New York State Master Plan for Aging

Prepared by the New York State Department of Health's Office of Aging and Long Term Care and the New York State Office for the Aging

Master Plan for Aging

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MPA REPORT

This Report (the "MPA Report") is presented to Governor Hochul in satisfaction of paragraph 4 of Executive Order #23 (EO23), establishing the New York State Master Plan for Aging (the "MPA"). The MPA Report is issued by the Master Plan for Aging Council (the "Council"), a collection of State agencies that has met since December 7, 2023. The Council's efforts to develop this report were aided by the incredible dedication of the more than 430 people who worked in the MPA workgroups and subcommittees to identify the most urgent needs of New York's older adults and people with disabilities and to develop proposals that address those needs. This MPA Report collects these proposals and provides commentary from the Council on each. Both the proposals and this commentary are being submitted to the governor and shared with the public to inform policymaking, so that New York can continue to improve its services and supports for older adults. This MPA Report complements other related efforts, such as the New York State Olmstead Plan, which is dedicated to improving the lives of New Yorkers with disabilities with a focus on improved community integration.

Introduction

The development of the Master Plan for Aging provided the opportunity for a system-wide assessment of how State programs and services currently function and how a variety of interventions could better support aging New Yorkers and people with disabilities. The process from the broad experience and knowledge held by community stakeholders and state agencies, who collaborated to develop informed views, priorities, and potential solutions.

This MPA Report provides an array of options to collaboratively support older New Yorkers, including proposals for infrastructural, near-term, and long-term actions that can be taken to achieve the vision of the Master Plan. If implemented, these proposals would require both State and stakeholder engagement, collaboration and advocacy to achieve, and would collectively serve the goal of reorienting government to better support the process of aging. The co-leading agencies of this process, the New York State Department of Health, New York State Office for Aging (NYSOFA) and New York Department of State (DOS), are committed to working together to achieve the vision presented.

The overall goal underpinning this MPA Report is to achieve the mission of ensuring older New Yorkers and New Yorkers with disabilities can live fulfilling lives, in good health, with freedom, dignity and independence to age in place for as long as possible. Success in achieving this goal will require revisiting existing policies and programs, improving coordination and collaboration among agencies, implementing new policies and programs, and advocating for federal actions to transform New York's long-term service and support system.

Development of the MPA

The MPA was initiated by the governor to inform long-term planning to transform and improve aging policy in the State. The process to develop the MPA has included the engagement of state agencies, leaders from the private, not-for-profit, and research and advocacy sectors, and other stakeholders from across the ecosystem of aging and

long-term care. The MPA drafting process, established in Executive Order 23, involved a Council of state agencies, a Stakeholder Advisory Committee, and eight subcommittees overseeing 34 workgroups. It also included public input from more than 20 town halls and listening sessions across the state, more than 10 industry roundtables, and a public survey that received more than 10,000 responses. It was further informed by the 2023 NYSOFA Statewide Needs Assessment Survey, which received more than 26,000 responses. This final MPA Report builds on a Preliminary Report issued in August of 2023 and an Interim Report issued in October of 2024. The MPA Report was also informed by an Advisory Report, completed by the Stakeholder Advisory Committee in the fall of 2024, that evaluated all of the proposals generated throughout the MPA process for both potential impact and feasibility.

The MPA process was grounded in engaging with and understanding the priorities of older adults. For example, the NYSOFA Statewide Needs Assessment Survey was critical to establishing a baseline understanding of the health and needs of older New Yorkers. That survey revealed that older New Yorkers are generally in good health, although they have concerns about access to health care: 71% of older adults considered their overall physical health to be "excellent or good" and 82% considered their overall mental health/emotional well-being to be "excellent or good," but 38% of older adults indicated getting needed health care was a problem.

Older New Yorkers want to age in place in their communities: 78% of older adults said their community was an "excellent or good" place to live. Many older New Yorkers want to stay in the workforce, but face challenges doing so: 52% of older adults indicated they did not intend to retire until at least 70, but only 19% of older adults felt they had an "excellent or good" variety of employment opportunities. Finally, older adults often feel they lack access to the opportunities or services they need: 56% of older adults indicated opportunities to participate in their community were fair/poor, 48% of older adults indicated opportunities to volunteer were fair/poor, and between 72% and 76% of respondents had concerns about the availability of resources like financial/legal planning and daycare for older adults.

Context for the MPA

Currently, New York has the 4th largest population of older adults in the country, with demographic changes leading to a larger and more diverse aging population across all communities. Older adults in New York are an integral part of the State economy. New Yorkers aged 50 and over account for most spending on health care, durable and nondurable goods, utilities, motor vehicles and parts, financial services, and household goods, including supporting the state's health care system through caregiving contributions made by informal caregivers, who are disproportionately over the age of 50. Individuals over age 50 represent 36% of the state's population yet contribute 43% ($719 billion) to the state's gross domestic product (GDP).[1] Spending by this population supports almost 6 million jobs, which generates $482 billion in wages and salary. Those over 50 in New York contribute $72 billion (39%) in state and local taxes, with older adults' pension and Social Security income infusing some $99.5 billion into New York's economy. Individuals 55 and older also have high rates of volunteerism,

[1] New York State Office for the Aging. (Last Accessed June 10, 2025). *Combating Ageism and Stereotypes with Data.* https://aging.ny.gov/combating-ageism-and-stereotypes-data

generating an economic value of $13.2 billion annually[2,3]. NYSOFA's 2023 Statewide Needs Assessment survey found that many older adults plan to continue working into their mid-70s. The development of an MPA presents an opportunity to better recognize, harness, and build upon the contributions of an aging population.

Yet the State's aging population also faces several challenges to aging in good health in the setting of their choice. Many systems that support the needs of aging New Yorkers are siloed, the growth in aging New Yorkers often leaves in-demand services out of reach, and the direct care workforce is not large enough to meet increasing demands. Additional challenges include infrastructure that is not designed for the volume, nor current preferences, of the people it will serve in coming years. For example, less than 4% of the housing stock across the country offers "a no-step entry, single-floor living, and wide enough doors and hallways to accommodate a wheelchair."[4] As another example, transportation services may be inadequate or difficult to understand, may lack routes to needed amenities and services, or may be too limited to be useful in some communities.

The State's projected demographic changes alone are likely to result in an increased demand for both community-based and skilled long-term care services and supports. The effects of these demographic changes are already being felt through growing capacity issues in aging and long-term care services, declining informal caregiving arrangements and volunteers, and increases in unmet needs for supports and services. Siloed systems have created inadequacies and confusion over where and how New Yorkers in need can receive the supports and services necessary to keep them healthy in their homes and communities as they age. Older adults represent a vulnerable and medically diverse population with complex biopsychosocial needs that can require a combination of clinical, behavioral health, cognitive, and custodial supports. As a result, long-term services and supports (LTSS) account for a substantial portion of Medicaid spending: in 2021, LTSS spending comprised approximately one-third of total Medicaid spending nationally.[5,6]

The availability and adequacy of a workforce necessary to support the provision of needed care will continue to be a primary issue. Changes in wage structure, availability of remote work and the fallout from the COVID-19 pandemic has led to tremendous attrition and difficulty in recruiting an adequate direct care workforce. In 2010, the number of working age individuals was equal to those over the age of 65, but since then, the number of New Yorkers over the age of 65 has grown while that of

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[2] *Ibid*

[3] New York State Office for the Aging. (2025, January 27). Governor Hochul's Budget Advances Historic Investments in NYSOFA Services, Prioritizes Vital Affordability and Public Safety Measures for Older New Yorkers and Families. https://aging.ny.gov/news/governor-hochuls-budget-advances-historic-investments-nysofa-services-prioritizes-vital

[4] Molinsky, J. (2022, August 18). *Housing For America's Older Adults: Four Problems We Must Address.* Housing Perspectives, The Joint Center for Housing Studies of Harvard University. https://www.jchs.harvard.edu/blog/housing-americas-older-adults-four-problems-we-must-address

[5] Colello, K.J., Sorenson I. (2023, September 23). *Who Pays for Long-Term Services and Supports?* Congressional Research Services. https://www.congress.gov/crs-product/IF10343

[6] Chidambaram, P. & Burns, A. (2024, July 8). *10 Things About Long-Term Services and Supports (LTSS)*. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/#:~:text=In%202021%2C%20Medicaid%20per%20person%20spending%20was%20substantially,did%20not%20use%20any%20LTSS%20%28%245%2C372%29%20%28Figure%204%29

working age New Yorkers has declined. The over-65 population is growing in every county of the State. The fastest rates of growth in the over-65 population from 2011 to 2023 have occurred in Hamilton County (33%), Columbia County (25%), Schoharie County (23%), Warren County (24%), Putnam County (19%), and Delaware County (26%).[7,8] In fact, the growth of New York's older adult population is outpacing overall population growth in the State's 19 largest counties and most of its largest cities, including Rochester, Syracuse, Yonkers, Albany, and New York City. According to Woods and Poole Economics, Inc., individuals aged 60 and over will make up over 25% of the populations in 50 counties in the State by 2030 and over 30% in a third of counties.

