Agency on Aging

OF SOUTH CENTRAL CONNECTICUT

Area Plan to Serve Older Adults in the South Central Region

FFY 2026 – FFY 2028

Verification of Intent

The proposed Area Plan is hereby submitted for the South Central Planning and Service Area for the period of October 1, 2025 through September 30, 2028.

The Area Plan includes all assurances to be followed by the Agency on Aging of South Central Connecticut under the provision of Title III of the Older Americans Act of 1965, as amended. The Area Agency, as identified above, will assume full authority to develop and administer the Area Plan in accordance with the requirements of the Act and related Federal and State regulation and policy. In accepting this authority, the Area Agency assumes responsibility to develop and administer the Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older adults in the planning and service area. The proposed Area Plan has been developed in accordance with all rules and regulations specified under the Older Americans Act and is hereby submitted to the Bureau of Aging for approval.

May 1, 2025	President & CEO
Date	Signature and Title of Area Agency Director

The governing body of the Area Agency has reviewed and approved the proposed Area Plan.

May 1, 2025	
Date	Chairperson, Board of Directors

May 1, 2025	Rick Liegl (see page following)
Date	Chairperson, Advisory Council

City of Meriden, Connecticut

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Rick Liegl,

Senior Affairs Administrator for the City of Meriden
Chair of the South Central Area Agency on Aging Advisory Council

Executive Summary

Agency on Aging of South Central Connecticut (AOASCC) is pleased to put forward this Area Plan that will be in effect, upon approval, during FFY 2026 – FFY 2028. The plan is designed to reflect the State Unit on Aging's most recent CT State Plan on Aging ("State Plan"). This ensures that AOASCC's vision and goals are aligned with an integrated, statewide approach to meeting challenges and incorporating opportunities to serve older adults and people with disabilities in CT.

AOASCC's goals follow the State Plan goals: Long Term Services and Supports, Healthy Aging, and Elder Rights, with clear and concise objectives, strategies and measures. Our identified regional priorities then fit within these goals: Community-Based Services; Health Prevention and Wellness; Elder Rights and Abuse Prevention; and Family Caregiver Support.

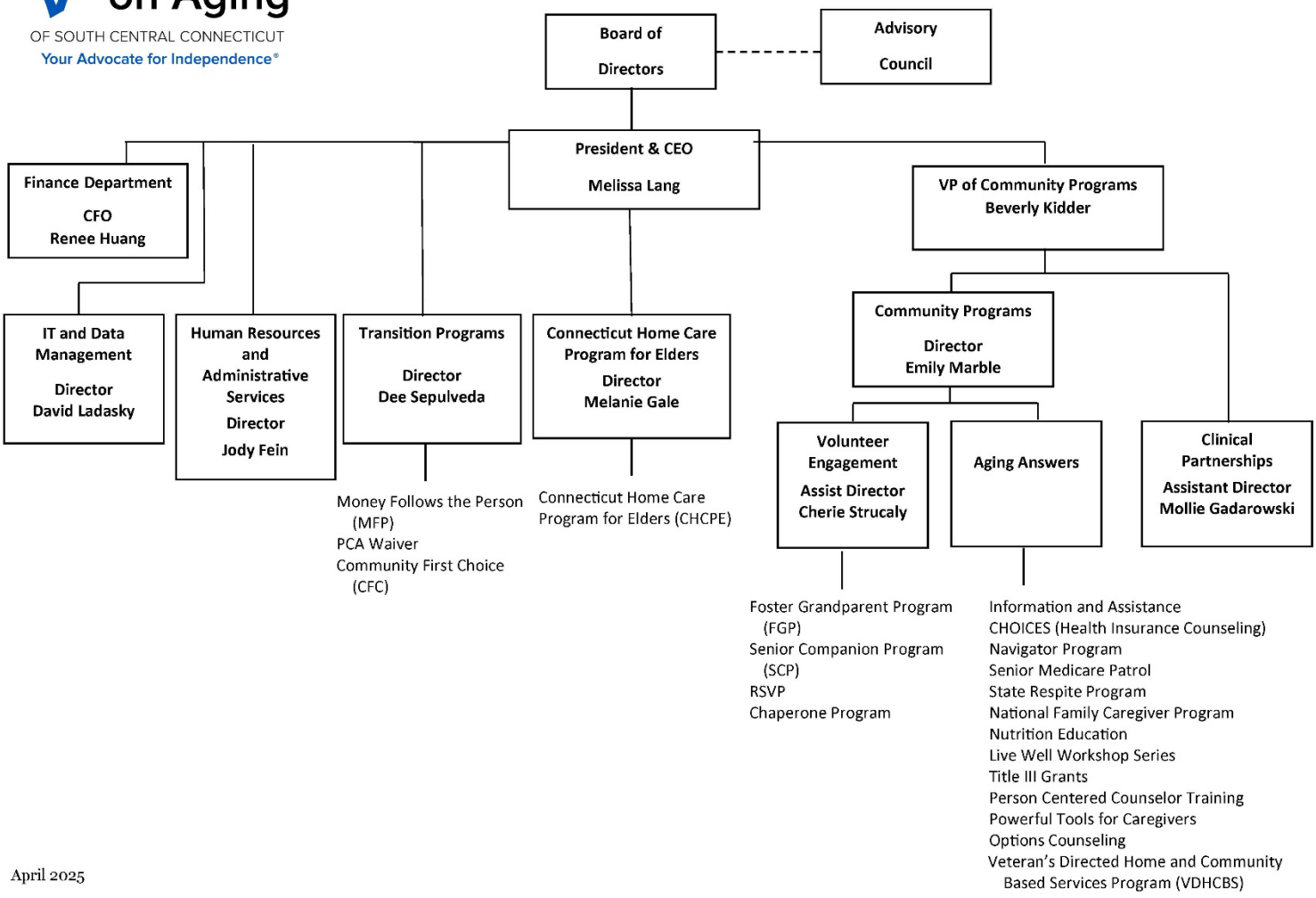
In the previous Area Plan period, the experience of the COVID-19 pandemic was a driver that resulted in the development of new programs at AOASCC. The process of gathering information for this plan demonstrated that many needs identified during the pandemic still exist. Our plan reflects the need to continue to focus on issues of food and transportation access, and to social isolation.

The plan also highlights strategies that reflect statewide collaboration among AAAs through AgingCT which will increase the capacity to provide equitable services statewide and maximize the impact of AAAs in representing issues confronting older adults.
This plan represents AOASCC's commitment to being a conduit of Older Americans Act services as an integral part of our dedication to serve as an advocate of independence in south central Connecticut.

Acronyms

AAAs: Area Agencies on Aging
ADRC: Aging & Disability Resource Center
A.L.I.C.E.: Asset limited, income constrained, employed
AOASCC: Agency on Aging of South Central CT
CHCPE: Connecticut Home Care Program for the Elderly
CHOICES: CT program for Health insurance assistance, Outreach, Information and referral,
Counseling, Eligibility Screening
CDSME: Chronic Disease Self-Management Education
CSRCP: Connecticut Statewide Respite Care Program
DSMP: Diabetes Self-Management Program
DSS: Department of Social Services
FPL: Federal Poverty Level
HDM: Home Delivered Meals
I&A: Information and Assistance
LTSS: Long-term Services & Supports
MFP: Money Follows the Person
MOW: Meals on Wheels
M-Team: Multi-discipline Team
NAMRS: National Adult Maltreatment Reporting System
NFCSP: National Family Caregiver Support Program
PCA: Personal Care Assistant
RSVP: Retired Senior Volunteer Program
SILC: State Independent Living Council
SMP: Senior Medicare Program
SNAP: Supplemental Nutrition Assistance Program
SUA: State Unit on Aging
TEARS: Timely Elder Abuse Resource System

Agency on Aging
OF SOUTH CENTRAL CONNECTICUT
Your Advocate for Independence®



April 2025

Mission Statement

Our mission is to champion and serve older adults and individuals with disabilities so that they remain independent and engaged within their communities.

Core Values

AOASCC is committed to the elimination of ageism; empowering people to live in their communities of choice; and ensuring access to services to meet basic needs of all older adults.

Accomplishments and Challenges

AOASCC participated in a successful project to create a statewide hub for the provision of long-term supports and services by the agencies on aging. The hub enables the provision of comparable services across the regions of the state. The experiences of each AAA informed the creation of a hub that is reflective of regional differences and maximizes opportunities for collaboration. One of the accomplishments of the newly formed hub was successful lobbying for the provision of CT state budget funding for a service navigator at each AAA.

Two new service programs were created at AOASCC in response to identification of unmet needs of older adults in the region. The Grocery Bag program was developed in response to the limitations placed on older adults by COVID-19. The program provides grocery delivery to older adults living at or below 150% FPL. During the period of the Area Plan, 1873 bags of groceries were delivered to qualified older adults. Financial support for the program was provided by 5 funding sources. The highly successful Chaperone program was developed to provide companions to accompany individuals with mobility challenges to medical appointments. The program seeks to establish long-term relationships between chaperones and seniors which decrease missed medical appointments and reduce difficulty in navigating medical facilities.

Successful Strategies

AOASCC employed interagency cooperation as a strategy to address gaps in services that limit the capacity of older adults to remain active in their community of choice. Participants included AAAs, community food banks, transportation providers, healthcare providers, and housing providers. AOASCC employed the use of a grant consultant to expand our ability to seek funding to increase our capacity to meet identified gaps in service. We expanded our mental health services to enable an increase in the number of individuals who receive

behavioral health supports in a timely manner, frequently provided in the privacy of their homes.

Core Strengths

AOASCC has a history of participation in multiple community organizations and is the convenor of the Interagency Council which provides the opportunity to work in collaboration with members of the aging network throughout our 20-town region. We employ trained, qualified staff and provide ongoing training for all staff. We are committed to recognizing contributions of older adults and demonstrate this through our annual Art of Aging celebration, support of our senior volunteer programs and celebration of our CHOICES and SMP volunteers. AOASCC is willing to explore new opportunities to expand our services and celebrate the people who provide their time to serve with us.

Challenges

COVID-19 presented challenges and provided opportunities for the development of new programs. Social isolation and social distancing revealed challenges faced by older adults that resulted in negative outcomes. However, when social distancing requirements were lifted, it became apparent that some of the negative consequences of social isolation were present in the lives of many older adults totally unrelated to COVID-19. This recognition identified challenges to be faced in areas of housing, loneliness, and transportation by AOASCC. Although temporary resources remain available using ARP funds, the challenge remains to find additional funding sources to maintain these essential programs after the ARP funds are expended.

Actions

AOASCC has prioritized grant-seeking for new opportunities to ensure successful programs continue. Additionally, we are collaborating wherever possible with other providers to establish relationships which can enable the continuation of successful programs and development of new services.

AOASCC worked to address the limitations in our region of mental health services for older adults. We funded a support program for older victims of domestic violence and case management services for older individuals with chronic, long term behavioral health challenges. Additionally, we created a new program, using ARP funding to identify

individuals who are experiencing social isolation and have become depressed. The program combines a benefit review to determine if the individual is eligible for benefits and screening for social isolation and depression. Based on the assessment individuals are provided with assistance completing benefit applications and referred to a licensed therapist for in-home counseling. The benefits counselor maintains a relationship with the individual, helping to engage *the individual in community-based social activities*.

The ENPs providing meals in our region were successful in eliminating waiting lists that existed at the beginning of the Area Plan cycle and increased the number of participants in the congregate dining programs. AOASCC counselors submitted 584 SNAP applications for low- income older adults.

AOASCC successfully fostered the development and maintenance of M-Teams in 4 areas in our region. The M-Teams meet regularly and have stable participation. Additionally, we convened the annual TEARS, elder abuse conference each year of the plan.

Primary Accomplishments

Strategies that were successful in accomplishing core program goals;

AOASCC employed interagency cooperation as a strategy to address gaps in services that limit the capacity of older adults to remain active in their community of choice. Participants included AAAs, community food banks, transportation providers, healthcare providers, and housing providers. We expanded our mental health services to increase the number of individuals who receive mental health services a timely manner that are frequently provided in the privacy of their homes.

Strengths that supported meeting core program goals;

AOASCC has a history of participation in multiple community organizations and is the convenor of the Interagency Council which provides the opportunity to work in collaboration with members of the aging network throughout our 20-town region. We employ trained, qualified staff and provide ongoing training for all staff. We are committed to recognizing contributions of older adults and demonstrate this through our annual Art of Aging celebration, support of our senior volunteer programs and celebration of our CHOICES and SMP volunteers. AOASCC is willing to explore new opportunities to expand our services and celebrate the people who provide their time to serve with us.

Challenges that limited the ability to meet core program goals;

COVID-19 presented challenges and provided opportunities for the development of new programs. Social isolation and social distancing revealed challenges faced by older adults that resulted in negative outcomes. However, when social distancing requirements were lifted, it became apparent that some of the negative consequences of social isolation were present in the lives of many older adults totally unrelated to COVID-19. This recognition identified challenges to be faced in areas of housing, loneliness, and transportation by AOASCC. Although temporary resources remain available using ARP funds, the challenge remains to find additional funding sources to maintain these essential programs after the ARP funds are expended.

