will be translated into, or in which languages presentations will be made in the community. Specifying Spanish language as mandatory would seem essential, as by 2020 the number of Hispanics aged 60 and older will be nearly equal to the number of African Americans age 60 and older in CT (p. 63), and also considering that the LTC needs assessment results shown in the plan make it clear that older Hispanics have much poorer health than Whites and in many cases poorer than African-Americans.

• Regarding workforce, perhaps a specific outcome would be for every AAA and agency that contracts with an AAA for OAA-funded service delivery, to have at least one staff member who speaks Spanish fluently.

• Aging network personnel training requirements: might all personnel at AAAs be required to get a “geriatrics update” focusing on the types of topics covered during the UCA summer series?

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May 26, 2010

The CT Council on Developmental Disabilities is pleased to offer their recommendations on the Department of Social Services Aging State Plan. Clarification is necessary to show that people with disabilities who are aging are inclusive with seniors. It is important to use ‘people with disabilities’ and not ‘disabled people.’ By this way, one is recognizing the person and their abilities first before their disabilities.

We are especially pleased to see goal two that would encourage seniors to remain in their homes with the necessary supports and services. The Council encourages the Aging Unit to explore and implement the Beacon Hill Model from MA in our state. This model promotes aging in place so that services and supports are delivered to people who need them as well as create a sense of community among the neighbors. Therefore, they can remain in their homes within the community while maintaining their independence and dignity.

The Council promoted the development of aging in place communities, based on the Beacon Hill Village aging in place community model. During the next year, the Council will be piloting the development of an aging in place community in Danbury. Specifically, this model will be inclusive of people with developmental disabilities who are aging and already living independently, or with whom they have chosen, in their homes in their communities with neighbors who may not have disabilities. This pilot is expected to prevent people with developmental disabilities from being placed in institutions and/or re-entering skilled nursing facilities as they age.

We recognize that some towns have funding for Independent Transportation Networks but all networks need to be accessible for seniors with disabilities. A majority of seniors will need accessible transportation because of their aging process.

We understand that people were notified about the plan and public hearings by a wide-spread list-serv. However, many key people were not aware of this important and option to comment on the plan.

Thank you for considering the comments from the Council.

Sincerely,
Mary-Ann Langton
Disability Policy Specialist
CT Council on Developmental Disabilities
Attachment G

End Notes

2. Connecticut Long-Term Care Planning Committee, “Long-Term Care Plan: A Report to the General Assembly January 2010”; Page 40


4. Administration on Aging, Department of Health and Human Services, “A Profile of Older Americans: 2009”; page 3

5. ibid; page 16


7. ibid; page 27

8. ibid; page 32


12. Connecticut Long-Term Care Services and Supports website: www.ct.gov/longtermcare