Demographic changes and workforce shortages have placed an additional burden not only on the formal health care system, but also on the State's more than 4.1 million "informal" – unpaid - caregivers. The services provided by these caregivers are critical - with some estimates - placing their value at roughly $39 billion.[9] Without these services, New York's health systems would be unable to meet the care needs of New Yorkers. Many of these caregivers work outside their homes, and the combination of their formal and informal responsibilities can be a tremendous burden, leading to an estimated $17 billion in increased health care costs for caregivers, diminished worker productivity, and increased worker turnover.[10] According to AARP, caregivers are in growing need of direct services and supports (such as respite, support groups, training, etc.) as well as indirect services and supports (those that take pressure off a caregiver, such as shopping assistance, transportation, nutrition support, etc.) to sustain their role. Community-based services and supports that help keep older adults safely in their homes and engaged in their communities are necessary to reduce the care burden many caregivers face daily.

The underlying demographic trends in both New York State, and the United States more broadly, are significant. When the baby boomer generation in the United States was young, as of 1960, there were six working-age adults for every person over the age of 65. As of 2020, that number had fallen to 3.6 working-age adults for every older adult, a decline of 40%. The number is projected to decline further, to a ratio of 2.8, by 2030.[11] This declining ratio of older adults to the rest of the population means that there are fewer workers available to provide care, fewer informal caregivers, and proportionally fewer people paying into pensions and government programs. At the same time, this evolution creates opportunities, as New York sees an increase in the share of the population capable of serving as mentors and teachers, and of bringing decades of experience to their own work. The MPA is launching at a generational

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[7] United States Census Bureau (2007-2011). American Community Survey. https://data.census.gov/advanced?t=Age+and+Sex&g=050XX00US36001,36003,36005,36007&y=2011

[8] United States Census Bureau (2019-2023). American Community Survey. https://data.census.gov/table/ACSST5Y2023.S0101?t=Age+and+Sex&g=050XX00US36001,36003,36005,36007

[9] Reinhard, S.C., Calendera, S., Houser, A., Choula, R.B. (2023, March). *Valuing the Invaluable: 2023 Update.* AARP Public Policy Institute. https://www.aarp.org/content/dam/aarp/ppi/2023/3/valuing-the-invaluable-2023-update.doi.10.26419-2Fppi.00082.006.pdf

[10] Albert, S. M., Schulz, R., Colombi, A. (2010, February). *The MetLife Study of Working Caregivers and Employer Health Care Costs*. MetLife. mmi-working-caregivers-employers-health-care-costs.pdf

[11] Mather, M., Kilduff, L. (2020, February 19). *The U.S Population Is Growing Older, and the Gender Gap in Life Expectancy Is Narrowing.* PRB. https://www.prb.org/resources/u-s-population-is-growing-older/

inflection point and both government and nongovernment systems must be prepared to rise to this historic moment.

Building on New York's Strengths

The MPA benefits from a foundation of work already underway. New York was the first state accepted by AARP into their Network of Age-Friendly Communities. The Age-Friendly Community designation reflects a recognition of New York's commitment to addressing, "the environmental, economic and social factors that affect the health and well-being of older adults."[12]

In 2018, Executive Order 190, establishing The Health Across All Policies initiative, directed all of State government to consider health and aging in the development of state policy. Since then, specific areas of focus by the State have included the Downtown Revitalization Initiative ("DRI"), Age-Friendly Health Systems ("Age-Friendly"), and the current Medicaid 1115 demonstration waiver.

The State has used the DRI to incentivize community development towards walkable, bikeable, transit-accessible communities with access to green spaces and outdoor recreation, providing opportunities for outdoor exercise, intergenerational social interaction, and connections with nature that provide positive mental and physical health outcomes.

The Age-Friendly initiative aligns New York with a national movement to restructure health systems to be more accessible to older adults and more responsive to their needs. Through Age-Friendly, the State is engaging with health care providers, industry, associations, statewide foundations, and the local Area Agencies on Aging (AAA) network, as well as other organizations, to incorporate evidence-based practices and service delivery methods to improve their ability to serve older adults and people with disabilities. To date, over 50% of health systems in the State have been certified by the Institute of Health care Improvement as an Age-Friendly Health System, with several developing accredited Geriatric Emergency Departments.

Finally, the State has engaged in multiple rounds of Medicaid reform and redesign to promote interventions on social determinants of health, sustainable support for providers, and quality of care and outcomes that directly benefit older New Yorkers. The current 1115 waiver demonstration program is incorporating an understanding of the impact of social determinants of health into Medicaid by including Social Care Networks and community-based organizations in the health care system.

These are a few among many current and planned programs upon which the MPA can build. These programs seek to bring together multiple agencies in a collaborative approach and foster changes in how service delivery is conceptualized and carried out to ensure greater access to services. They also ensure that these services consider the populations they are to serve by being culturally and linguistically appropriate and sustainable to meet increasing demands.

Vision for the State's Master Plan

The governor's issuance of EO23 directed the creation of a blueprint of strategies to be implemented to "ensure older New Yorkers can live fulfilling lives, in good health,

[12] Executive Order No. 190, 9 CRR-NY 8.190 (2022). https://www.governor.ny.gov/sites/default/files/atoms/files/EO_190.pdf

with freedom, dignity and independence to age in place for as long as possible." To create this plan, many of the proposals promote the development of innovative care networks and the multidisciplinary coordination across systems and services necessary to keep people healthy across their lifespan. At the same time, the proposals promote developing adaptable models of long-term care delivery to slow down or halt progression toward higher-acuity care.

These changes require a reorientation of governance to collaboratively approach design and oversight, promoting better access to services and supports, and improving access to the social determinants of health across the lifespan to better meet older adults' care needs before they reach old age. They also require changes that meet the diverse needs of older adults and persons with disabilities where they are. They also require evolving regulatory and statutory systems through models of primary, secondary, and tertiary prevention to implement efficient and effective projects and policies, and produce impactful outcomes.

Over the course of the MPA development process, the following categories emerged as critical components of the MPA's vision: Prevention, Promoting Equity, Community Integration, Supporting Families and Caregivers, Continuum of Care, and Workforce.

Prevention

This MPA Report considers the aging experience of New Yorkers long before they become older adults because quality of life in later years is heavily impacted by social determinants of health earlier in life. As the Department of Health's Prevention Agenda acknowledges, prevention is integral to extending good health, reducing the need for acute care, and improving quality of life. This MPA Report also seeks to advance prevention at its three basic levels, putting in place programs to help people make choices that extend their period of good health (primary prevention), that keep them safe when they begin to experience frailty (secondary prevention), and that prevent further injury once they require higher acuity care (tertiary prevention).

Prevention encompasses interventions addressing the conditions in which people age, work, play, eat, are educated, and are housed – such as public health education, health care provider training, accessibility of housing, support for aging services, and addressing social isolation. For example, prevention includes creating tools and systems to diagnose and properly coordinate treatment for physical, behavioral, and social needs sooner, and in a better integrated way across agencies and programs. Prevention also includes ensuring adequate housing options by expanding the supply of affordable and appropriate housing, which advances prevention efforts by allowing older adults and people with disabilities to live in a setting that meets their needs and remain integrated in their community while increasing their ability to afford other necessities. Prevention also involves addressing nutritional needs and improving access to balanced diets, which requires addressing the underlying disparities across communities that can create barriers to healthy eating, such as food deserts. These are just a few examples.

A policy built around prevention cannot succeed without educating people on the importance of prevention and how personal choices can positively or negatively impact health and lifestyle. Education can take many forms, such as public action campaigns. Further, including aging adults in prevention education for children and young adults, can establish social engagement opportunities and intergenerational experiences for those older adults, while raising awareness of the importance of a prevention lifestyle.

Ultimately, the State must build upon and extend primary prevention strategies and programs to alleviate the burden on care and support systems of aging and long-term care in the future. A population that has broad adoption of prevention-linked lifestyle choices will stay healthy longer, have more successful recovery from injury and illness, and be able to engage more with their families, careers, and communities. As people age, continued alignment with prevention principles will continue to prevent the need for acute care, to reduce costs of care, and to improve quality of life.

Promoting Equity and Prioritizing Social Determinants of Health

New York's older adult population is not only expanding, but also diversifying. For example, the number of older immigrants statewide is growing at nearly double the rate of older adults born in the U.S., increasing 41% since 2007. The MPA provided that the process and development integrated access and diversity, equity, and inclusion into the Master Plan for Aging construct. Accordingly, the MPA deliberative process considered diversity, equity, and inclusion within every workgroup and subcommittee, and had consistent participation from the NYSOFA's Advocacy Specialist and the State Health Department's Office of Health Equity and Human Rights. The MPA process engaged a wide variety of stakeholders to ensure that it reflects the widely varying experiences that people have aging in New York, and any effort to improve the aging experience in New York State must address the needs of all New Yorkers, across lines of geography, race, ethnicity, sexual orientation, gender identity, disability status, carceral status, and the many more areas of diversity that exist in the state.