Actions taken to strengthen the agency

AOASCC is collaborating wherever possible with service providers in our community to establish relationships which can promote the development of new services and opportunities to collaborate with the Aging Network. AOASCC continues to seek new grant opportunities to continue successful programs and develop new programs that meet identified needs. We continually work to ensure our Board of Directors and Advisory Council reflects our community and has knowledge about older adults and issues of concern in our communities.

Changes in AOASCC role in the community over the past Area Plan period

AOASCC made a commitment to raise the visibility of AOASCC as a convenor of aging-related activities. AOASCC is developing training about issues related to aging for staff and members of the aging network in an attempt to provide an increased understanding of age-related issues that impact access, quality and effectiveness of services provided. AOASCC has a commitment to provide a comprehensive vision of aging that includes problems and challenges but also features the contributions of older adults to the greater society and the importance of providing engagement activities to ensure older adults are recognized for their essential roles in society.

Needs and Targets

AOASCC implemented a multi-pronged assessment strategy to ensure needs, gaps and opportunities were adequately addressed. The strategy included:

1. Extensive literature review
2. Older Adult Consumer survey
3. Family Caregiver survey

4. Aging Network Survey
5. Older Adult Consumer focus groups
6. Caregiver focus group
7. Aging Network focus group
8. Public Forum
9. Advisory Council focus group

Assessment tools and data

AOASCC conducted a 2 pronged approach to gathering data: Surveys: consumer survey, caregiver survey, aging network survey and Focus Groups: consumers, caregivers, aging network, Advisory Council. It was determined that having 3 separate surveys would help ensure targeted responses and increase probability of receiving completed surveys. This approach was successful. Each survey was developed with the help of volunteers, who fit each category. They provided questions and reviewed final surveys.

Three focus groups were conducted with consumers: in Spanish (Casa Otonal, social service center in African-American community, (Q House Community Center, senior center in greater New Haven (Dixwell Senior Center. Two caregiver focus groups: at AOASCC and 1 caregiver support group in the Valley, (St. Thomas Church; Aging Network (2 groups: 1 AOASCC Advisory Council, 1 Aging Network Grantees.

1 public forum was held at AOASCC. March 27, 10:30-12:00, AOASCC Community Room.

500 older adults were asked to complete a consumer survey asking about needs, priorities, gaps in service. 310 completed surveys were returned. See attached blank survey and data summary sheets.

300 family caregivers were asked to complete a caregiver survey asking about caregiver relationship, needs, gaps in service, stress and training. See attached blank survey and data summary sheets. 130 surveys completed surveys were returned.

150 Aging Network members were asked to complete a survey of professionals in aging field. 110 completed surveys were returned. See attached blank survey and data summary.

Key results:

Quality Of Life

There were major differences in findings regarding Quality of Life when contrasting the data from consumers, caregivers, and aging network professionals. The majority of older consumers (78%)reported being very satisfied with their quality of life, whereas the majority of aging network professionals reported the quality of life of their clients was poor (72%.

Health status

95% of older adults reported their health status was fair – good, whereas aging network professionals indicated 85% of older adults are in poor health. Family caregivers reported 60% of older adults are in poor health.

Housing

Aging network professionals reported housing was the biggest issue facing older adults due to the limited number of accessible housing units available. Family caregivers did not identify housing as an issue of concern, however, 22.5% of older adults indicated their housing did not meet their needs and are looking for a change in housing.

Transportation

Consumers, caregivers and aging network professionals all identified transportation as a problem. Consumers indicated that the lack of social transportation is a barrier to participating in community activities. Caregivers and aging network professionals only identified medical transportation as a problem.

Food

Caregivers and consumers denied any problem accessing food. 37% are receiving SNAP benefits; 15% use food pantries regularly. None of the consumers or caregivers report using soup kitchens. Aging network professionals identified food insecurity as a major problem for older adults.

Isolation

Caregivers identified social isolation as a problem for themselves and for the person for whom they provide care. Older adults (35%)reported being socially isolated. Aging

network professionals reported 40% of the older adults with whom they work are socially isolated. They also reported that 55% are lonely. Neither caregivers nor consumers reported loneliness, however, 70 older adults reported being "depressed" due to social isolation.

The resulting planning document attempts to address the needs identified by participant groups, gaps in services, stakeholder priorities and state plan priorities.

Current and projected needs

Outline the current needs among the PSA's population age 60 and older, in order of priority, and the projected needs of this population in the PSA during the Area Plan period. Use information gathered through the agency's needs assessment, demographic data, survey instruments, community meetings or hearings, and documented reports of unmet needs for supportive services.

Based on findings from the surveys, focus groups and literature review, 4 areas of need were identified where gaps in services exist:

a. transportation

b. food security

c. social isolation

d. housing,

The order of priority differed based on the status of the survey respondents. Aging network professionals identified food and transportation gaps as top priorities, whereas caregivers ranked caregiver stress as the top priority and consumers ranked housing higher than transportation but identified both as issues needing attention. A high number of consumers indicated dissatisfaction with the quality of life and 110 refused to answer the question, despite having answered all the other questions.

Projected change

There was a 3% increase in the number of older adults living in New Haven County during the previous Area Plan period. Older adults now represent 33% of the population in the region which is 8% higher than the statewide average. New Haven is the fastest growing city in the state. It is anticipated that 5,708 people will be added to the region by 2027. Marginalized groups currently comprise 72% of the population in the city of New Haven and 27% in New Haven County. Based on population trends, those numbers are expected to

increase over the Area Plan period. Fewer older adults in New Haven have access to privately owned vehicles; pockets of older adults in towns in New Haven County have higher rates of poor health; and there is a high rate of social isolation and anxiety/depression throughout the region.

The increase in population of older adults in New Haven impacts delivery of supportive services in several ways: 1. increased need for transportation services for both medical and non-medical purposes; 2. increased need for senior center programing to accommodate growth in population of older adults; increased need for mental health services.

Private ownership of automobiles by older adults in New Haven is significantly lower than most other regions, therefore affordable, accessible transportation services are needed to enable older adults to participate in activities.

The lower health status of older adults in both New Haven and several Lower Naugatuck Valley towns require additional disease prevention programs targeted toward greater participation in health promotion activities in addition to existing social activities.

As AOASCC reviews applications for Title III funding, we will focus on closing the gap in services for transportation and increase support for health promotion activities. We developed a medical chaperone program with initial support from the Department of transportation and subsequent funding from ARPAto reduce transportation challenges for individuals with limited mobility. We continue to seek funding for continuation of the program.

Additionally, AOASCC, with ARP funding, piloted a mental health project to address issues of social isolation, anxiety/depression. We will endeavor to identify additional funding support to continue the provision of mental health services.

Provider Information

Providers in the region demonstrated their capability of reducing need when resources are available. During the previous Area Plan, food insecurity in New Haven was significantly higher than the state average. During the past 4 years several food councils were formed and agencies worked together to reduce food insecurity. As a result of combined efforts, the rate of food insecurity in New Haven is now 1% lower than the statewide average. Even with progress on this issue, however, food insecurity remains a problem with 13% of older adults being food insecure.

In New Haven 25% of residents don't own a car therefore there is heavy reliance on public transportation and use of alternate transportation providers. Although many older adults throughout the state no longer drive, they rely on family to provide transportation. In New Haven 1 in 4 older adults lack the opportunity to be driven by family. Therefore, AOASCC funds multiple transportation providers to help offset the lack of family transportation. However, based on available funds, funding is provided predominantly for medical appointments only. This leaves a gap that prevents older adults from participating in the life of the community since there is minimal public transportation available on evenings and weekends. Pending available funding AOASCC plans to increase funding for non-medical transportation.

The gap between available, affordable housing and demand is significant. The number of housing-burdened older adults in New Haven and the increased number of older adults living in the area drives the gap. Despite efforts by public housing authorities, public/private development projects and HUD projects, the demand far exceeds the available resources. Multi-year waiting lists for housing openings are common in each town in the region. Despite a boom in the creation of "Senior Housing" complexes, "affordable" housing is significantly more costly than the subsidized housing rate, making it more costly than 79% of New Haven older adults can afford. At present, 49% of older adults in New Haven are housing-burdened and cannot pay market-rate rents.

The availability of mental health services for older adults presents a challenge. In the region, Sixty-percent of practicing psychologists are not accepting new patients and those who are accepting new referrals report at least a 10 person waiting list.

Strategies for targeting

The following strategies will be employed to ensure activities are targeted toward individuals in the greatest economic and social need:

Raising awareness of existing benefits and programs that can reduce poverty, enhance ability to travel in the community, decrease food insecurity, support caregivers and provide volunteer opportunities.

Providing volunteer stipends in Chaperone Program, Grocery Bag Program,

Neighborhood-based recruitment of volunteers in RSVP, Chaperone Program and Grocery Bag Program.

Streamlining referral systems at community health centers and large senior housing sites.

Increased use of website/FB to provide information about programs, benefits and opportunities.

Presentations at libraries and senior centers about available services to help remain at home

- Conferences targeted toward care in the community
- Use of Language Interpretation program.
- Translation of agency materials into Spanish.
- Spanish/English simultaneous trainings for volunteers.
- Collaboration with providers of services to LBGTQ community.
- Support groups with Alzheimer's Association.
- Small group discussions with consumers.

Number of persons in each of the target groups in the south central region

age 60 and older = New Haven (City) =14,630 (11% County= 139,000 (18%

low-income minority individuals = 17,000 (30%

at risk for institutional placement=19%

limited English proficiency, 17%

living in rural areas, = 0

older Native American individuals, = .03%

Alzheimer's Disease and related disorders, 12.1%

severe disabilities= 18%

living with HIV = total =1,700; 60+=35%

Methods used to support older individuals within the south-central region through administered services and programs:

Provide **care management** services to 65+ older adults through a contract with the CT Department of Social Services

Conduct **benefits screening**, in-person or online through I&A waiver and service navigator.

Provide one-to-one **information counseling** about programs and services designed to enable individuals to remain living in their community of choice through Information and Assistance waiver.

Provide **application assistance** through I&A waiver, CHOICES and Service Navigator.

Provide one-to-one **health insurance counseling** about Medicare benefits and programs through the CHOICES program.

Provide **home-delivered meals** (HDM) to individuals at greatest nutritional risk through Elderly Nutrition Providers, sub-grantee of AOASCC.

Deliver groceries to older adults with low incomes and individuals with disabilities utilizing multiple funding sources.

Provide **chaperone assistance** to individuals requiring help when traveling to medical appointments utilizing multiple funding sources.

Provide **caregiver support groups** in-person and online through National Family Caregiver Support Program (NFCSP) and CT Statewide Respite Program (CSWRP).

Provide **care management services to caregivers** in NFCSP and CSRCP.

Provide **respite** breaks to caregivers through NFCSP and CSRCP.

Provide **education and volunteer opportunities** regarding fraud and abuse through SMP.

Meeting Targets

AOASCC has been successful in meeting the established targets for services to the following target population groups.

AOASCC was successful in meeting targets for 63 (88%) of its established targets in the previous Area Plan period. The submitted annual report on the Area Plan activities documents the progress and completion of each Goal, Objective and Strategy in the Plan. Below are some highlights:

Implemented in partnership with all AAAs strategies to increase efficiencies. Developed new website providing statewide information to improve consumer experience and helping to ensure consistency of information about programs and services throughout CT. Began providing navigation services in FFY 2023.

Chaperone program expanded, with funding from multiple grantors throughout the Plan period, ensuring availability of the program throughout the region. The program received national attention and AOASCC was asked to participate in 2 national

committees designed to expand the use of chaperones for older adults and people with disabilities.

Each year of the Plan, despite limitations of COVID-19 restrictions, AOASCC convened a conference to support and celebrate family caregivers and provided the annual TEARS (elder abuse) conference to help ensure members of the aging network have access to information about elder abuse and elder rights, irrespective of the size or budget of the agency they represent.

AOASCC continued its commitment to demonstrating the contributions of older adults to our community through the annual Art of Aging each May, despite the limitations imposed by COVID-19. The Art of Aging was mounted as an online celebration and more than 100 works of art were placed on permanent display in a special section of the website. An official "opening reception" was held and the artists, their supporters, staff and supporters of the agency participated. The Art of Aging returned to an in-person model when social distancing limitations were lifted.

AOASCC expanded its capacity to provide caregiver training and began a commitment to provide Powerful Tools for Caregivers multiple times each year. At present, 7 staff and volunteers are trained and certified to serve as class leaders. In addition to Powerful tools, AOASCC also provided training on effective communication with health care providers and communication techniques with individuals with dementia.

AOASCC staff completed and submitted SNAP applications for 1,800 in the Plan period, thereby helping to improve income security and reduce food insecurity for a large number of the most marginalized members of our community.

There were 9 targets that were not completed. Five (60% of incomplete targets were a direct result of COVID-19 limitations, such as closing of senior centers thereby preventing planned outreach programs, cancellation of meals at congregate dining sites, social distancing limits preventing in-person trainings and inability of providers to meet target for in-home counseling due to COVID-19 impact of the health care work force. Three targets weren't met due to a lack of financing that was needed to support the target to expand restaurant-based congregate sites and 1 target wasn't accomplished due a lack of trained providers in the region to provide Moving for Better Balance.

Data collection

Data for Title III, non-aggregate data, is collected by Information Counselors and Care Managers using Form5s. The data is entered into Wellsky by 2 data entry clerks. With the exception of the data gathered by the Elderly Nutrition Providers, data for all Title III funded programs is entered by the AOASCC data entry staff. At the present time, the staff have

been consistently able to meet timelines for reporting requirements. Expansion of the use of Form 5s for Information & Assistance would challenge the ability to enter the additional data and meet reporting deadlines.

Monthly performance reports are pulled from Wellsky to track progress toward targets. Data entry staff collaborate with BOA to correct missing or incomplete data.

Information & Assistance data and family caregiver data are tracked using Excel documents and submitted quarterly to BOA program coordinators.

AOASCC is in the process of implementing an AgingCT based data system that will facilitate data collection and reporting and have the capability to upload data to Wellsky.

Quality Management

AOASCC has procedures in place that ensure the performance of all programs provided through sub-grantees, service providers and waivers meet established standards of practice and are using funds for the authorized use, in compliance with statutes and regulations and the terms and conditions of the grant award.

Each sub-grantee's risk of non-compliance is evaluated by the AOASCC Grants Department, Fiscal Department and the Allocation Committee of the Board of Directors prior to making awards. Additionally, annual site visit evaluations are conducted by AOASCC Grants Department staff, grants accountant, Advisory Board members and members of the Board of Directors to review actual performance records, fiscal practices, agency policy manuals.

Fiscal Monitoring: The grants accountant reviews sub-grantee fiscal records and determines if the grantee is complying with the terms of the contract and utilizing the funding as awarded and within the approved timeline. The grants accountant and AOASCC Chief Financial Officer (CFO) determine whether the sub-grantee is in stable financial condition and able to provide the funded services. The grants accountant and CFO review required audits to ensure fiscal soundness of sub-grantees.

Program Monitoring: The Grants Department conducts monthly performance assessments by reviewing Wellsky data to track performance units. The data is compared with anticipated monthly figures and if a significant variance is identified, the Grants

manager meets with the sub-recipient to provide technical assistance to improve performance.

Sub-grantees are required to submit quarterly Social Service reports to ensure program performance is on track and unanticipated problems that arise are addressed during the funding year to minimize the risk of underspending grant budgets and/or failing to meet service needs as planned.

Each sub-grantee and waiver are required to conduct consumer satisfaction activities at least annually. Services provided that require licenses or certifications are reviewed to ensure current documents are in place.

Service providers maintain required licenses, certifications, insurances, and quality performance reports that are included in MOAs between AOASCC and the Provider.

Area Plan Development Process

AOASCC began the development process with a comprehensive review of the literature published about older adults during the 2021-2025 Area Plan period. This included noted journals, reports from national organizations and data gathered through the US Census Bureau, the Kaiser Family Foundation, and InformUSA. CT specific data was obtained from Data Haven, CT.Gov, CT Department of Labor, CT Department of Health.

A summary of key findings was presented to The AOASCC Advisory Council. Based on key findings members of the Advisory Council provided recommendations about topic areas for agency surveys.

Three agency surveys were created: 1. Consumer Survey; 2. Caregiver Survey; 3. Aging Network Survey. Each category of surveys was distributed to a convenience sample of participants in relevant categories. Surveys were distributed by staff working in programs across the agency; sub-grantees were enlisted to distribute the surveys to clients; senior centers distributed surveys to members; aging network surveys were distributed through the Interagency Council, service providers lists, residence service coordinators; caregiver surveys were distributed through caregiver support groups. Surveys were emailed to identified email groups and mailed by post to individuals for whom we lacked email addresses. Volunteers were trained to conduct the survey telephonically. Calls were made to a group of consumers selected at random who previously contacted the AOASCC seeking information about agency services.

Separate focus groups were held with consumers, caregivers and aging network members. Locations of focus groups were selected to maximize participation by traditionally underrepresented individuals.

A community forum was held at AOASCC that included a cross section of older adults, volunteers, and caregivers.

Goals, Objectives, Strategies and Measures

Strategic Goal # 1:

Influence **health and wellbeing** of CT's Older Adults by addressing Social Health Care Needs

Objective 1	**Improve access to health care and/or expand access to services that address chronic illnesses.**
Strategy 1	Fund Chronic Disease Self-Management Programs to be delivered with a focus on OAA target populations.
Outcome	IIID programs reviewed annually
Measure	Consumers have access to DSMP
Strategy 2	Partner with disease-specific organizations to create opportunities for synergy and cross-sector collaboration with a focus on OAA target populations.
Outcome	Partnerships between community-based organizations creates opportunities to expand visibility and reach additional consumers.
Measure	Expanded sources of referrals is demonstrated
Strategy 3	Maximize Medicare covered services by offering New To Medicare Presentations with focused outreach OAA target populations.
Outcome	Medicare beneficiaries are aware of their preventive benefits, coverage options and important deadlines.
Measure	CHOICES contract deliverables are met or exceeded
Objective 2	**Address upstream factors contributing to the rising rates of homelessness among older adults.**

Strategy 2.1	Fund pre-eviction housing assistance through legal assistance organizations that focus OAA target populations.
Outcome	Greater availability of information and advocacy and legal representation to combat impacts of landlord pressure.
Measure	Program monitoring indicates funded agencies meet targets for representation of older adult in housing crises..
Strategy 2.2	Work with housing advocates to establish annual communication and training opportunities.
Strategy 2.3	Conduct benefits outreach to connect individuals with greatest economic and social need benefit programs that can increase available funds that can be used by the consumer to help defray housing costs.
Outcome	Older adults and individuals with disabilities are being identified earlier, and benefiting from increased access to benefits. These interventions are leading to increased opportunities to avoid homelessness.
Measure	Number of housing assistance interventions provided by AAA staff annually.
Objective 3	**Develop multi-faceted approaches to wellness by addressing food insecurity and malnutrition.**
Strategy 3.1	Fund or provide nutrition programs that are innovative, exhibits cultural sensitivity, and/or expands access to meals through non-traditional means.
Outcome	Additional options are available to consumers in lieu of traditional home-delivered meals or community cafes and diversification encourages participation.
Measure	Utilization data shows increasing diversification and utilization of alternate food delivery options.
Strategy 3.3	Conduct benefits outreach to connect individuals with greatest economic and social need with public income support programs such as Supplemental Nutrition Assistance Program SNAP.
Outcome	Increased participation in public benefit programs by dually-eligible population provides greater economic stability and access to necessary services.

Measure	MIPPA deliverables met or exceeded.
Objective 4	**Address issues of social isolation and loneliness as significant threats to the health and well being of older adults through Older Americans Act funding.**
Strategy 4.1	Fund programs designed to foster community connections or dispel loneliness and isolation among home-bound elders.
Strategy 4.2	Assess and enroll consumers (as appropriate) in Caregiver Support Programs to access services including person-centered planning, care management, support groups and in-home services to relieve caregiver burden, reduce health & safety risks and ease the burden of loneliness and isolation (for both caregivers and care-recipients).
Strategy 4.3	Introduce Title III nutrition services (congregate or home delivered as appropriate) to relieve caregiver burden, support healthy nutrition and access to food, and establish “eyes” through the HDM volunteer/driver.
Strategy 4.4	Utilize regional Information & Assistance program to connect at-risk older adults to community-based supports with a focus on OAA target populations.
Outcome	Enrollment in and access to community-based support programs ameliorates negative health impacts from Isolation and loneliness.
Measure	Decrease in self-identified loneliness and isolation in BetterAge pilot users.
Measure	Utilization data confirms that targets for the Fed Contract have been met or exceeded.
Objective 5	**Improve continuity of care across state systems by Bridging Aging and Disability Services**
Strategy 5.1	Member(s) of AgingCT/AAAs will participate in Bridging Aging & Disability Community of Practice
Strategy 5.2	Members of AgingCT/AAAs will participate in advocacy discussions and activities around items of common concern.
Strategy 5.3	Members of AgingCT/AAAs will seek out and attend trainings, webinars etc. for professional development around A&D issues.

Outcome	Greater communication and coordination opportunities between Aging & Disability networks allows creative ways to address unmet social health care needs and identifies potential opportunities for systems change.
Measure	Staff engagement includes a variety of cross-disability and cross-lifespan activities.
Measure	Utilization data indicates an Increased number of Medicare Beneficiaries under the age of 60.

Strategic Goal 2:

Improve access to **long-term services and supports** for Older Americans Act target populations

Objective 1	Equitable access across underserved populations
Strategy 1	Bi-lingual presentations on LTSS to senior companions who serve older adults living in housing predominantly occupied by Spanish speakers.
Strategy 2	Presentation to community health care workers who work with target population about LTSS
Strategy 3	Utilize focal points to distribute information about LTSS
Strategy 4	Participate in planning multi-town community fair that showcases LTSS services
Strategy 5	Distribution of LTSS information at AOASCC caregiver support groups
Outcome	Information about LTSS is shared with older adults and people with disabilities and their caregivers.
Measure 1	Requests to AOASCC for assistance accessing LTSS, are made by target population.
Measure 2	Referrals from CHWs for LTSS increase.
Measure 3	Information about LTSS is sent to focal points for posting and promoting.
Measure 4	Multi-town community fair held.
Measure 5	Information table containing LTSS resources available at caregiver support groups
Objective 2	Equitable access to transportation services
Strategy 1	Provide information about community transportation services through I&A counselors

Strategy 2	Fund community transportation programs to provide alternatives for individuals who feel their needs are not adequately met by public transportation options
Strategy 3	Provide Chaperone program for individuals and caregivers who require assistance in traveling to medical appointments
Outcome	Information about transportation and transportation services are available for target population.
Measurement 1	Number of individuals provided Information by I&A counselors
Measurement 2	At least one community non-profit receives funding for medial transportation.
Measurement 3	1000 units of chaperone services will be provided to individuals with mobility issues
Objective 3	Equitable Access to Nutrition Services
Strategy 1	Screen callers for home delivered meals
Strategy 2	Assist callers with SNAP application submissions
Strategy 3	Provide free grocery delivery to low income older adults and people with disabilities
Outcome	All qualified consumers have access to groceries and prepared meals
Measurement 1	1,000 older adults receive home delivered meals.
Measurement 2	500 consumers received application assistance for SNAP benefits
Measurement 3	2,000 bags of groceries are delivered.

Goal 3: Elder Rights

Protect elder rights and well-being, and prevent elder abuse, fraud, neglect, and exploitation