This focus on equity quickly highlighted the importance of including social determinants of health in the MPA. The Department uses the term "social determinants of health" to describe the different conditions in a person's life that can influence their ability to be as healthy as they can be. Some examples of the conditions in a person's life that influence their ability to achieve optimal health are: access to safe and secure housing; living wages, secure employment, and safe working conditions; access to quality education; access to quality health care services; and access to affordable and nutritious food. While the social determinants of health overlap substantially with efforts at prevention, as discussed above, they warrant a separate discussion in the context of advancing equity across the state.

Disparities in education, housing, transportation, nutrition, economic resources, technology, and other social determinants of health result in disparities in physical and mental health, in access to and quality of health care, in access to nonmedical services and supports, and in people's ability to age in a safe environment that meets their needs. The cumulative effect of these disparities is that historically underserved communities face particular barriers to aging in the setting of their choice with independence and dignity. Inequitable access to social determinants of health underscores the need to develop policy that understands and accounts for the different contexts in which people age. The State must have a health system that acknowledges the existing distribution of resources as it seeks to raise the baseline of available services and supports across all communities in New York. This includes, for example, addressing social determinants of health by facilitating greater transportation integration across regions, and expanding the supply and availability of affordable housing. This also includes taking steps to ensure the availability of service providers in underserved communities, and the quality of medical and social facilities and infrastructure.

Achieving the vision of the MPA to ensure all can live a fulfilling life in the community of their choice requires an acknowledgment of the diversity of New York's residents and the use of an equity lens to identify and address the needs of traditionally underserved communities while being mindful of the unique needs of those who live with disabilities.

Community Integration

Older adults are a tremendous asset to New York's communities. By helping these adults to remain integrated in their communities, New York can simultaneously address the challenge of social isolation for older adults, improve the overall health and well-being of older adults, and allow older adults to continue to make significant social, civic, and economic contributions to their families, communities and regions.

Effective community integration involves local organizations, local government, schools, faith communities, employers, technology, and families to foster social interactions with aging adults and people with disabilities, while creating opportunities for aging adults to volunteer or bring social interaction into the homes of friends and family.

Community integration also involves ensuring that physical infrastructure is designed in a way to support and empower aging New Yorkers. The way in which planning, zoning, design, and development decisions are made in communities, including infrastructure decisions and investments, has a profound impact on older New Yorkers. Communities built on the principles of Smart Growth – an approach to development that encourages walkability, mobility, and incorporation of green spaces – are associated with higher quality of life, better health, stronger economies, more diversity, and greater resilience to climate change.

Smart Growth facilitates movement between community anchors, like shopping, housing, health care, and green spaces, and offers benefits to older New Yorkers in nursing homes and long-term care facilities. Nursing homes, adult care facilities, and independent living facilities that are remote from the community at large can contribute to the social isolation that causes and exacerbates the mental health issues endemic in older populations and can constrain access to health care services. Conversely, facilities located within, and with direct access to, the surrounding communities in which older New Yorkers live, work, and raise their families can prolong a sense of belonging and social inclusion, avoid isolation, and support the efficient provision and coordination of services.

Community integration also significantly benefits communities. Increasing opportunities to integrate aging adults and people with disabilities into their communities of choice can help alleviate workforce shortages, bring extra volunteers to not-for-profit and community organizations, increase mentorship, and support family caregivers. Successful community integration has many components.

There are many ways for communities to more fully integrate older adults. Communities can harness technology, lowering the barriers to regular interaction with others in the community and in congregate settings. Communities may use organizational structures such as Naturally Occurring Retirement Communities (NORCs) that put in place a structure and staff resources to allow older adults in a community to support each other. The housing-with-services model, also a component of the continuum of care, allows aging adults to remain in lower-acuity settings, with

greater independence, and consequently gain greater opportunity to engage with their community for a longer period of time.

Community integration also requires education for workers and employers, including education about existing protections against ageism and best practices for training and hiring older adults. Community integration requires taking action to protect older adults against fraud and abuse. Robust protections against physical abuse, financial abuse and fraud enable older adults to continue to live independently. Finally, people cannot integrate in a community if there is not enough space for them to safely inhabit or enough housing to constitute a community. By increasing the housing supply, particularly for aging adults, people with disabilities, and underserved populations, more people will be able to find and maintain acceptable housing in their community, and to remain integrated in their communities as needs change over the course of their lives.

Supporting Families and Caregivers

Millions of New Yorkers are or have been informal caregivers for older adults, people with disabilities, and other underserved populations. Supports and services provided by family members and other informal caregivers are an essential component of the health and long-term care systems – helping to expand access to care, improve quality of care, and prevent the need for more costly care. Implementing a service infrastructure that sustains these informal services and supports is critical, especially as demographic changes drive increased demand for long-term care.

Informal caregivers can face challenges balancing caregiving with their other primary responsibilities and personal needs. The shortage of paid caregivers adds to this pressure, reducing the external support that informal caregivers can rely on. Given these challenges, there are many ways New York can support informal caregiving.

Efforts to recognize a caregiver's work are one avenue. Employers should recognize and adopt policies and practices that allow for caregivers to work and continue their responsibilities. This includes providing tools and resources to ensure that those caregivers can maintain their professional lives and balance caregiving responsibilities. New York should also explore pathways for informal caregiving experience to lead to a caregiving career. New York must explore ways to ensure that informal caregivers and those they care for are aware of benefits to which they are entitled, and to streamline and clarify processes to apply for these benefits. Families, aging service providers, and health service provider systems must work to align resources, including respite care and both social adult day and adult day health care programs. Efforts must be taken to support and grow the formal caregiving workforce to ensure professional care is available to supplement informal caregiving.

Given the near unavoidability of caregiving – most New Yorkers at some point in their life will care for a friend or a loved one – and the associated financial and physical burden, planning and preparing for caregiving is imperative. New Yorkers throughout their careers must be aware of the potential costs of long-term care and need to plan ahead. Advance planning will ease the burden on informal caregivers while also allowing individuals to age appropriately according to their unique preferences and circumstances. Efforts to ensure older adults can remain in the workforce longer, if they so choose, will also help alleviate these burdens, while also preserving for many older New Yorkers a sense of value and inclusion. To that end, aging adults should also have robust protections against ageism in the workplace and opportunities for job retraining.

Continuum of Care

Ensuring that older adults and people with disabilities have equitable access to services and supports requires a well-functioning system - a continuum of care that corresponds to the continuum of life. This requires an integration of health care and community-based services that can allow for seamless transitions in care, the ability to obtain care and services in preferred settings, a well-trained and supported workforce, and the flexibility to access both established and new support models.

As people move through a well-integrated continuum of life, care must interact in such a way that documentation is comprehensive, instructions are consistent between providers, and needed services remain available as people transition across payor sources, providers, and care settings. Such a continuum must also include collaborative networks of care and access to consumer information that helps to avoid unnecessary care and save costs. A healthy continuum of care also provides opportunity for services early, when they are lowest-cost and highest-impact. Those services, delivered through a system that is responsive to regional and individual needs, can facilitate aging in place while improving health outcomes through prevention, thus reducing costs.

The current organizational model of services and supports across different federal, state, and local agencies, as well as across different provider types, has led to artificial distinctions between those services and supports, creating gaps in care that are inefficient and that prevent optimal outcomes. Opportunities to better integrate the continuum of care range from simplifying and coordinating credentialing, to standardizing electronic client and patient record systems, to training medical and nonmedical providers in gerontological practices, to coordinating benefits across agencies and payors.

Examples of tools that can facilitate an effective continuum of care are peer-to-peer networks and benefits counseling like those provided by AAAs, local Health Insurance Information Counseling and Assistance Programs (HIICAP), and NY Connects. The network of AAAs, and the aging services providers who partner with those agencies, work to prevent declines in health, keep people from needing to enroll in Medicaid, and facilitate aging in place. Since there is one AAA in each county, these AAAs can serve as a hub for a network of services that is responsive to local and regional needs, reflecting the diversity of communities across the state.

Housing-with-services models are another example of a tool that can be a highly effective component of the continuum of care. These models pair services and supports with independent and low-acuity senior housing, allowing people to remain in the community and delaying the need for higher-cost care. Similarly, within congregate care settings, granting more flexibility for the range of services allowed in the facility can extend the time that residents can age in place before transitioning to higher-acuity settings.

Workforce

A well-supported workforce is a central component of any system for providing long-term supports and services. New York must be intentional in designing workforce policies and programs that support and fully harness the direct care workforce.