Objective 1	**Identify new members and increase sustainable stakeholder participation throughout the aging network consistent with the Coalition for Elder Justice in Connecticut and other organizations.**
Strategy 1.1	Build person-centered capacity with a focus on Elder Rights through

	education, information, and awareness campaigns targeting emergency and first responders.
Outcome	Increased education, information and awareness campaigns targeted to emergency and first responders to reinforce knowledge and awareness of the need to adopt a person-centered attitude and skills among service providers.
Measure	One presentation per year to first responders and provision of carry cards with our information to first responders in every town and state police that cover our region. Strive to offer education as free continuing education units whenever possible.
Strategy 1.2	Identify opportunities to increase coordination of initiatives identified among aging network (including CEJC members) on issues of prevention of fraud, abuse, and exploitation to prioritize Elder Rights awareness.
Outcome	Increase knowledge and awareness of issues affecting older adults from varied agencies and community partners which creates collaborative opportunities to prioritize Elder Rights across the aging network.
Measure	Provide educational outreach events consistent with program contracts for CHOICES, SMP, MIPPA and Title IIIB Public Education, with emphasis on topics which relate to Elder Right issues. Promote community education events for Title IIIB community funding for Legal Services and the Consumer Law Project. Continue M-Teams meetings to coordinate aging network providers to discuss confidential case issues and gaps in services related to Elder Rights. Support financial management training to older adults and caregivers or promote assistance when needed. Convene annual TEARS conference on Elder Abuse.
Strategy 1.3	Share, and disseminate information and resources about elder abuse prevention throughout the aging network.
Outcome	Share information through Aging Networks including Senior Centers, Municipal Agents for the Elderly, M Teams, Banks. Share or create information to share through various platforms including YouTube, Social Media, etc.
Measure	Number of Elder Justice related topics conveyed through AAA Newsletters, social media or other communication methods
Strategy 1.4	Strengthen collaboration with Protective Services for the Elderly (PSE) to educate the public about abuse, neglect, and exploitation, and the mechanisms for reporting concerns, and continue to refer individuals as appropriate.
Measure	EPS makes presentations at TEARS conference to Aging network and community members on abuse, neglect, and exploitation of older adults, and are aware of how to report concerns.
Outcome	Provide educational outreach, including appropriate referrals to PSE or other Aging Network resources, through public access television, public presentations, websites, etc. Encourage partnership or panel presentation with Protective Services for

	the Elderly and other CEJC focused programs. Promote awareness of Aging Answers programs at AAAs and examples of complex Service navigation scenarios that were prevented, resolved or improved.
Objective 2	**Empower marginalized or disempowered groups, including those in long term care facilities, to increase participant knowledge of resident rights, as well as the role and duties of the Long Term Care Ombudsman Program (LTCOP).**
Strategy 2.1	By 2027 or as available, assist to disseminate information about five (5) informational videos to be produced by the LTCOP that will promote awareness and enhance the quality of life and care for Connecticut's citizens receiving various long-term supports and services.
Outcome	More older adults are aware of the informational videos and feel informed about resident rights, the quality of life and care they receive from long term care supports and services. Increased number of residents understand how the role of the LTCOP and rally support from LTCOP to enhance their quality of life and care as needed.
Measure	LTCOP makes presentation to the Interagency Council of SC CT. Recording of the presentation will be stored on AOASCC website library for use by Aging Network, consumers and caregivers and students.
Strategy 2.2	Analyze data to understand the concerns of marginalized groups and tailor the program's educational communication strategies to increase individual knowledge base.
Outcome	Increased data providing more knowledge about the concerns of underserved groups.
Measure	Implement BetterAge software with sublicensees at Senior Centers to gather data on participant concerns and needs. M Team discussion of gaps in services as well as ongoing discussion related to Area Planning. Consider gathering data on needs of interpreting DSS, SSA and other government program literature. Underserved populations to consider include: those released from incarceration, Solo Agers, and those living in remote locations. Consider forming support groups for families of residents in SNFs, or collaborate with local groups to provide them. Available as professional speaker for public outreach and education to all areas, including long term care facilities.
Outcome	More older adults and caregivers, including residents of long-term care facilities, take action to reach out for support more often when in need. Underserved groups and marginalized residents are educated about their rights and engage in planning for and addressing barriers to better quality of life as recipients of long-term supportive services and care.
Measure	Offer Public Education events to long term care facilities like those topics provided in the community, senior centers, etc.

Objective 3	**Support the State's initiative to offload excess nursing home beds by approximately 2,500 and rebalancing of the long-term care continuum, while protecting resident rights.**
Strategy 3.1	Educate and engage residents, including those of long-term care communities, of their rights regarding where long term supports and services can be received, for communities that are undergoing rightsizing projects.
Outcome	More residents in communities undergoing rightsizing projects understand impending lifestyle changes and accept informational engagements about alternative communities offering long term supports and services.
Measure	Avoidance of nursing home placement through programmatic goals of home and community based long term supports and services. Collaborative support of homelessness diversion supports. Information, referral and assessment as well as Service Navigation roles in person centered planning. Referral to MFP as appropriate.
Strategy 3.2	Monitor and support State Ombudsman participation in the Medicaid Long-Term Services and Supports Rebalancing Initiatives Steering Committee to advocate for long term care recipients. Offer involvement to Steering Committee for community Medicaid long term supported clients as well.
Outcome	Engage long term Medicaid services participants to identify relevant strategies and action plans to uphold Elder Rights.
Measure	Build partnerships with state agencies and other organizations for broader impact and resource-sharing around long term care services and resident rights. AAAs will support partnerships.
Objective 4	**Increase equity for Connecticut residents, including those in nursing homes, residential care homes, and assisted living communities, by expanding their access to Home and Community-Based Services (HCBS) and ensuring their voices are heard by public officials.**
Strategy 4.1	Advocate for Home and Community Based Services and Long Term Supports to create safe, person-centered plans of care in the community.
Outcome	More citizens from underserved groups, including those in residential care communities, participate in assessments to identify barriers to eligibility of supportive services.
Measure	Offering informational presentations in various living environments, including Residential Care Homes, assisted living and independent housing in our region. The Service Navigator helps individuals in these communities to access CHCPE.
Strategy 4.2	Expand and strengthen individual advocacy by providing information on efforts and ways to be involved and express individual concerns.
Outcome	Identify resources, annual workshops, and forums where residents can voice their concerns to public officials and relevant training necessary to

	facilitate representation of their peers.
Measure	Share information about AAA advocacy activities and focus topics. Provide educational opportunities to discuss ways to be involved. Encourage participants to share the story of how programs and services impact their lives in the community.

Attachment H

Request for Waiver from Procurement to Provide Direct Service

Waiver Requests:

For the 2026 – 202 planning period, AOASCC is requesting approval from the SUA for the following direct service waivers:

Title IIIB Waiver Request: I&A

Title IIID Waiver Request: Powerful Tools

Title IIIE Waiver Request: NFCSP

Title IIIB Waiver Request: Information & Assistance Waiver

AAA Name: Agency on Aging of South Central Connecticut
Date Submitted: May 1, 2025

Waiver Title: Information & Assistance Waiver

Time Period of Waiver (Federal Fiscal Years): Oct. 1, 2024 – Sept. 30, 2027

Please check which Categories of this waiver you are requesting:
Information & Assistance Title IIIB Funds_____

Number of Clients to be served: _3500_____
Number of Units to be provided: __4200_____

Title III-B Waiver Total $170,057
Match: At least 15% $30,010
Program Income: ___0_____
Total Program: $ 200,067
Other Resources: ___0_____
Grand Total: $ 200,067

Program Waiver Justification

Statement of Need: In a brief paragraph, provide information regarding the need of the service and the need for the AAA to provide the service directly. Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. If applying for more than one Category (i.e., Information & Assistance, Aging and Disability Resource Center, etc.), your request should indicate how services would be coordinated between categories. Include any relevant data to support or justify your need statement.

> Information & Assistance at the Agency on Aging of South Central CT (AOASCC) is provided by InformUSA certified staff. Information topics include: social programs & services, health topics, economic, and social issues of importance to older adults.

Older adults often need assistance in navigating the maze of available information, from multiple sources. In 2024, The World Health Organization pointed out that "The growing conversion of services and documentation, to computer technology could be alien to seniors, increasing social exclusion." https://extranet.who.int/agefriendlyworld/age-friendly-practices/communication-and-information/ - Research demonstrates older adults feel information from the government is confusing and intimidating and feel they need help when applying for benefits (NIA-NIH/Gov/tips for improving communication, 2021).

Because of the close working relationship between our Information & Assistance counselors and Service Navigators and our sub-grantees, funded through the Older Americans Act, AOASCC can efficiently refer consumers to appropriate services and ensure that the referral loop is closed. Collaborating with aging network partners, through our Interagency Council, AOASCC ensures its information program doesn't duplicate existing programs, but rather compliments the network by providing an additional resource in towns where basic information programs exist and providing in-depth information in towns where there aren't other, trusted sources of information provided through the towns..

Category 1: ___Information & Assistance

Title III-B Funds $_85,028___

Number of clients to be served: ___3500_____

Number of units to be provided:_____4,200_____

Category 2: Person Centered Counseling___ Title III-B Funds $85,029___

Number of clients to be served: _____24_____

Number of units to be provided:_____140_____

Total Budget Summary for all waivers:

Title III-B Waiver – Category 1:	____$85,028_____
Title III-B Waiver – Category 2:	_____$85,029_____
Title III-B Waiver – Category 3:	_____
Title III-B Waiver Total All Categories	____$170,057_____
Match: At least 15%	____30,010_____
Program Income:	_____0_____
Total Program:	_____$200,067_____
Other Resources:	_____0_____
Grand Total:	_____$200,067_____

A. NARRATIVE: In narrative form, address the following items in two pages or less:

1. **Service Description:**
   a. For each category of services to be provided under this waiver (i.e., Information & Assistance, Aging and Disability Resource Center, etc.), provide a brief overview of the services to be provided, including the service definitions to be used, and how these services will be coordinated.

Services	**Target Population**	**Geographic Areas Served**	**Unit Definition**	**Clients/units**	**Measurement**
Telephone Information	Individuals 60+ years	20 town region of SC CT	1 contact	3500/4200	I&A database
Public Education	Individuals 60+ years	20 town region of SC CT	1 contact	1200/12	Aggregate/Attendance records
Benefits Education	Individuals 60+	20 town region of SC CT	1contact	300/12	I&A database

Position	FTE	Role
Information Counselors	1.5 FTE	Education for Medicare/ Medicaid Beneficiaries; Provision of information and assistance; Outreach; Public Education; Volunteer training/coordination
ADRC Director	.05 FTE	Supervision
Grants Accountant	.04 FTE	Fiscal management
Clerical Support	.25 FTE	telephones

Trained, certified counselors, provide information about programs and services, Medicaid issues, benefits and community resources. Multiple forms of information distribution are utilized: telephone counseling, in-person counseling, small groups, community education programs, fairs, AOASCC website, and limited home visits for older adults with disabilities.

Service descriptions:

- Telephone counseling: Calls triaged at ADRC main desk and assigned to available information counselors.
- In-person counseling: available on a more limited basis for individuals who are unable to utilize telephone assistance. Clients are seen by appointment.

- Small group information services: provided at select times to groups of individuals with need for similar information such as SNAP or home heating or senior housing options.
- Community education programs: delivered by information counselors and outreach staff at locations throughout the community such as senior housing, libraries and senior centers.
- Counselors participate in senior and health fairs throughout the year, bringing information about community programs and the programs and services of AOASCC.
- The AOASCC website is used increasingly by consumers. Counselors receive email, forwarded from the website, from people seeking information about services
- Outreach is targeted to low income and minority group members and individuals at risk of institutionalization. Traditionally, AOASCC targets outreach to African-American and Latinx older adults and older adults with disabilities, particularly dementia disorders and people at risk of institutionalization.

b. Complete the table below following the examples provided. For each Category, list the services to be provided, target population and geographic areas served.

Example 1: Category 1: Information & Assistance

Services	**Target Population**	**Geographic Areas Served**
I & A, Outreach	Medicare Beneficiaries	Entire AAA region

Example 2: Category 2: Aging and Disability Resource Center

Services	**Target Population**	**Geographic Areas Served**
Person-Centered Counseling	Persons needing LTSS; those with complex issues, those requiring short term support	Entire SC Region
Benefits counseling	Individuals referred for meals on wheels	Greater New Haven

Category 1: Information & Assistance

Services	Target Population	Geographic Areas Served
Telephone Information	Individuals 60+ years	20 town region of SC CT
Outreach	Individuals 60+ years	20 town region of SC CT
Benefits Counseling	Individuals 60+ referred for HDM	20 town region of SC CT

Category 2: Person Centered Counseling

Services	Target Population	Geographic Areas Served
Person-centered counseling	Individuals 60+ with disabilities	20 town region of SC CT

2. **Service Delivery:** Describe how the service will be provided, how potential consumers will be informed about the availability of the services and how the services will be targeted and tracked within the MIS system (SAMS). Provide a chart outlining the FTE staff position(s) dedicated to each category of the waiver and the coordination between Title III-B waiver categories.

   AASCC's services are provided in a handicapped accessible building with ample handicap parking. Signage is prominent to ensure ease of access. The agency subscribes to translation services that enable staff to provide counseling to individuals irrespective of language. Text for information materials complies with guidelines for screen reader use. Most written information is available in English and Spanish, and increasingly, information flyers are created in a bilingual format.

   AOASCC maintains a database of email addresses for consumers who contact us for services. Information about programs and services are distributed regularly through email. Additionally, the AOASCC website and Facebook are utilized to provide service information. AOASCC participates in senior fairs throughout the year.

   AOASCC has an agency link on the websites of our grantee organizations.

   Information & Assistance clients are tracked with in an excel data system with information from client intake sheets. Data entry is completed by agency staff and volunteers. Data is reported in the aggregate for all information services. At this time, AOASCC does not have sufficient data entry staff to increase data entry by 4,000 additional I&A clients, into the SAMS system. Consumers who attend fairs and educational presentations would add another 2,000 – 3,000 clients. Volunteers

cannot enter this data into SAMS because of licensing restrictions. AOASCC seeks permission to continue reporting I&A services in the aggregate.

Staff Member	Services
Information Counselor (in hiring process)	Telephone benefits counseling; in-person counseling
Chris Clark	Outreach
Carolyn Ciccarella	Telephone counseling; in-person counseling
Wai Kam Cheng	Call center facilitation.
Ellen Torgeson	SNAP benefit enrollment
Beverly Kidder	Supervision

2. Client Satisfaction: Describe how the service staff will determine client satisfaction and make improvement if problems are identified. Provide copy of survey tool.