Just as housing and residential care models need to be flexible to allow a smoother transition across life, employment models similarly need to offer a greater range of options as a person’s ability to work changes across life’s journey. This includes the options to move between home and congregate care settings as a direct

care worker and development of credentials that allow for a career ladder and wage growth as responsibilities and care tasks increase. This type of employment model both benefits members of the workforce, by providing opportunities for career growth and flexibility, and facilitates a continuum of care that is efficient, person-centered, and improves outcomes and quality of life.

New York must also find ways to grow the workforce. Today, direct caregiver positions often compete directly with many other industries, including frontline food service and other entry-level roles. Especially given the intense level of responsibility that can be involved in direct caregiving – such as going into a home and assuming responsibility for another person's well-being – there must be a clear value proposition for direct caregivers. This value proposition consists not only of compensation, but also career pathways, including training opportunities that enable caregivers to build knowledge and experience that ultimately benefit their clients and patients. Incentives need to be in place to encourage people to pursue careers as caregivers and to train in gerontological fields.

Finally, New York must be thoughtful in regulating and overseeing the workforce to maximize the impact of its caregivers. This includes revisiting scope of practice rules and the role of technology in caregiving.

Master Plan for Aging Proposals & Implementation

Proposals

Throughout the MPA process, more than 100 proposals were developed, thanks in particular to thousands of hours of work by external stakeholders and members of the public. These proposals are organized across 9 pillars identified through the subcommittee and workgroup group process. These 9 pillars are:

1. Informal Caregiver and Workforce Support and Modernization of Community-Based Aging Network Service
2. Modernization and Financial Sustainability of Health Care, Residential Facilities and Community-Based Aging Network Service Providers
3. Prevention, Wellness Promotion and Access
4. Housing Access and Community Development
5. Affordability of Basic Necessities
6. Access to Services in and Engagement with Historically Underserved Communities
7. Social Engagement of Older Adults
8. Combatting Elder Abuse, Ageism, Ableism and Stigma
9. Technology Access and Development

Within these pillars, proposals seek to address challenges through common methods including, but not limited to, education and training, cross-system coordination, targeted administrative or regulatory changes, major budget initiatives, and major system changes. Some examples of each include:

- *Education:* increasing public awareness, professional training, and education resources for caregivers.
- *Cross-System Coordination:* integrating data systems, coordinating benefits programs, and ensuring safe transitions through the continuum of care.

- *Targeted Administrative or Regulatory Changes:* addressing existing rules governing facility operations, scope of practice, and program eligibility.
- *Major Budget Initiatives:* addressing the waitlist for services and supporting capital improvements to facilities.
- *Major System Changes:* empowering an office or agency to monitor benefits programs across State government, evaluating zoning codes across the state to address the needs of older adults, and creating a commission to coordinate supports for caregivers.

Appendix G includes details on those proposals as submitted to the MPA Council for consideration, including a brief overview and justification for each. In addition, each proposal is annotated with brief commentary from the MPA Council, which consists of State agencies. These proposals and the MPA Council commentary are being submitted to the governor and shared with the public to inform policymaking.

The MPA Council commentary divides proposals into three categories that describe both the potential timeline for implementation, and the way each proposal impacts state policy and operations. Those categories are: near-term changes, long-term opportunities, and infrastructure initiatives. Near-term changes could impact New Yorkers within the next 1-2 years if pursued; long-term opportunities would take 3+ years if pursued; infrastructure initiatives are structural changes that could lay the foundation for future further initiatives.

Implementation

The vision laid out in this MPA Report and the proposals presented to the MPA Council reflect a coordinated effort involving every corner of government as well as the private sector, social sector, advocacy community, and other stakeholders across New York State. Achieving the vision laid out in this report – a New York that helps all older adults and people with disabilities remain engaged with their families, careers and communities along their life journey, and to continue to contribute their wisdom, experience, and spirit in a dignified and respectful way – will similarly require partnership across State government and far beyond.

Many of the proposals presented to the MPA Council focus on State government actions, but the participation of the private sector will be necessary for reshaping care and service delivery networks, encouraging and facilitating the integration of older adults into the workplace, and changing communication and outreach strategies that foster greater connections for older adults into society. As older adults and people with disabilities continue to become a larger proportion of the consumer population, and as many businesses continue to make older adults a key customer group, companies will need to reorient their offerings. That reorientation may range from age-friendly store environments to large-print packaging, with the goal of creating a consumer environment that recognizes and supports aging in place.

As New York seeks to achieve the vision of the MPA, the State must also recognize the limits on its own resources. Many of the proposals presented to the MPA Council recognize the importance of developing innovative financing models to support implementation – especially as demand for long-term supports and services grows. For example, the proposals presented to the MPA Council include ideas for exploring new insurance models, leveraging private debt markets to facilitate capital investment, and experimenting with innovative cost-sharing approaches. At the same time, the State must continue to seek out efficiencies, such as reducing fraud, waste, and abuse,

identifying and rationalizing duplicative programming or services, and consistently evaluating performance and shifting resources toward the most promising and highest impact initiatives.

The federal government and peer states also have a critical role to play. Throughout the process of developing the MPA, New York has learned from the ways multisector plans for aging are being developed and implemented in other states. New York's MPA process identified many challenges and opportunities that mirror those of other states. Many of the proposals presented to the MPA encourage changes in federal policy. New York must partner closely with peer states and the federal government in this work.

New York must also consider steps to monitor progress toward achieving the MPA's vision. Several statewide data sources report on key indicators aligned with the MPA's vision, including the Department of Health's Prevention Agenda Dashboard[13] and County Health Indicators by Race and Ethnicity.[14] A national effort breaking down health across social factors is also contained in the County Health Rankings[15] published by the University of Wisconsin Population Health Institute supported by the Robert Wood Johnson Foundation. The State and external partners should continue efforts to establish appropriate evaluation tools aligned with the MPA's vision.

Executive Order #23, establishing the MPA, represented the beginning of a renewed commitment to ensuring that older New Yorkers and people with disabilities can live fulfilling lives, in good health, with freedom, dignity and independence to age in place for as long as possible. This MPA Report is being submitted to the governor and shared with the public in service of this commitment and to inform aging and long-term care policymaking for the benefit of all New Yorkers.

Acknowledgements

First and foremost, the MPA team extends their thanks to Governor Hochul for her commitment to New York's older adults and people with disabilities, for issuing EO23, and for committing resources to supporting the MPA process. In addition, the NYS MPA process would not exist without the support of key people from across the state. Nora O'Brien-Suric and Bob Blancato, as chairs of the MPA Coalition, were early leaders in marshaling support for the MPA from every corner of the state, and engaging leaders from associations, foundations, and service providers. The members of the Stakeholder Advisory Committee ensured there was a critical mass for continued engagement in the MPA process through each of its phases and were gracious and generous with their time even throughout the process.

Industry roundtables helped build complete pictures of the disparate parts of the aging and long-term care ecosystem, and those roundtables would not have been possible without the efforts of key leaders in their fields, including Stuart Kaplan,

[13] Department of Health. (2025, February). *Prevention Agenda Tracking Dashboard.* https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/

[14] Department of Health. (2024, May). *County Health Indicators by Race and Ethnicity (CHIRE).* https://www.health.ny.gov/statistics/community/minority/county/

[15] University of Wisconsin Population Health Institute. *County Health Rankings & Roadmaps. 2025 Report: Building power for health and equity.* https://www.countyhealthrankings.org/

Kathryn Haslanger, Ann Marie Cook, Ruth Finkelstein, Doris Green, Vicki Been, Bea Grause, Dennis Short, Kristin Proud, Becky Preve, and Beth Finkel.

People who organized, attended or spoke at the MPA town halls helped bring our message to the public across the state, and the support of the following, among many others, was critical in getting feedback from diverse communities: Congressman George Latimer, Senator Cordell Cleare, Assemblyman Ron Kim, Assemblyman Billy Jones, Borough President Mark Levine, Councilwoman Gale Brewer, Commissioner Lorraine Cortes-Vazquez, James O'Neal, Fr. John Anderson, Colette Phipps, Pastor George Nicholas, Dr. Anderson Torres, Paul Nagle, Dr. Martha Sullivan, Richard Allman, Marcella Goheen, Robert Vitelli, and Pearl Ha.

Finally, many staff at the Department of Health and the NYSOFA dedicated their professional lives to the MPA over the last two years, and this report is a testament to their diligence, perseverance, and commitment.

Overview of Appendices

The appendices that follow provide an overview of the MPA development process and include the MPA's work products.