Client satisfaction is monitored using quarterly surveys of a 50-person sample, per quarter, of all callers to the agency and targeted surveys to areas of special interest. Satisfaction ratings continue to be high with most categories exceeding 90% and none lower than 75% in both general surveys and targeted surveys. A copy of the survey is attached.

☐

3. Sub-Contracts (if applicable): Describe plans for sub-contracting services components.

NA

BUDGET: Attach a line item budget for each waiver requested using the form provided by SDA.

Please note: your Title III-B waiver budget request shall not exceed 25% of the AAA's Title III-B allocation for the previous federal fiscal year, prior to transfers, per SUA-SPI-17-01.

We, the undersigned approve and submit the attached service description for Title III-B waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

_____ _____

Area Agency on Aging Director Date

_____ _____

Authorized Official of Agency on Aging (optional) Date

For SDA Use Only

____ Approved _____

Time Period of Approved Waiver

____ Denied

_____ _____

Commissioner, State Department on Aging Da

Title IIID Waiver Requests

Name AAA Agency on Aging of South Central CT

Date Submitted May 1, 2025

Title of Waiver Powerful Tools

Time Period of Waiver` FFY 2026

Waiver Request: EBHP Program Coordination Title III-D Funds $20,000

Number of clients to be served: 40
Number of units to be provided: 40

FFY2022 Waiver Budget Summary:

Title III-D Waiver Total **$ 20,000**
Match: At least 15% $ 3,870

Program Income: $ 0

Total Program: 23,870

Other Resources:

Grand Total: $23,870

A. NARRATIVE In narrative form address the following items in two pages or less:

1. **Service Description**

AOASCC will provide the evidenced-based Powerful Tools program. This 12 session in-person model or 6 session ZOOM model teaches individuals how to establish priorities, utilize behavioral strategies to manage stressful situations, improve communication, develop effective relaxation techniques, develop self-confidence and utilize community resources. This 1 program was deemed to have met the highest-level criteria of evidence-based disease prevention and health promotion programs by the Administration for Community Living/Administration on Aging. Classes will be provided in 2 formats: in-person and on Zoom accommodating the special needs of consumers.

Service	Target Population	Geographic Area	Unit Definition	Client/Unit	Tracking
Powerful Tools	Individuals 60+ and caregivers	Entire 20 town SC region	1 completer*	40/40	Wellsky

*Completers are defined as participants who attended at least 4 out of 6 workshop ZOOM sessions or 8 of 12 in-person sessions.

2. **Service Delivery**

- Promote Powerful Tools program through outreach activities: Newsletter, Facebook, email, presentations, church newsletters, local news weekly publications, senior fairs and community employer provided information fairs for employees.
- Educate aging network about Powerful Tools.
- AOASCC staff person certified as master trainer.
- Provide 2 new volunteer trainings by master trainer.
- Provide 1 Powerful Tools training annually for family caregivers (12 sessions) in-person at AOASCC offices, lunch provided; training manuals provided; community resources kit provided.
- Provide 3 Powerful Tools training annually on Zoom (6 sessions), Training material provided; package of community resources provided.

    - Trained presenters (2) conduct 3 hour sessions, for 6 consecutive weeks. Program combines scripted session instruction and small group exercises and participant journals Each participant identifies 1 or 2 goals for good health and develops a behavioral activation plan to achieve the goals. Information, training, Peer support, and relaxation training are key elements of the program.
- Provide 21, 1 hour sessions with caregivers taking the training in the ZOOM format, (7 per Powerful Tools Training offered on ZOOM) to initially present a description of the program and enroll caregivers. Subsequently, 1 hour per week to address questions, and resource topics not included in the ZOOM version of the evidenced based program. The University of Iowa recommends the additional hour per week in recognition of the fact that the in-person version of Powerful Tools provides informal opportunities for caregivers to engage with course leaders that is missing, but needed, in the abbreviated ZOOM version.

3. **Client Satisfaction**
   Powerful Tools utilizes a standardized client evaluation tool used for all trainings. See attached.

4. **Sub Contracts**
   N/A

5. **Budget**
   Line item budget attached

Title III-E Waiver Request: Family Caregiver Support

AAA Name: __Agency on Aging of South Central CT_____

Date Submitted: ___May 1, 2025_____

Waiver Title: _____Family Caregiver Support_____

Time Period of Waiver (Federal Fiscal Years):2026 -2028___

Geographic Areas Served: _South Central CT_____

Program Waiver Justification

Statement of Need: Provide information regarding the need for the service and the need for the AAA to provide the services directly (1 to 2 paragraphs). Include an explanation how assurances in the Title III Waiver PI (SUA-SPI-17-1) are met. Please attach any relevant data to support or justify your need statement.

According to the Center for Disease Control 2024 data:

- There are 53 million caregivers who provide care to adult family members.
- 24.4% of caregivers are between the ages of 55-65 + years of age
- 18% are between the ages of 66-75 years of age
- The average number of hours per week spent care giving is has tripled since 2020
- 22% of caregivers work a fulltime job in addition to caregiving
- Caregivers report significantly higher rates of physical, mental and financial distress than non-caregivers
- The average number of years the caregiver has been providing care is 4.5
- 96% provide assistance with ADLs
- 59% of caregivers report high caregiver burden
- 69% caregivers provide care for someone with dementia

Caregivers report significant need for education and training in the tasks of the caregiver role. The need for caregivers to have support and respite is apparent. AOASCC is uniquely positioned to provide the full range of caregiver services identified in the National Family Caregiver Support Program federal regulations to educate and support caregivers: assistance, benefits education, public education, caregiver counseling, respite, supplemental services, training, and support groups. Intra-agency relationships at AOASCC and external relationships with agency sub-grantees and service providers maximize AOASCC's capacity to meet the needs of family caregivers. Care Managers and Information Counselors who are CHOICES and A.I.R.S.-certified and certified care managers, provide information and assistance and person-centered care

planning to family caregivers through telephone and in-person counseling and case management, and support groups. This interconnected range of services enables AOASCC to provide needed services in a more efficacious manner than can be provided by other community service providers. AOASCC is acknowledged by agencies in our region as the authority on caregiver issues and is sought out by other members of the aging network for referrals and training. The waivered caregiver services provided by AOASCC are delivered at no cost to the caregiver which contrasts with other providers who have a fee for service model for care management.

Service Delivery – Caregivers/Grandparents

Services are divided into two sections: Section 1: Title III-E Waiver (Non-Respite Care and Non-Supplemental Services) and Section 2: Respite Care and Supplemental Services. Services are also divided into two populations: Caregivers and Grandparents.

When completing the section below, provide information of the number of caregivers and grandparents expected to be served, the number of units served to those individuals, and the amount of Title III E funds by service.

Non-Respite Care and Non-Supplemental Services

Section 1

Title III-E Waiver Funding for Services to Grandparents $_____183,062_____

Service	# of Caregivers	# of Units	# of Grandparents	# of Units	Title III E Funds
NFCSP Public Education	6,000	12	0		6741
NFCSP Benefits Education	650	12	0		6741
NFCSP Case Management	100	1,000	0		76,709
NFCSP Caregiver Counseling	60	150	0		8000
NFCSP Caregiver Support Groups	50	36	0		2465
NFCSP Caregiver Training (Not including Powerful Tools)	48	4	0		2000

Service	Estimated Unduplicated Count of Caregivers Served	# of Units	Estimated Unduplicated Count of Grandparents Served	# of Units	Title III E Funds
NFCSP Information and Assistance*	1,500	2,000	0		70,406
					10,000
*Approved aggregate data					

*Denotes a permissible aggregate service. For all other services, ADS-SUA approval is needed to report aggregately. Provide a detailed explanation why an individual registration cannot be obtained.

Respite Care and Supplemental Services

Section 2

Service	# of Caregivers	# of Units	# of Grandparents	# of Units
Respite	80	40,000	0	
Supplemental Services	150	34,000	0	

Title III-E Request for Funding for Respite for Caregivers $ __57,456_____
Title III-E Request for Funding for Supplemental services for Caregivers $ __35,291_____
Title III-E Request for Funding for Respite Services for Grandparents $ ____35,000___
Title III -E Request for Funding for Supplemental Services for Grandparents $ __5,000_____

Budget Summary:
Total Title III-E Waiver Funds from Section 1 $ _183,062_____
Total Title III-E Funds – Respite and Supplemental Services from Section 2 $ 132,747_____
Match: At least 25%: $ ___107,485___
Program Income: $ _____
Total Program: $ ___423,294____
Other Resources: $ __0_____

Grand Total: $ __423,294_____

A. Narrative: In narrative form, address the following items in two pages or less.

1. **Service Description:** Provide a brief overview (one paragraph) of the services to be provided.

   AOASCC provides the full complement of services identified in Title IIIE of Older American's Act: assistance, benefits education, public education, caregiver counseling, respite, supplemental services, training, and support groups.

2. **Service Delivery**: Describe how the AAA will deliver service(s) (four paragraphs or less).

   a. How potential clients will be informed and receive the services

   AOASCC will conduct a minimum of one outreach activity per month to inform the public about the availability of services provided through NFCSP. These activities include fairs, public forums, newsletters, social media posting, radio & television appearances and newspapers, church bulletins and direct mailing to former consumers AOASCC in our database, who self-identified as caregivers.

   Clients are referred to the program by AOASCC information counselors in multiple agency programs, agency sub-grantees, senior center staff, community agencies and self-referred.

   Referred families are contacted by AOASCC care management for initial interview, application is sent to family for signatures, family data entered into AOASCC FoxPro system for fiscal tracking and Wellsky. Care Management assessment is completed by AOASCC care management staff, and care plans are developed and implemented. Respite/supplemental services are arranged. Monthly respite billing is reviewed by AOASCC director, NFCSP care manager and fiscal department staff. Case management and counseling is provided as needed by respite care management staff.

   Caregiver support groups (1 in-person, 2 online) are offered monthly.

   Caregiver training is provided 4 times per year at AOASCC offices.

   Benefit education activities are offered 12 times per year at community locations throughout the 20 town region.

   Public Education activities are provided 12 times per year at community locations, through social media, newsletters, bulletins, online news articles, radio programs, and You Tube.

   b. How services will be targeted and tracked within MIS (WellSky Aging and Disability)

      All Care management, counseling, and training activities are tracked in Wellsky. Public education and outreach activity are reported in the aggregate.

      I&A activities are tracked using the aggregate database provided by BOA.

      All support group activities are tracked using the aggregate database provided by BOA.

   c. To request approval for aggregate reporting, provide a detailed explanation which describes why an individual registration cannot be obtained. ADS SUA approval is required.

Public forums do not provide the opportunity for registration. Participation is estimated by attendance. I&A clients are served by information counselors working in multiple agency programs and client data from these interactions is recorded in a database mandated by BOA. Extracting the information for those I&A clients who are caregivers and re-entering the data into Wellsky would create an undue burden on AOASCC and increase the cost of data management.The data system currently in use at AOASCC enables us to determine which I&A calls are caregivers we are able to complete accurate reports for SUA quarterly caregiver reporting.

d. Provide a chart which clearly outlines the individual staff positions dedicated to this waiver including specific duties performed and the portion of FTE.

Position	**Staff Name**	**FTE**
Care Manager	Susan Shultz	1
Care Manager	Patricia Soos	0.52
Supplemental Coordinator	Patricia Soos	0.38
Data Entry	Saundra Strong	0.23
Supervisor	Beverly Kidder	0.02
Billing staff	Pat Archer	0.2

3. **Client Satisfaction:** Describe how client satisfaction is measured and how improvements are made when problems are identified. Provide a copy of the Title III E waiver survey tool.
4. Client Satisfaction: Client satisfaction surveys will continue to be distributed to participants. Survey data is collected, tabulated, and analyzed. Results are used to improve the quality-of-service delivery as appropriate. AOASCC will issue evaluations upon the completion of all caregiver trainings. Evaluations will include a place for participants to indicate topics for which they would like to receive additional training and materials. AOASCC consumer satisfaction survey tool used for caregiver programs is attached.
5. **Sub-Contracts**: Describe plans for sub-contracting service components and how all program requirements are being met.

   There are no sub-contracts

B. BUDGET: Complete the line-item budget workbook as provided by ADS and submit to ADS with completed waiver request. The budget and budget narrative reflect the scope of work. Please include the staff position name and FTE equivalent in the budget narrative section of the workbook.

We, the undersigned, approve and submit the attached service description for Title III Waiver and assure that the description represents a formal commitment to carry out the service program and to utilize state and federal funds as described herein.

_____ _____

Signature of Area Agency Director Date

_____ _____

Signature of Authorized Official of Area Agency (optional) Date

---

For BOA Use only

_____Approved _____

Time Period of Approved Waiver

_____Denied

_____ _____

Commissioner, Aging and Disability Services

Aging Network Survey

Thank you for agreeing to complete this survey. The survey is being distributed to ensure we have heard the voices of individuals who work in the aging sector. The information provided will help inform the strategies developed in the greater New Haven area to address needs, gaps in services and opportunities for development of new strategies to ensure older adults live in communities that meet their needs and preferences. There is no compensation provided for completing the survey. There is no identifiable information in the survey questions. Completion of the survey is entirely voluntary. There are no negative consequences if you opt out of the opportunity to share your opinions.