Appendix A:	Executive Order 23
Appendix B:	MPA Organizational Diagram
Appendix C:	Members of the MPA Council
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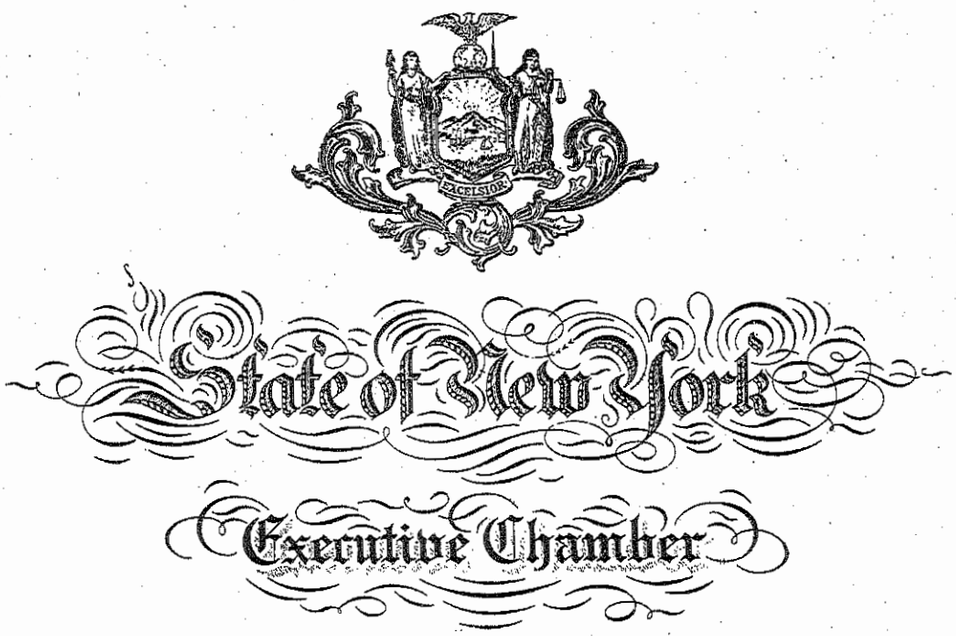
Appendix H:	Advisory Report of the Stakeholder Advisory Committee
Appendix I:	Preliminary Report
Appendix J:	Interim Report

Appendix A: Executive Order 23



No. 23

EXECUTIVE ORDER

Establishing the New York State Master Plan for Aging

WHEREAS, New York has demonstrated its commitment to an age-friendly environment to ensure that all New Yorkers can age with dignity and independence through policies that promote the value of healthy, meaningful aging; these policies include the New York State Prevention Agenda, Health Across All Policies, Age-Friendly New York, the Age-Friendly Health System Initiative, and the New York State Plan on Aging;

WHEREAS, New York has the fourth-largest population of older adults in the U.S., with 3.2 million New Yorkers (16 percent of the population) over 65. New York's population of those over the age of 60 is projected to grow to 5.3 million by 2030 with those over eighty years of age exceeding 1.2 million; By 2030, it is projected that 25 percent of the population in more than 51 counties will be 60 and older with at least 30 percent of the population in 18 counties 60 or older. The older adult population is growing faster than any other age group in the state;

WHEREAS, New York takes great pride in being named the first Age-Friendly State in the nation by the American Association of Retired Persons (AARP), a status based on the World Health Organization's eight domains of livability: outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, work and civic engagement, communication and information, community and health services;

WHEREAS, New York has been a leader in advancing policies that address social determinants of health, including the conditions in which people are born, grow, work, live, play, and age, as well as the wider set of forces and systems shaping the conditions of daily life, which have a tremendous impact on the health and well-being of all people;

WHEREAS, the majority of New Yorkers want to remain in the State during their retirement years. Older adults and baby boomers generate sixty-three percent of the household income in the State, supporting the economy and the tax base;

WHEREAS, with aging there is an increase in health care utilization and health-related conditions, including chronic diseases. New York needs to assure that our health care system is prepared to handle the coming demands and preferences for care, especially long term care;

WHEREAS, the public funding of long-term care through Medicaid and Medicare is substantial, and should support the broad goals of healthy aging;

WHEREAS, health care workforce issues must be addressed, along with ways to better support informal and family caregivers;

WHEREAS, older adults, and those with disabilities, should be able to choose to remain in their communities and whereas meaningful choice requires access to a broad range of public and private programs, resources, and supports, including health care, home care, food and nutrition, human services, housing and transportation;

WHEREAS, family caregivers struggle to balance work and caregiving, provide essential care for older adults and those with disabilities, and demand for this family care is growing.

WHEREAS, issues regarding access to affordable, suitable housing, transportation, the ability to age in place, mental health, isolation, ageism, opportunities for civic engagement and the prevention of elder abuse must be addressed in a comprehensive manner;

WHEREAS, it is important for the State to prioritize the needs of our aging population with a positive focus and to engage the public and those who serve older citizens in a meaningful planning process;

WHEREAS, planning for the opportunities and challenges that will result from change in the State's aging population, so New Yorkers of all ages can continue to live fulfilling lives, as independently as possible, in good health, and with the freedom to choose to age in place, requires a new level of strategic planning;

NOW, THEREFORE, I, Kathy Hochul, Governor of the State of New York, by virtue of the authority vested in me by the Constitution and Laws of the State of New York, and more specifically, Article IV, Section 1 of the New York State Constitution do hereby order and direct as follows:

1. That a New York State Master Plan for Aging shall coordinate existing and new state policy and programs creating a blueprint of strategies to be implemented to ensure older New Yorkers can live fulfilling lives, in good health, with freedom, dignity and independence to age in place for as long as possible.

2. The New York State Department of Health, in coordination with the State Office for the Aging, shall convene a Master Plan for Aging Council to advise the Governor in developing the New York State Master Plan for Aging. The Commissioner of Health, or their designee, shall serve as the Chair of the Council, and the Acting Director, or their designee, of the State Office for the Aging, shall serve as the Vice Chair of the Council. Members of the Council shall include the Commissioners and Directors of relevant Executive agencies and offices, as determined by the Governor, or their designees.

3. Executive branch agencies are directed to participate on and assist with the work of the Master Plan for Aging Council.

4. The Master Plan for Aging Council shall be convened within sixty days of the enactment of this order and present the recommended Master Plan for Aging to the Governor for issuance no later than twenty-four months following the first meeting of the Stakeholder Advisory Committee.

5. The New York State Department of Health, in coordination the State Office for the Aging and Master Plan for Aging Council, shall convene a Stakeholder Advisory Committee to advise the Governor and the Master Plan for Aging Council in the development of the Master Plan. The Chair and Vice Chair of the Council shall serve as the Chair and Vice Chair of the Stakeholder Advisory Committee.

    a. The Stakeholder Advisory Committee shall include representation from a broad array of those committed to the planning necessary to keep and improve New York's standing as one of the most age-friendly states. The Advisory Committee members shall be recommended by the Chair and Vice Chair, and may include, but not be limited to, health care and support service providers, consumers, informal caregivers, older adults - particularly those in communities experiencing disparities, health plans, labor organizations, community-based organizations, employers, experts on aging, academic researchers, foundations, local governments, and tribal communities.

    b. The Stakeholder Advisory Committee shall prepare a preliminary report within six-months of the first meeting of the Stakeholder Advisory Committee that details the intended activities of the Committee and shall include target measures that will be tracked over time. Reports detailing the Committee's activities and progress shall be available upon request.

    c. The Stakeholder Advisory Committee shall prepare an advisory report to be delivered to the Master Plan for Aging Council and the Governor, no later than eighteen months following the first meeting of the Stakeholder Advisory Committee.

    d. The Stakeholder Advisory Committee shall have subcommittees dedicated to long term care services and supports, community-based services, and caregivers. These subcommittees shall make a report directly to the Advisory Committee, the Master Plan for Aging Council and the Governor within twelve months following the first meeting of the Stakeholder Advisory Committee.

    e. The Stakeholder Advisory Committee may form additional subcommittees.

6. The Master Plan for Aging plan development process shall include ongoing opportunities for engagement with the public, which may include public comment periods during Advisory Committee meetings, town hall or similar forums for input, or any other means of public engagement deemed appropriate by the Chair.

7. The Master Plan for Aging Council and the Master Plan for Aging Advisory Committee shall have the authority to convene meetings, form subcommittees, workgroups and focus groups to work on specific issues, and create a website for the purpose of posting notices, meeting materials and other information necessary to carry out the development of the Master Plan for Aging.

GIVEN under my hand and the Privy Seal of the State in the City of Albany this fourth day of November in the year two thousand twenty-two.