Check all that apply.

Town(s) in which I work

- ☐Ansonia
- ☐Branford
- ☐Derby
- ☐East Haven
- ☐Guilford
- ☐Hamden
- ☐Meriden
- ☐Milford
- ☐Madison
- ☐New Haven
- ☐North Branford
- ☐North Haven
- ☐Orange
- ☐Wallingford
- ☐West Haven
- ☐Woodbridge

Type of organization

- ☐Human Services
- ☐Home Care
- ☐Care Management
- ☐Information & Assistance
- ☐Action Agency
- ☐Counseling Service
- ☐Primary Care Provider
- ☐Other Health care provider
- ☐Disability Service Provider
- ☐Transportation Provider
- ☐Nutrition Provider
- ☐Senior Center
- ☐Volunteer Organization
- ☐Assisted Living
- ☐Adult Day Care
- ☐Nursing/Rehab Center
- ☐Visiting Nurses

☐Assistive Technology Provider
☐Pharmacy
☐Senior & Disabled Housing
☐Municipal Government
☐State Government
☐Federal Government
☐Academic
☐Policy/Planning
☐Research
☐Faith-based
Other_____

Please select 3.

In your opinion, what are the needs of older adults:

☐ Healthcare
☐ Transportation
☐ Food Security
☐ Homecare
☐ Affordability of medications
☐ Housing Availability
☐ Social Isolation
☐ Engagement
☐ Economic Security
☐ Tax Relief
☐ Utility Assistance
☐ Heating Assistance
☐ Home Repair/Modifications
☐ Access to Technology
☐ Dementia Care
☐ Life Planning
☐ Legal Issues

Check all that apply

In what setting do you interact with older adults:

☐ Older Adults' Homes
☐ Organizations' Offices
☐ Senior Centers
☐ Community Centers
☐ Healthcare Centers
☐ In vehicles
☐ Classrooms
☐ Volunteer Sites
☐ Libraries

☐ Telephone

The following questions seek your impressions, your best guess . Please do NOT verify your answers by reviewing agency data.
Please answer all the questions and select one answer for each question.

In your opinion, are most older adults with whom you work in good health? Yes☐No☐

In your opinion, are most older adults with whom you work happy? Yes☐No☐

In your opinion, are most older adults socially isolated? Yes☐No☐

In your opinion, are most older adults lonely? Yes☐No☐

In your opinion, are most older adults managing well in their current circumstance?
Yes☐No☐

In your opinion, are most older adults safe at home? Yes☐No☐

In your opinion, are most older adults able to live within their current budget? Yes☐No☐

In your opinion, do most older adults have social support to rely upon in crisis situations?
Yes☐No☐

Answer these questions based on your guesses. Please don't verify your answers. We want your impressions.

What percentage of older adults with whom you work have family caregivers helping make decisions for them? _____%

What percentage of older adults with whom you work have a person-centered long-term care plan in place? _____%

What percentage of older adults with whom you work have Advanced Directives in Place? _____%

What percentage of older adults with whom you work participate in disease prevention programs/activities? _____%

Caregiver Survey

Thank you for completing this survey. Your answers help us to determine the most effective ways to serve family caregivers.

There is no requirement to complete the survey and no reward for returning the completed survey to us beyond our genuine appreciation for sharing your experiences.

Are you a caregiver who is caring for a spouse? **Yes☐No☐**

Are you a caregiver who is caring for a parent? **Yes☐No☐**

Are you caring for someone other than a spouse or parent? **Yes☐No☐**

Are you providing care to more than one adult? **Yes☐No☐**

Are you receiving help to provide care from any organizations (including the Agency on Aging?

Yes☐No☐

If you answered Yes, do you feel the amount of help you receive is enough to keep your relative living at home? **Yes☐No☐**

Do you feel that you are under stress? **Yes☐No☐**

If you answered yes, do you feel you can manage the stress? **Yes☐No☐**

Have you participated in any Caregiver training? **Yes☐No☐**

If you answered Yes, did you think the training was helpful? **Yes☐No☐**

Do you think you have enough information about caregiving? **Yes☐No☐**

Are you interested in receiving information about caregiving from the Agency on Aging? **Yes☐No☐**

If there was a problem related to providing care for your relative, do you know who you would call for help and information? **Yes☐No☐**

Please share any thoughts that might assist us in providing services to family caregivers. Click or tap here to enter text.

Consumer Survey

Demographics

Age Click or tap here to enter text.

Town Click or tap here to enter text.

Sex Click or tap here to enter text.

Married☐ Single☐ Widowed☐

Health (check all that apply**)**

Cancer☐ Heart Disease☐ COPD/Asthma☐

Arthritis☐ Dementia☐ Depression☐

Mobility challenges☐ Uses cane☐ Uses walker☐

Uses wheelchair☐ Medicare☐ Medicaid☐ Private Health Insurance☐

Do you think you are in good health☐

Economics (check all that apply)

Social Security Recipient☐ Pension☐Employed☐

Fulltime Employment☐ Parttime Employment☐

Annual income from all sources: <$15,000 ☐ $15,000 - $25,000☐

$25,001 - $40,000☐>$40,000☐

Banking: Savings <$10,000☐ $10,000- $35,000☐ >$35,000 ☐

Investments >$50,000☐ $50,000 - $100,000☐ >$100,000☐

Housing (check all that apply)

Owns Home☐ Renter☐ Lives alone☐ Lives with spouse☐

Lives with adult children☐ Lives with grandchildren☐

Lives with roommate☐ Unhoused☐ Lives in senior housing☐

Monthly housing payment (rent or mortgage) ☐

Housing accessibility meets clients' need☐

Wants to move☐

Transportation (reply yes or no to the following questions)

Owns vehicle YES☐ NO☐

Uses public transportation YES☐ NO☐

Relies on others for transportation YES☐ NO☐

Uses transportation program YES☐ NO☐

Is transportation a problem for you? YES☐ NO☐

Are there things you **do not do** because you lack transportation?

YES☐ NO☐

Can you travel independently in the community? YES☐ NO☐

Social Connections

Do you feel socially isolated☐

How often do you see family/friends/

neighbors☐

How often do you speak on the phone with friends & family☐

Are you involved in any social groups/clubs☐

How often do you leave your home☐

Do you do your own shopping☐

Do you go on trips/vacations☐

How did you spend the most recent holiday?

At home alone☐ At home with friends/family☐ At the home of others☐ At a community event/activity☐

Are you satisfied with the quality of your life ☐

Food Security (respond yes or no to each question)

Do you have enough to eat each day YES☐ NO☐

Do you ever go to bed hungry YES☐ NO☐

Can you afford your monthly food costs YES☐ NO☐

Do you receive SNAP benefits YES☐ NO☐

Are you on Meals on Wheels program YES☐ NO☐

Do you ever eat at congregate meal sites (senior center/housing)

YES☐ NO☐

Do you ever go to food pantries YES☐ NO☐

Do you ever go to soup kitchens YES☐ NO☐

Community Accessibility (reply yes or no to the following questions)

Can you travel comfortably within your community YES☐ NO☐

Are you able to cross the street alone YES☐ NO☐

Are there places you want to go but stairs present a barrier to you

YES☐ NO☐

Have you attempted to participate in a community activity but found it inaccessible for you YES☐ NO☐

Ageism (reply yes or no to the following questions)

Have you ever been the victim of ageism YES☐ NO☐

Do you feel television commercials and programs show a fair representation of older adults YES☐ NO☐

Please complete the following sentence:

I think being an older person Click or tap here to enter text.

Focal Point, Points of Contact.

Branford Senior Center Nancy Cohen, Assistant Director 46 Church Street, Branford, CT 06405 Email : ncohen@branford-ct.gov Phone : 203.315.0682	**Town of Orange** Stacey Johnson, Director 525 Orange Center Rd, Orange, CT 06477 Email : sjohnson@orange-ct.gov Phone :203.891.4786
City of New Haven Tomi Veale, Director of Elderly Services 165 Church St. New Haven, CT 06510 Email : TVeale@newhavenct.gov Phone : 203.946.7854	**Town of Oxford** New Director? Oxford Senior Center 10 Old Church Rd, Oxford, CT 06478 203.881.5231 Ext. 3104
East Haven Senior Center Bob Petrucelli, Director 91 Taylor Avenue, East Haven Ct 06512 Email : bpetrucelli@easthaven-ct.gov Phone : 203.468.3277	***Towers at Tower Lane*** *Carol Davino,* Facilities Manager 18 *Tower* Lane, New Haven, CT 06519 Email: carol@towerlane.org Phone: 203.772.1816 ext. 330
Guilford Community Center Terry Buckley 32 Church Street, Guilford, CT06437 Email :buckleyt@guilfordct.gov Phone 203.453.8086	**Wallingford Senior Center** William Viola, Jr., Executive Director. *238 Washington St*. Wallingford CT 06492 Email : bviola@wlfdseniorctr.com Phone :203.265.7753
Miller Senior Center Kim Craft, Director 2901 Dixwell Avenue Hamden Ct 06518 Email: kcraft@hamden.com Phone: 203.287.2547	**Woodbridge Senior Center** Kristy Moriarty, Director 4 Meetinghouse Ln. Woodbridge, CT 06525 Email : kmoriarty@woodbridgect.org Phone : 203.389.3430
City of Meriden Rick Liegl, Senior Affairs Administrator 22 West Main Street, Meriden, CT 06451 Email: rliegl@meridenct.gov Phone: 203.630.4701	**Town of Madison** Austin Hall, Director of Beach, Recreation and Senior Services Email: halla@madisonct.org Phone: 203.245.5623
Milford Senior Center Leonora C. Rodriguez, Executive Director Gerontologist 9 Jepson Drive, Milford, CT 06460 Phone: 203.877.5131 Email: lcrmilfordseniorcenter@yahoo.com	
Town of North Haven Paulette DeMaio, Senior Center Manager 189 Pool Road, North Haven, CT 06473 Email: demaio.paulette@northhaven-ct.gov Phone: 203-239-5432 X525	

Area Plan 2022-2024
Goals and Objectives

Accomplishments

Goal 1: Empower older individuals to reside in the community setting of their choice.

Objective 1: Enhance Long Term Services Supports		
Strategies	**Measurement**	**Date of Completion**
Develop and fund Aging & Disability Answers, a public/private partnership statewide hub for LTSS information. The program shall enhance and complement LTSS including but not limited to 211- Infoline, MyPlaceCT, and the CHOICES and Older Americans Act programs to improve client experience.	Implemented in partnership with all AAAs FFY 2022. Assess and improve AAA efficiencies and partner development FFY 2023 Launch website by end of FFY 2023 Provide navigation services by end of FFY 2023 Completed: • Navigation services begun April, 2022 • Website Launched 6/1/23 • Navigation services instituted 4/1/22	Completed FY'23 All measures implemented as planned.
Fund Adult Day Centers		
Fund In-home Services		
Fund Medical Transportation		
Fund Social Transportation		
Fund Chore Services		
Provide Person-centered planning	Maintain ADRC/Disability database	9/30/24 completed. Database revised to include housing options throughout AOASCC region, plus additional 20 towns covered by CHCPE program. SNs and trained I&A counselor provided person-center planning for 24 consumers.
Participate on planning committee of Valley Health & Human Services Council to establish an Adult Day Center in Lower Naugatuck Valley.	AOASCC attends monthly adult day center planning meetings	3/30/24 Decision to add an ADC in the Valley reconsidered after COVID. Survey of community in the CHIP plan shows families

		won't use the ADC.
Coordinate visit of planning committee to ACL- funded adult day centers to learn best practices.	AOASCC coordinates site visits to adult day centers to develop model for Valley ADC Visits arranged by AOASCC completed by Valley HHS ADC planning committee May 1, 2022, Milford Senior Center ADC; Clelian 5/19/2022; Orchard House, 6/2/2022.	Completed 12/30/23
Fully implement Chaperone program to enhance transportation services	Chaperone program available throughout SC region FFY 2024 Program implemented Oct 1, 2022 using CNCS funds; 2023 NADTC grant.	FY'24 Completed 9/30/24 9/30/23 Chaperone program completed CNCS grant requirements; received funding for 2022 from NADTC and met grant requirements to grow the program. In 2023 funding obtained, to continue program using ARP funds. Funding for program ended on 6/30/24. AOASCC continues to seek funding to continue the program beyond the current funding cycle. 1/1/24 Funding from City of New Haven obtained to provide program for New Haven residents.

Objective 2: Improve Economic Security of Older Adults		
Strategies	**Measurement**	**Date of Completion**
Provide information through presentations on ZOOM and at senior centers when they are re-open to the public, for the following benefit programs: SNAP Medicare Savings Program Li-Heap Tax Rebate Medicaid Lifeline Employment Assistance	10 benefit program benefit program presentations will be completed annually. Data in STARS	Completed. Choices staff made 23 presentations between 1/1/23 – 3/30/24

Participate in annual Health & Senior fairs sponsored by the city of New Haven, the town of Hamden, the town of West Haven and the Valley region, to provide information about programs, when public gatherings are resumed.	Participate in at least 4 Heath & Senior fairs annually.	Completed. AOASCC at :Meriden Senior fair 5/8/23; East Haven senior day 8/5/23;New Haven Senior Fair 8/11/23; Hamden Senior fair 10/5/23
Information Counselors will assist with application completion and submission for above benefits.	AT least 500 consumers will receive application assistance.	Completed application assistance Consumers received=834
Provide information presentations about benefit programs listed above, in Spanish to individuals with low English Proficiency	Annually, at least 2 presentations about benefits will be made by Spanish speaking counselors.	Completed. 3 Presentations made in Spanish provided on 1/12/24, 2/9/24 3/10/24 At Keefe Center.

Objective 3: Provide Services & Supports to Family Caregivers		
Strategies	**Measurement**	**Date of Completion**
Through NFCSP provide the following services: • Counseling • Care Management • Respite • Support Groups • Training • Information & Assistance	Review WellSky reports, FC I&A report, and AOASCC/FoxPro database and fiscal invoices for providers to ensure contract targets are met.	Completed I&A = 1876 clients served Training=15 clients served Support Groups=55 clients served Respite = 44 clients served. Care Management=197 clients served. Counseling= 0 served.
Through CSRCP provide respite services and care management to family caregivers.	100 families receive respite services annually	Completed 111 families received respite and care-management
In collaboration with the Alzheimer's Association educate families about dementia.	AOASCC participates with Alzheimer's Assoc in training for family caregivers at AOASCC support groups FFY 2022 – FFY 2024	Completed. Alzheimer's' Assoc. presented at support group in Oxford, 10/19/23 Branford support group is co-led by Alzheimer's Assoc staff every month, Oct.2023 – March 2024. March – Sept. 30, 2024 Support group with Alzheimer staff continued to meet. An additional AOASCC staffer completed Alzheimer Support Group leader training.
Utilize CSRCP funding to create a bridge to the CHCPE to provide in- home services to families during the application process for CHCPE.	25 CSRCP clients transition to CHCPE.	Completed. 24 clients transferred to CHCPE 7/1/23 – 12/30/23
Assist families to facilitate applications to CHCPE.	30 clients per year assisted with CHCPE application process	Completed.102 clients assisted with CHCPE application
Through Chaperone program provide relief to caregivers by providing accompaniment to medical appointment for their relatives.	100 seniors will receive chaperone services	Completed 10/1/23-3/30/23 51 consumers received chaperone services 4/1/23 -9/30/24 130 consumers were served with funding from multiple sources during the Area

		plan period. The number of rides provided far exceeded expectations. Consumers averaged 12 rides each per year equaling 2,172 units (rides)

Objective 4: Expand public awareness of Care Management services available through AOASCC		
Strategies	**Measurement**	**Date of Completion**
Organize a conference on best practices in care management	Conference to be held in 2024	Completed. April 22-24, 2024, in-person. Program presented by Care Management Consultant Services. 97 care managers participated.
Provide information to family caregivers about care management services through AOASCC newsletter and electronic newspaper article.	At least one article published on AOASCC website and one in Patch newspaper annually about care management services available through caregiver programs.	Completed Nov, 2023 re: caregiver services through NFCSP in website article. Dec 5, 2023 Re Caregiving During the Holidays published in Patch.
Provide information about care management services to dementia clients when completing assessments for the CSRCP	50 families will receive information about care management services when applying for NFCSP annually.	Completed 92 families received information about care-management services between July 1,2022 – June 30, 2023.
Participate in in-person and ZOOM senior fairs to distribute program materials about care management services.	AOASCC participates in at least 4 senior fairs to distribute care management materials by 2024.	Completed Table at Fearless Caregiver Conference 11/8/23; Table at Valley Senior Council Caregiver Fair, 11/30/23. Table and presentation at Yale Employee fair 1/15/24. Table at Shoreline Elder Care Alliance Fair, 1/30/24.

Objective 5: Provide Information about programs, services and issues of importance to older adults, families and members of the aging network		
Strategies	**Measurement**	**Date of Completion**
AIRS certification of at least one Information Specialist in each Agency- ongoing	AIRS certification on file for I&A counselors	Completed 12/30/23 All I&A counselors have AIRS Certification on file. Additionally, Service Navigators have AIRS on file 3/30/24
Facilitate opportunities for at least one annual workshop for statewide AAA Information and Assistance staff to discuss best practices- ongoing	AOASCC participates with other AAAs to plan conference FFY 2023 9/30/23: AOASCC staff and grantees participated in conference planning for AgingCT Summit.	Completed FFY 2023
Provide information to consumers about the availability of home ownership and home improvement services through New Haven Housing Services.	I&A counselors inform 50 consumers per year	Completed. 10/1/23 – 3/30/24 59 consumers referred to New Haven Housing Services.
Provide information to consumers about rental assistance.	500 consumers/caregivers provided with senior housing information.	Complete. Extreme housing shortages have caused housing locations and towns to stop taking applications for rental assistance. Consumers now must wait for a town to announce a lottery drawing to get a space on a wait list. RAP vouchers are reserved for clients in DSS funded programs. Requests for information about rental assistance programs continue to come in. 10/1/23 – 3/30/24 Consumers served =417
Provide information to consumers about accessing senior housing.	100 seniors receive counseling and housing directory to explore senior housing options	Completed. 3/30/24 Housing Directory now posted online. It was accessed by 218 people 10/1/23 – 3/30/24.

Update south central region housing directory.	revised housing directory completed FFY2023 7/25/23: Housing directory updated	Completed FFY2023 Online Housing Directory updated (/30/24
Provide information to caregivers about the availability of respite services.	150 caregivers receive information about respite services at Fearless Caregiver Conference, annually.	Completed 11/14/23 156 Caregivers received information about respite at the Fearless Caregiver conference
Expand chaperone program to 5 additional towns providing door thru door transportation.	Transportation Advisory Committee completes report on recommendations about door thru door transportation in SC region FYY 2022 10/1/22: Chaperone service extended to Ansonia, and concentration on 5 high risk zip codes in New Haven & West Haven	Completed fy'22 Completed in FY 2022
Increase the capacity to provide chaperones to New Haven residents through the recruitment and training of more volunteers.	AOASCC hires volunteer recruitment coordinator FFY 2022. 10/30/21 Vol recruiter hired	Completed fy'22 9/30/23 AOASCC recruited 20 new volunteers to provide chaperone services
Provide bus passes to seniors to enable participation in volunteer programs.	40 seniors receive bus passes and volunteer in AOASCC programs FFY 2023 9/30/23: Volunteers did not want bus passes. Instead, 20 volunteers were provided with mileage reimbursement.	Completed FFY 2023 FFY2024 Mileage reimbursement provided to 18 volunteers.
Form a time-limited, transportation advisory committee with mobility managers, senior transportation providers, aging network representatives and consumers to explore the expansion of door thru door transportation possibilities in SC region.	Advisory committee meets in FFY 2022: 6 meetings of advisory committee held as planned FY'23: • 5 meetings of the volunteer advisory committee were held • 4 sub-committee meetings were held to address transportation access for wheelchair users	Completed FFY2023 Committee formed & met as planned. FFY2024. Committee continues to meet bi-monthly. Transportation sub-committee conducted listening sessions with area older adults to identify local needs. Mobility manager, Laurie McElwee, presented to committee about resources. Transportation sub-grantee, TEAM, presented

		to committee about volunteer-based transportation options available through Volunteer Coordinators..

Objective 6: Participate in planning activities designed to increase the availability of affordable housing.

Strategies	Measurement	Date of Completion
Work with community non-profits to hold a housing forum with housing leaders, non-profit organizations, building developers and consumers.	AOASCC rep serves on planning committee 2022 Completed 5/30/23 Housing forum held at Scinto Center, Shelton. Planning by TEAM, Valley Health & Human Services, AOASCC, Derby Housing Authority	Completed FFY 23

Goal 2: Provide older adults with prevention and wellness opportunities

Objective 1. Broaden access to and awareness of evidenced-based, holistic health and wellness.

Strategies	Measurement	Date of Completion
Fund CDSME workshops	Conversations held with Griffin Hospital and Yale Medical Center to become sites for workshops and volunteer recruitment for CDSME 9/30/22 Griffin Hospital funded with TIIID funds to provide CDSME. Plans with Yale to become a site for workshops were not successful	Completed Yale Medical Center had staff trained to become part of CDSME. Griffin Hospital was funded again in FFY2024 for evidenced-based Health Prevention & Promotion Griffin Hospital withdrew its plans to provide CDSME in the Valley, not finding that they were able to attract consumers. 10/1/24 Despite concerted efforts with community partners, promotion of CDSME continued to be unsuccessful. Yale was unable to prioritize CDSME as a workshop site, due to lack of interest. Title

		IIID funds for evidenced based disease prevention & promotion were awarded to other evidenced based programs.
Fund Monitor My Health	Conduct online CDSME 2 online workshops	Completed 10/1/23 – 12/30/23
Provide Powerful Tools training	Conduct in-person workshop annually FFY 2023-2024.	Completed 10/1/23 – 3/30/24, 2 Powerful Tools workshops were completed. 10/1/24

Objective 2. Increase access to dental prevention opportunities.

Strategies	**Measurement**	**Date of Completion**
Fund Merricare Dental	Review WellSky reports; AOASCC manual database; aggregate public education reports	3/30/24 . Completed. Merricare Dental funded. Consumers =273
Promote Mission of Mercy (free dental clinics)	50 consumers receive dental information annually from I&A counselors	Completed 10/15/23 AOASCC sent email info to sub-grantees to share with their consumers. 1117 consumers received dental care. AOASCC had an information table at the event. SMP coordinator provided Scam Alert info table at the event.
Provide information about dental services & insurance	AOASCC Facebook promotes Mission of Mercy annually.	Completed 11/13/23 AOASCC posted dates of Mission of Mercy on Facebook 9/30/24 Next MOM event will be on Nov 9, 2024 and will be promoted to our consumers
Objective 3. Reduce fall risk.		
Strategies	**Measurement**	**Date of Completion**

Provide information about fall risk in collaboration with the CT Healthy Living Collective	AOASCC will add 2 staff/volunteers, trained through the CT Healthy Living Collaborative to participate as workshop leaders.	Not Completed. 9/3023 AOASCC trained 1 new staff person. No volunteers were recruited. 10/1/23 -3/30/24 1 additional volunteer was trained. 9/30/24 trained volunteer withdrew from program. Fall prevention training not offered in 2024 to add an additional volunteer.
Fund Moving for Better Balance training	Title IIID funds will be used to fund Moving for Better Balance.	Not completed. 9/30/23 There were no applicants for Title IIID funding for this service. 10/1/23-3/30/24 Again there were no applicants for this funding. There are no trained leaders in the SC region and there haven't been any training programs for new volunteers 9/30/2024 No trainings offered in 2024.
Evaluate fall risk in care management clients	Care management department will screen all new program referrals for fall risk.	Completed. 10/1/23 -3/30/24, 1009 older adults were screened for fall risk.
Objective 4. Improve Stress Coping		
Strategies	**Measurement**	**Date of Completion**
Train older adults & caregivers in Powerful Tools	32 seniors complete Powerful Tools training in 2022	Not completed. 2022 Covid shutdown cancelled training. Switch to ZOOM training not approved initially. 11 consumers completed training on ZOOM. 2023 Zoom program approved and staff trained in online model. 1 program provided. 2024 Zoom programs offered with limited uptake by 60+ aged participants. Majority of caregivers were 50 -60 year old daughters and wives who don't count toward this strategy. Additionally, online

		programs resulted in out of region and state participants who were directed to the online program by the Powerful Tools organization, but their presence isn't captured in the data system. A new plan for marketing will be included in the next Area Plan..
Fund behavioral health screening through BH Care and Bridges	50 behavioral health screenings are completed for seniors annually	Completed 94 screenings completed by Bridges.
Fund in-home emotional support through Franciscan Home Care in- home counseling program	25 clients receive in-home counseling annually.	Not completed. Franciscan Home Care was unable to provide service as planned due to Covid staffing problems at the Home Care agency. Funds not paid to Franciscan.2023 Franciscan did not return as a grantee,
Objective 5. Improve nutrition status		
Strategies	**Measurement**	**Date of Completion**
Fund Home Delivered Meals	Review Nutrition risk scores, WellSky reports, NCOA reports, Fiscal invoices.	Lifebridge & TEAM continue to be funded for HDM. 333 consumers nutrition risk scores reviewed.
Provide nutrition education for HDM clients	All HDM consumers will receive education annually.	Completed 588 HDM consumers received nutrition education.
Fund congregate meals programs	Through OAA fund congregate meal programs throughout the SC region annually	Completed Lifebridge & TEAM continue to be funded to provide congregate meal program.
Assist 500 seniors with preparation of SNAP mandated documents, for application completion and submission of forms to DSS.	500 SNAP applications will be submitted by FFY 2023. 9/30/23: 584 applications submitted	FFY 2023 Completed. 584 applications submitted

Collaborate with ENPs to expand restaurant dining option for congregate meal program by forming a task force with ENPs, congregate site representatives and area restaurants to develop options for expanding restaurant sites.	Number of restaurant days will be increased by FFY 2024. 1/15/23 Restaurant task force convened. Members sent out survey to area restaurants to gauge interest in becoming a congregate meal site. Of the 26 surveys returned, none of them were willing to partner because the rate of reimbursement was too low for them to make a profit. The Greek Olive, congregate site closed operations.	Not completed: Based on lack of interest in participation by restaurants, due to reimbursement rate. There will not be an increase in restaurant options in SC region. 3/30/24 Additional "restaurant" days added in TEAM region at Griffin Hospital cafeteria.
Seek flexibility in unit cost rate in next Title IIIC contract to enable expansion of restaurant option.	Reimbursement rate for restaurant option is increased to reflect market demand by FFY 2023.	Not completed 9/30/23 Letters of support provided to ENP providers in their bid to increase reimbursement rates for restaurant options, but their requests for an increase was denied. was denied.
Promote healthy eating through Facebook posts using materials in compliance with federal nutrition guidelines.	12 Facebook posts will be made annually.	Completed. Healthy Eating posts on Facebook : 10/6/23,11/8/23, 12/5/23, 1/8/24, 1/12/24, 2/9/24, 3/1/24, 3/7/24, 3/15/24, 5/15/24, 9/26/24, 9/27/24.