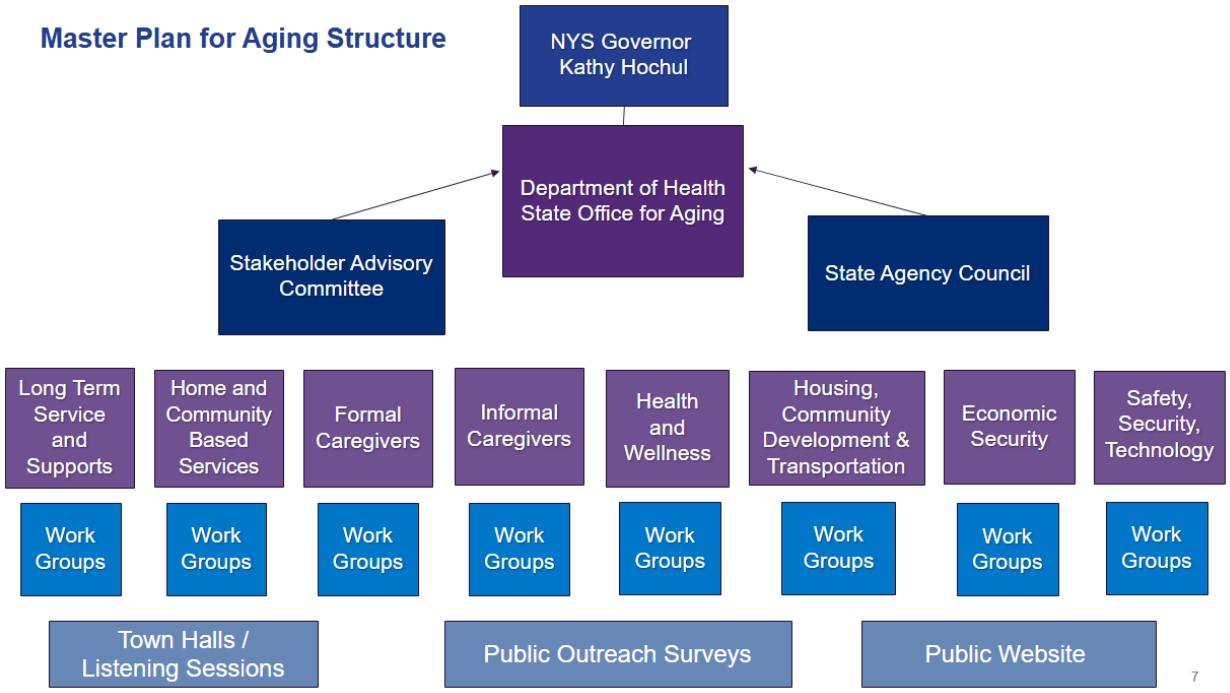
Kathy Hochul

BY THE GOVERNOR

Secretary to the Governor

Appendix B: MPA Organizational Diagram

Appendix B: MPA Organizational Diagram



Subcommittees and Subsidiary Workgroups:

Housing, Community Development and Transportation

- Housing
- Community Design
- Transportation

Formal Caregivers

- Recruitment and Training
- Retention, Compensation and Benefits
- Scope of Practice

Informal Caregivers

- Caregiver Supports
- Kinship Caregiving
- Communication Strategies
- Finances

Economic Security

- Retirement and Lifelong Planning
- Benefit Programs
- Workforce Engagement

Long Term Services and Supports

- End of Life Care
- Levels of Care
- Care Transitions and Navigation
- Payor Structures

- PACE
- Equitable Facility Transformation
- Licensed Professionals

Home and Community-Based Services

- In-Home Services
- In-Community Services
- Critical Partnerships

Safety and Security

- Financial Exploitation, Scams
- Abuse (physical, sexual, neglect, psychological)
- Guardianship/Alternatives to Guardianship
- Technology Development and Access
- Disaster Preparedness

Health and Wellness

- Promote and sustain physical and mental health, wellbeing and quality of life, including primary and secondary prevention and self-management of chronic disease
- Access to Medicare and Medicaid
- Mental Health and Substance Use Disorders
- Cognitive health
- Nutrition and Food Insecurity

Appendix C: Members of the MPA Council

Appendix C: MPA Council

1. Willow Baer, Acting Commissioner - Office for People with Developmental Disabilities (OPWDD)
2. Amir Bassiri, Director - Office of Health Insurance Programs (OHIP)
3. Jackie Bray, Commissioner - Department of Homeland Security and Emergency Services (DHSES)
4. Lorraine Cortes-Vazquez, Commissioner - New York City Department for the Aging
5. Chinazo Cunningham, MD., Commissioner - Office of Addiction Services and Supports (OASAS)
6. Viviana DeCohen , Commissioner of the New York State Department of Veterans' Services - Department of Veterans' Services (DVS)
7. Marie Therese Dominguez, Commissioner - Department of Transportation (DOT)
8. Laura Gonzalez-Murphy, MD., Executive Director of the New York's State's Office for New Americans - Office for New Americans (ONA)
9. Barbara Guinn, acting, Commissioner - Office for Temporary and Disability Assistance (OTDA)
10. Bea Hanson, Director of Office of Victim Services - Office of Victims Services (OVS)
11. Adrienne Harris, Superintendent - Department of Financial Services (DFS)
12. Dr. DaMia Harris-Madden, Commissioner - Office of Children and Family Services (OCFS)
13. Kim Hill, Governor's Chief Disability Officer - Governor's Chief Disability Officer
14. Amanda Hiller, Acting Commissioner (Deputy Commissioner and General Counsel) - Department of Taxation and Finance (TAX)
15. Hope Knight, President, CEO and Commissioner of Empire State Development - Empire State Development (ESD)
16. Dr. James McDonald, Commissioner - Department of Health (DOH)
17. Walter T. Mosley, Secretary of State - Department of State (DOS)
18. Greg Olsen, Director - Office for the Aging (NYSOFA)
19. Roberta Reardon, Commissioner - Department of Labor (DOL)
20. Ann Marie T. Sullivan, MD., Commissioner - Office of Mental Health (OMH)
21. Ruth Anne Visnauskas , Commissioner and CEO - Homes and Community Renewal (HCR)
22. Blake Washington, Budget Director - Division of Budget (DOB)
23. Caura Washington, Director of Faith and Nonprofit Development Services - New York State Office of Faith and Non-Profit Development Services (FKA-Faith Based Initiatives)

Appendix D: Members of the Stakeholder Advisory Committee

Appendix D: Stakeholder Advisory Committee

- Jessica Bacher – Pace University
- Stephen Berger – Odyssey Partners
- Dr. Jo Ivy Boufford – New York University School of Global Public Health ‘
- Courtney Burke – Rockefeller Institute of Government
- Dr. Thomas Caprio – University of Rochester Medicine Geriatric Assessment Clinic
- Anne Marie Cook – Lifespan of Greater Rochester
- Imran Cronk – Ride Health
- Sara Czaja – Center on Aging and Behavioral Research at Weill Cornell Medicine
- Emma DeVito – CEO Village Care
- Ruth Finkelstein, PhD – Brookdale Center for Healthy Aging at Hunter College
- Dr. Linda Fried – Columbia Mailman School of Public Health
- Doris Green – New York State Caregiver and Respite Coalition
- Kathryn Haslanger – Jewish Association Serving the Aging (JASA)
- Linda James – LifeSpan of Greater Rochester
- Stuart Kaplan – Selfhelp Community Services
- Lora Lee La France – St. Regis Mohawk Office for the Aging
- Scott LaRue – ArchCare
- Stephanie Lederman – American Federation for Aging Research
- Raj Mehra – SAGE
- George Nicholas – Buffalo Center for Health Equity
- Karen Nicolson – Center for Elder Law and Justice
- Allison Nickerson – LiveOn New York
- Wade Norwood – Common Ground Health
- Nora O’Brien-Suric – Health Foundation for Western and Central New York
- James O’Neal – AARP New York
- Dan Savitt – VNS Health
- Timothy Seymour – Herkimer County Department of Social Services
- Dennis Short – 1199/SEIU

Appendix E: List of MPA Town Halls and Listening Sessions

Appendix E: List of MPA Town Halls and Listening Sessions

Master Plan for Aging Town Hall - Stonewall (NYC)

- June 11, 2024
- The Lesbian, Gay, Bisexual and Transgender Community Center

Master Plan for Aging Town Hall - NYC

- May 22, 2024
- Church of the Epiphany

Master Plan for Aging Town Hall - NYC

- May 17, 2024
- SAGE Center Harlem

Master Plan for Aging Town Hall - Westchester

- March 7, 2024
- Westchester County Center

Master Plan for Aging Town Hall - Long Island

- February 27, 2024
- LGBT Network

Master Plan for Aging Town Hall – NYC (Bronx)

- February 5, 2024
- R.A.I.N. Boston Road Older Adult Center

Master Plan for Aging Town Hall – NYC (Brooklyn)

- January 10, 2024
- Center for Successful Aging

Master Plan for Aging Town Hall - NYC (Manhattan)

- January 9, 2024
- B'nai Jeshurun

Master Plan for Aging Town Hall - NYC (Harlem)

- December 6, 2023
- ARC A. Philip Randolph Senior Center in Harlem

Master Plan for Aging Listening Session - Utica

- November 20, 2023
- Mohawk Valley Community College

Master Plan for Aging Listening Session - Johnson City (Binghamton)

- November 9, 2023
- Johnson City Senior Center

Master Plan for Aging Town Hall - NYC (Queens)