Provide healthy cooking demonstrations, consistent with the Healthy Eating Index on TikTok by nutrition educator.	4 cooking demonstrations will air FFY 2022 –FFY 2023. 9/30/23 Nutrition educator with cooking demo skills retired. New educator cannot provide cooking demos. AOASCC not funded to hire a consultant to perform cooking demos.	Not completed as planned due to staffing and funding constraints. However, an alternate strategy was implemented. Nutrition educator provided cooking demonstrations in-person at 3 senior center and 1 housing site.
Meet with congregate site representatives and consumers to explore menu revitalization to better meet consumer preferences.	Congregate Site committee will complete at least 3 meetings in FYY 2022 and then meet twice, yearly in subsequent years.	Not completed as planned. Plan changed due to COVID 19 impact in 20233. Site Committee met 1/5/24 at Ansonia Senior Center. Second meeting at Griffin Hospital Cafeteria site 9/17/24. 9/30/24 Meeting held on Zoom

Meet with ENPs bi-weekly, to address issues before they become problems.	ENP contract identifies plan for notifying consumers of impending meal cessation FFY 2023.	Completed 9/30/23 bi-weekly meetings with ENPs continued throughout FY 2023. ENP contracts contain provision for meal closures. . 3/30/24 ENP contract extended for 1 year. RFP for next contract requires provision of plan for meal cessation. 9/30/24 Meetings with ENPs reduced at request of ENPs due to staffing priorities. With end of COVID 19 limitations, the need for frequent, face to face communications changed. ENPs provide a monthly update on number of clients, (wait list if any), new clients enrolled, clients leaving the program. ENPs also agreed to inform AOASCC of any problems with consumers, caregivers or sites the same day they become aware of a problem. This has worked effectively, replacing the meetings.
In the Valley region, participants in the area soup kitchens and shelters will be provided with information about congregate meal sites by TEAM, elderly assistance program in cooperation with AOASCC nutrition educator.	Annual distribution of listing of congregate meal sites completed by ENP	*Completed* *3/30/24 TEAM distributed listing of congregate sites at soup kitchens and homeless shelters and to service providers in the Valley region through the Valley Health & Services Council and the Valley Council on Aging.*
Ensure access to food for HDM clients during emergencies through provision of shelf stable foods and double meal delivery during impending weather emergencies.	AOASCC reviews plan for morning of emergency to ensure pans have been implemented as designed.	Completed 3/30/24 AOASCC meets monthly with ENPs and reviews status of emergency meals. Clients were provided with a supply of shelf stable meals and when weather predictions indicate possibility of closures, double meals are provided the day prior to the

		storm date. AOASCC is in contact with ENPs by 7:30 AM when emergency plans require implementation. AOASCC notified SUA on 1/16/24, at 9:15 AM of closure.
Require ENPs to have a method of informing clients when HDM or congregate site meals are interrupted.	Contract contains plan for client notification of interruption in meals	Completed 3/30/24 Lifebridge successfully implemented client notification plan on 1/16/24. TEAM did not have any closures during this report period.

Objective 6. Reduce risk of social isolation through social engagement		
Strategies	**Measurement**	**Date of Completion**
Recruit & train volunteers for RSVP	50 new volunteers recruited and trained, as documented in RSVP data tracking tool	Completed. 9/30/23
Provide Intergenerational Tutoring opportunities	Development of volunteer option to train seniors on tech use	Completed. 3/30/24 Volunteer job description developed for tech trainer. Presentation about volunteer opportunity presented at volunteer fair at Albertus Magnus college.
Place trained Foster Grandparents in community daycare centers	AmeriCorps Seniors data tracking tool	Completed 3/30/24 1 foster grandparent at child daycare center. 5 placed at adult day centers.
Place Senior Companions in community housing	AmeriCorps Seniors data tracking tool	Completed. 3/30 24 22 senior companions placed in senior housing sites.
Provide volunteer chaperones in Trusted Ride Certified program	Senior Companions serve as chaperones for seniors	Completed. 4 senior companions served as chaperones.
Facilitate placement opportunities for trained Medicare volunteers in at community locations	SHIP online data tool.	Completed Certified Medicare counselors are placed at numerous community locations including senior centers, senior housing and healthcare providers..
Create training and outreach opportunities for SMP volunteers	4 new training and outreach opportunities created annually	Completed. 3/30/24 outreach opportunities created at Shelton Senior Center, Griffin Hospital, Ansonia

		Senior Center, Mary Wade senior housing.
Host annual Art of Aging	Art Show held annually in May	Completed. 3/30/24. Planning for Art of Aging conducted. Art of Aging scheduled for 5/16/24. Art of Aging held in May 2024.
Include older adults on the AOASCC advisory Council	At least 10 members of AOASCC Advisory Counsel are seniors.	Not completed 3/30/24. 5 members of AOASCC Advisory are older adults. 9/30/24. Despite offering Zoom meetings to reduce risk and fear, we have been unable to attract 5 over the age of 60. We are working with our Transportation Advisory Committee and our Volunteer Advisory Committee to identify potential members who would serve on the Advisory Council of AOASCC. Two of our older Advisory Members were asked to join the Board of Directors and their spots on the Advisory Council haven't been filled by other older adults. Our RSVP program manager has developed an agency, volunteer group for older adult volunteers that meets monthly at our facility. We are planning to provide information about the agency regularly to them to help build a body of volunteer who will serve on Advisory as new members.
Include older adults in the Ageism Coalition	At least 10 members of AOASCC Advisory Counsel and Ageism Coalition are seniors.	Completed 3/30/24 24 members of the Ageism Coalition are older adults. See above re: Advisory Council.
Provide access to technology by seeking funding for purchase of Ipads to be distributed through senior center partnership.	Ipads purchased and distributed based on available funding. 9/30/23: Plans cancelled due to direct funding to senior centers to fund information technology which resulted in senior centers not completing	Not completed due to senior centers receiving direct funding and no longer seeking funding through AOASCC..
Develop a volunteer training program to teach seniors how to use technology.	5 Volunteers recruited and trained to teach technology use to seniors.	Completed 3/30/24 3 volunteers recruited & trained by AOASCC.

		Relationship established with new non-profit that recruits, trains and places volunteers with older adults to assist them to become tech savvy. 9/30/24 Partnership with Interfaith Volunteers of Greater New Haven recruited additional volunteers to provide tech trainings.

Objective 7: **Support populations at greatest-risk of adverse health outcomes due to social determinants of health.**		
Strategies	**Measurement**	**Date of Completion**
Enhance culturally-sensitive training and service coordination for individuals with Alzheimer's disease and related dementias through partnerships with the Alzheimer's Association and LiveWell e.g.	100% CSRCP and NFCSP staff have received Dementia Friends training.	Completed. 9/30/2022
Public awareness of Alzheimer's disease and available resources are expanded to include materials in multiple languages	Family Resource Center Library contains materials about dementia in language in addition to English with graphics showing multi-cultural images FFY 2022.	Completed. 9/30/2022
Utilize purchased consumer data bases targeted to identify low income older adults to expand MIPPA outreach.	100 seniors will be identified through purchased data base and assisted with MSP application filing FFY 2023.	Completed 9/30/23
Screen I&A callers for food insecurity	500 seniors will be screened by I&A counselors for SNAP by FFY 2024.	Completed. 3/30/24 584 older adults were screened for SNAP
Utilize chaperone program to ensure seniors at high risk of institutionalization have support to get to medical appointments	50 high risk seniors will be provided with chaperones to accompany them to medical appointments FFY 2023.	Completed. 9/30/23 51 older adults received chaperone service. 3/30/24 31 older adults received chaperone service in FFY24
Utilize Spanish language newspapers and radio to provide information about SNAP	At least 2 articles will appear in Spanish language newspapers and 2 radio appearances will be made during plan period.	Completed 3/30/24 article in LaVoz about SNAP. 2 appearances on WNHA by AOASCC staff re: SNAP

		9/30/24 Spanish Language article posted on 9/27/24

Goal 3: Protect elder rights and well- being and prevent elder abuse, fraud, neglect and exploitation

Objective 1: Increase Elder Rights protection by increasing control over health care decisions.		
Strategies	**Measurement**	**Date of Completion**
I&A counselors will mail information about Advanced Directives to 100 callers to the ADRC call line.	50 clients will receive Advanced Directives packet FFY 2022-2023 9/30/23: 54 clients received packets	Completed. 3/30/24 50 clients received advanced directives packets.
Consumers will be directed to Advance Directives - CT.gov by counselors.	100 consumers receive I&A regarding advance directives	Completed. 3/30/24 134 consumers referred to CT.Gov.
Refer 25 seniors and families to elder law attorneys re: Conservators.	50 seniors/caregivers will be referred to elder law attorneys FFY 2022-2024	Completed. 3/30/24 31 consumers referred to elder law attorneys.
Fund New Haven Legal Assistance to provide assistance with housing and public benefits disputes.	100 seniors will receive assistance from NH Legal Assistance annually.	Completed Clients served = 168.
Fund CT Vet Legal Center to assist low-income, homeless veterans access VA benefits, obtain missing documentation of veteran status and represent veterans in challenging discharge status that blocks access to benefits.	50 senior veterans will be served by CT Vet Legal Center annually.	Complpeted Clients served=78
Objective 2 : Increase knowledge of aging network re: elder abuse		
Strategies	**Measurement**	**Date of Completion**

Host annual TEARS conference on ZOOM	TEARS conference held annually in October 2021, 2022, 2023 for aging network professionals	Completed TEARS scheduled for Nov 2024 to avoid duplication with Elder Rights Coalition conference.
Share elder abuse information through Ageism Coalition	Elder abuse information shared quarterly with Ageism Coalition members comprised of consumers and aging network professionals FFY 2022 -2024.	*Completed* 3/30/24 Mailings to Coalition members sent 10/ 30/ 2023, 11/29/23, 12/30/23, 1/26/24, 2/22/24, 3/27/24
Fund Elder Abuse Prevention programs about domestic violence as a form of elder abuse, presented by BH Care at senior centers, senior housing sites, Griffin Hospital and soup kitchens	BH Care presents 8 education programs annually to seniors and family caregivers FFY 2023	Completed Presentations made at Ansonia Senior Center, TEARS Elder Abuse Conference, Inter-Agency Council, Valley Senior Services Council, Hamden High School, New Haven Senior Network, Shoreline Elder care Assoc., Senior Companion Program.
Host south central M-Team bi- monthly	AOASCC M-Team comprised of aging network clinical staff, meets bi-monthly at AOASCC annually.	Completed. 3/30/24 M-team meetings held: 10/19/23, 11/16/23, 12/14/23, 1/18/24, 2/15/24/3/21/24.
Participate in M-Teams in Meriden, the Valley and East Shore	AOASCC participates in M- Teams when they are hosted in Meriden, East Shore and the Valley, annually.	Completed 3/30/24 M-Team/Valley:10/12/23, 11/9/23, 12/7/23, 1/18/24 2/14/24, 3/14/24 M-Team Meriden: 1/16/24 East Shore M-Team disbanded during COVID19 and has not reconvened.