- October 18, 2023
- Queens Library, Flushing

Master Plan for Aging Town Hall - Long Island

- October 17, 2023
- Temple Am Echad

Master Plan for Aging Town Hall - Amherst

- September 8, 2023
- Amherst Center for Senior Services

Master Plan for Aging Town Hall - Buffalo

- September 7, 2023
- Lincoln Memorial United Methodist Church

Master Plan for Aging Listening Session - Syracuse

- August 24, 2023
- Vineyard Church Syracuse

Master Plan for Aging Listening Session - Rochester

- August 10, 2023
- Pieters Family Life Center

Master Plan for Aging Town Hall - Plattsburgh

- July 12, 2023
- Clinton Community College

Master Plan for Aging Town Hall - Capital Region

- July 11, 2023
- The College of St. Rose

Master Plan for Aging Town Hall - Hunter College

- June 7, 2023
- Silberman Campus

Appendix F: List of MPA Topic and Industry Roundtables

Appendix F: Topic and Industry Roundtables

Agency Areas on Aging (AAA) Roundtable

- August 25, 2023

Transportation Roundtable

- September 13, 2023

Health Plan Roundtable

- September 22, 2023

Food Policy, Nutrition, and Healthy Aging Roundtable

- October 25, 2023

Hospital Executive Roundtable

- November 28, 2023

1199 SEIU Roundtable

- December 18, 2023

Older Adults with Developmental or Intellectual Disabilities Roundtable

- September 13, 2024

Older Adults in the Prison System Roundtable

- September 30, 2024

Housing Roundtables (2)

- November 4, 2024
    - Purpose-Built Housing for Older Adults
    - Accessibility and Affordability of Existing Housing

Elder Law Roundtable

- December 17, 2024

Appendix G: Proposals Presented for The Master Plan for Aging

Appendix G

New York State
MASTER PLAN FOR AGING (MPA)
Proposals Presented for the Master Plan for Aging

Context on Proposals

Throughout the MPA process, more than 100 proposals were developed thanks in particular to thousands of hours of work by external stakeholders and members of the public. These proposals are organized across 9 pillars identified through the subcommittee and workgroup group process (see Table of Contents). Within each pillar, the proposals are organized according to their ranking in the Stakeholder Advisory Committee's Advisory Report.

This Appendix includes details on those proposals as submitted to the MPA Council for consideration, including a brief overview and justification for each. In addition, each proposal is annotated with brief commentary from the MPA Council, which consists of State agencies.

The MPA Council commentary divides proposals into three categories that describe both the potential timeline for implementation, and the way each proposal impacts state policy and operations. Those categories are: near-term changes, long-term opportunities, and infrastructure initiatives. Near-term changes could impact New Yorkers within the next 1-2 years, if pursued; long-term opportunities would take 3+ years, if pursued; infrastructure initiatives are structural changes that could lay the foundation for future initiatives.

In addition, the MPA Council commentary indicates proposals that may require legislative action and/or have fiscal implications. Any proposal with a fiscal impact would need to be addressed as part of the annual budget process. Please note that cost estimates included in the proposals submitted to the MPA Council have not been validated by the MPA Council or relevant state agencies.

These proposals and the MPA Council commentary are being submitted to the governor and shared with policymakers and the public to inform policymaking. These proposals represent a starting point for discussion. Further discussion is necessary between relevant state agencies and stakeholders to both refine these proposals and assess which may be appropriate to adopt and implement.

I. Informal Caregiver and Workforce Support and Modernization of Community-Based Aging Network Service

Proposal Presented for the Master Plan for Aging (#38):
Regulatory Reform to Support Direct Care Workforce Recruitment

Summary: Establish financial investment in workforce recruitment and provide education about training provided at the nursing home. This proposal includes recommendations to decrease educational barriers, review safety, efficacy and requirements of technicians and assistants, and promote flexible career ladder opportunities.

Justification: As a result of the current and historic staffing shortages that have afflicted the Long Term Services and Supports (LTSS) field, workforce training needs to be modified to a more functional, effective, and efficient approach. This should be reflected through a focus on career ladders with flexible opportunities and doing away with the Administrator-in-Training (AIT) requirements that obstruct talented individuals from joining the nursing home administration field. Established training centers within nursing homes with accredited educational institutions will not only enhance the quality of the labor pool but will support recruitment efforts for bolstering the workforce.

Full Proposal:
The paradigm shift away from a task-oriented model for labor requires financial investment in the workforce for recruitment, and to provide education about training provided at the nursing home.

1. Establish training centers within nursing homes, with accredited educational institutions, by incentivizing providers and universities, which not only enhances, but supports the labor pool.
2. Remove the AIT requirement and increase the flexibility of educational requirements and qualifying field experience to encourage new entrants into the licensed nursing home administrator field.
3. Continue to consider the safety and efficacy of the use of medication techs/assistants to support clinical care. This can be done by looking at information from other states that have implemented the use of this level of staff. Explore a program to be implemented in nursing homes for using medication techs/assistants, and a study of their use, including evaluation of resident satisfaction, staff satisfaction, and quality outcomes.
4. Revisit regulatory requirements for training to make it easier for nursing homes to use feeding assistants.
5. Promote more flexibility, career ladder opportunities and integrated use of direct care staff, including the use of residential care assistants (RCA) that can become Certified Nursing Assistants (CNA) in facilities with approved training programs. Much work remains regarding the implementation and impact of current New York State required staffing ratios in nursing homes, especially as it relates to the pending implementation of federal rules from the Centers for Medicare and Medicaid Services (CMS).

MPA Council Commentary: *This proposal is categorized as long-term. Governor Hochul's FY23 to FY26 Executive Budgets included a proposal to allow certified medication technicians to provide care in New York nursing homes, but the proposal has not yet been included in the Enacted Budget. The Department of Health and the State Education Department (SED) are engaged in discussions regarding direct care worker training and credentialing to improve the accessibility of caregiving employment.*

Proposal Presented for the Master Plan for Aging (#114):
Support Community-Based Aging Services

Summary: Expand access to in-home personal care services by providing funding to NYS counties to allow Area Agencies on Aging (AAA) to hire home health and/or personal care aides to reduce and limit existing waiting lists for personal care services and focus resources prior to the enrollment in Medicaid.

Justification: The demand for personal care aides is expected to rise exponentially (440,000 in 2018 to 700,000 by 2028). Barriers to entry into the profession affect turnover and within the 10-year period 2018-2028, nearly a million job positions must be filled to meet the demand. Implementation of this proposal would enhance workforce development and reaffirm New York's commitment to aging in place.

Full Proposal:
The New York State Office for the Aging's (NYSOFA) in-home program successfully operates coordinated nonmedical care for older adults who are not Medicaid eligible, preventing Medicaid spend-down and unnecessary service utilization and fostering aging in place. NYSOFA's ability to provide fewer Medicaid care hours at a more competitive economic cost than LHCSAs has created waitlists for personal care aide services. The need for home health aide and personal care aide jobs is projected to rise as the demand for care continues to increase. High turnover rates, staffing shortages and barriers to entering the home care profession exacerbates this issue. This proposal suggests supporting the existing and increasing population of older adults served by NYSOFA, strengthening the home care workforce, and enhancing annual Medicaid savings by:

1. Providing funding to NYS counties to hire up to 6 aides per AAA to reduce/limit existing waiting lists and focus resources prior to reliance on Medicaid.

MPA Council Commentary: *This proposal is categorized as long-term. In-home care and other essential services are critical to allowing older adults to age in place, yet New York State is experiencing a direct-care workforce shortage. The State is already taking significant steps to address the need for in-home services. NYSOFA currently works to promote aging in place by allowing AAAs to supplement informal care with in-home personal care, case management, noninstitutional respite, and ancillary services by directly contracting with direct care workers to provide Personal Care Level I, Personal Care Level II, or both. In the FY26 Enacted Budget, Governor Hochul invested $45 million in additional funds for in-home and community-based services offered by NYSOFA and the AAAs. These additional funds will make it possible for AAAs to reduce the number of older adults waiting for critical in-home and community-based services. Any additional investments in community-based aging services would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#39):
Universal Direct Care Worker Model

Summary: Establish a revised training and credentialing infrastructure for direct care workers that allows for portability across long-term care settings through a combination of legislative, regulatory, and administrative actions. Revise current training curriculum to create a foundational direct care worker training program with the goal of establishing a recognized universal direct care worker credential.

Justification: Staffing shortages exacerbated during the COVID-19 pandemic demonstrated the need for direct caregivers to be able to move between settings to meet need. In NYS, varying credentials are needed to provide care in the home and care in a facility. SED, Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD) and the Department of Health offer training programs with differing requirements. This proposal aims to increase portability by revising the training and credentialing infrastructure to establish a foundational direct care worker training program. The goal would be to establish a recognized universal direct care worker credential. Other states are considering or beginning to implement a universal direct care worker framework as well.

Full Proposal:
Establish a revised training and credentialing infrastructure for direct care workers that allows for portability across long-term care settings through a combination of legislative and administrative actions. This would build an established, stackable credential to allow for specialization, mobility, and advancement of direct care workers while effectively meeting the needs of all long-term care clients. This proposal would help to increase the supply of direct care workers in all settings.

1. Convene industry experts (including NYSOFA) and agency staff from the Department of Health, OMH, OPWDD and SED and task them with articulating the core competencies required by all direct care, workers across programs/settings.
2. Require alignment between the Department of Health, OMH, OPWDD and SED – potentially through a consolidation of direct care worker training oversight – to support a more streamlined training system.
3. Revise current training curriculum to establish a foundational direct care worker training program (based on the core competencies identified by the group of industry experts and agency staff) with the goal of establishing a recognized universal direct care worker credential.
4. Include training content that prepares direct care workers for the current long-term care landscape including client acuity, cultural competency, social norms, and inclusivity. Require rigorous evaluation to inform necessary adjustments to curriculum and training and monitor outcomes. In addition, any new barrier to entry into training needs to be evaluated and mitigated.

MPA Council Commentary: *This proposal is categorized as long-term. The Department of Health and SED are engaged in discussions regarding direct care worker training and credentialing to maximize the efficacy of the caregiving workforce. Implementation of this proposal would also require discussion and collaboration with other agencies involved in direct care certifications, such as OMH and OPWDD. Such discussions would need to consider the tradeoffs between establishing a more universal training model and maintaining appropriate levels of specialization.*

Proposal Presented for the Master Plan for Aging (#32):
Establish Regional Caregiver Support Hubs

Summary: Have the Department of Health procure Regional Caregiver Support Hubs (Hubs). Hubs will facilitate support services for individuals training to become direct caregivers and will provide assistance in navigating changes to benefits that result from caregivers achieving full-time employment (i.e., where their employment results in them losing eligibility).

Justification: The Department of Health is currently working to procure Hubs to work in conjunction with Regional Direct Caregiver Training Centers also being procured. The support centers will assist in providing career guidance and assistance for overcoming barriers to successful completion of training and workforce participation, which includes food security, transportation, affordable housing and childcare access.

Full Proposal:

1. The Department of Health will procure Hubs to address employment barriers for Home Health Aides.
2. Regional Training Centers, also procured by the Department of Health, will operate or subcontract with Hubs. See proposal 30 for additional information on this component.
3. These Hubs will assist in addressing issues such as Home Health Aides case acceptance to full-time employment that eliminates eligibility for entitlements or other benefits, and career pathing. Hubs will also assist those training for direct care work in accessing services needed for them to work, including childcare, housing and nutritional support, if needed.
4. Hubs will hire appropriate staff who specialize in career pathing for this population.

MPA Council Commentary: *This proposal is categorized as infrastructure. Components of this proposal and proposal 30 are both currently being implemented at the Department of Health through a Request for Applications (RFA) issued on December 3rd, 2024. The Department of Health will consider the details of this proposal as it proceeds with the procurement process. As the Department of Health proceeds with implementation, it will assess the impact on metrics such as employment rates and self-reported access to necessary services among direct caregivers.*

Proposal Presented for the Master Plan for Aging (#56):
Caregiver Tax Credit and Reimbursement Program

Summary: Create a caregiver tax credit to be paid directly to the caregiver and a reimbursement program for caregiving expenses to offset expenses such as home safety modifications, medical equipment, hiring of home health aides, etc.

Justification: Informal caregivers spend an average of $7,242 per year out of pocket for costs relating to caregiving such as medical equipment, hiring of home health aides or personal care attendants, and other health technology.[1] A caregiver tax credit and/or reimbursement program will not only ease the financial burden on New York State's unpaid caregivers but also help offset their out-of-pocket expenses.

Full Proposal:
Create an expansive caregiver tax credit to be paid directly to the caregiver and a reimbursement program for caregiving expenses, easing the financial burden on the caregiver. The programs should aim to offset expenses such as home safety modifications, medical equipment, hiring of home health aides, etc.

1. This credit would provide up to $6,000 per caregiver and would be allocated directly to the caregiver for 50% of their total out-of-pocket spending in a tax year.
2. To qualify for the caregiver tax credit, the caregiver would have to:
    a. Be caring for an individual aged 18 years or older and require assistance with at least one activity of daily living (ADL), as defined per NYCRR Title 10 Section 69-10.1.
    b. Qualify as a dependent spouse, parent, any blood relative, or partner as defined in state statute.
    c. Meet the income eligibility requirements based on the Empire State Child Tax Credit program.
3. The reimbursement program would provide a set amount of funding to the family caregiver to offset out-of-pocket spending, including up to 50% for home modifications and assistive technology.

MPA Council Commentary: *This proposal is categorized as long-term. While tax credits may reduce the financial burden to caregivers, they are administratively complex and may not provide immediate relief. For example, filers may have to wait for up to a year before filing their taxes, at which point the Department of Taxation and Finance (DTF) would need to collaborate with other agencies to review and certify claims. Further work would be required to assess the administrative feasibility and fiscal impact of such a proposal, and funding would be subject to the annual budget process and the availability of resources.*

[1] Skufca, L., Rainville, C. (2021, June 29). *Caregiving Can Be Costly — Even Financially.* AARP. https://www.aarp.org/pri/topics/ltss/family-caregiving/family-caregivers-cost-survey/

Proposal Presented for the Master Plan for Aging (#62):
Establish Administrative Infrastructure to Support Kinship Caregivers

Summary: Support older kinship caregivers through identifying unmet needs and providing assistance by establishing an Interagency Council on Kinship Care and Kinship Legal Network that would leverage the existing Kinship Navigator program to collect data and recognize trends. These would serve as a means to identify success stories as well as identify unmet needs related to: housing, mental health access, financial assistance, childcare and respite care for kinship caregivers, including systemic challenges and solutions, as well as to document the benefit of the program.

Justification: Kinship caregivers often face restrictions and limited access to necessary resources making it challenging to care for themselves and their loved ones. Limited coordination across systems concerning the needs of kinship caregivers can create silos and limited-service integration. The establishment of an interagency council would aid in eliminating silos across systems and uplifting supports for kinship caregivers. Kinship caregivers frequently find themselves engaging in legal proceedings regarding custody and guardianship situations. New York State should develop a coordinated kinship legal network that will provide informed legal assistance from counsel experienced in kinship issues to help caregivers effectively navigate these challenging situations. Safe, affordable housing is a critical element in overall well-being for both kinship caregivers and the children they are caring for. The existing housing needs and obstacles for kinship caregivers need to be better understood and analyzed to inform appropriate action and future policy decisions with this unique population in mind.

Full Proposal:
Put administrative infrastructure in place to support kinship caregivers:

1. Establish an Interagency Council on Kinship Care (Council) under the auspices of the NYS Caregiver and Respite Coalition and NYSOFA. This Council would invite representation from each agency that is involved in the kinship experience including the Office of Child and Family Services (OCFS), Department of Health, Office of Temporary and Disability Assistance (OTDA), Office of Court Administration (OCA), OMH, SED, Division of Housing and Community Renewal (HCR), Office of Addiction Services and Supports (OASAS), as well as representation from kinship caregivers and kinship service providers throughout the state, both rural and urban. The role of this Council is to focus on and to amplify unique issues of kinship caregivers.
2. Establish a Kinship Legal Network, a program to provide legal representation, information and advice to nonparent caregivers interfacing with New York's justice and social services systems.
    a. The Kinship Legal Network would use a proven model that has been replicated in a variety of legal services areas; it will develop a network of legal services providers who will serve clients, as well as look across the

state to collect data and recognize trends as a means to identify success stories, systemic challenges and solutions, and to document the benefit of the program to NY families and the State. The program will leverage the existing Kinship Navigator, a successful statewide program which provides an information and referral network for kinship caregivers across all of New York State.

b. Kinship housing: Conduct a statewide needs assessment to identify unmet needs of related to housing, mental health access, financial assistance, and childcare and respite care access for kinship caregivers.

3. Once unmet needs are identified, plans should be developed to meet those needs, including any funding, set asides for kinship families in new projects, and applying for federal funds available for kinship housing (such as the Legacy program).
4. Provide funding assistance to assist low-income older adults with moving expenses in the event they need to relocate to larger housing due to becoming a kinship family.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as implementation would require legislative action to grant authority to NYSOFA to establish and administer the items proposed. Before implementing this proposal, relevant state agencies would likely need to do a comprehensive review of existing state and federal efforts to improve the kinship system of care (e.g., OCFS' kinship caregiver efforts across age cohorts), in order to avoid duplication of effort and ensure that implementation of this proposal would complement and build on these existing efforts. Any additional funding would need to be considered through the annual State budget process and would be subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#30):
Procurement of Regional Direct Training Centers to Increase Accessibility and Availability of Training

Summary: Direct the Department of Health to procure Regional Direct Care Training Centers (Centers) throughout NYS to increase access and availability to training. The proposal includes the regulatory framework for operating the training centers.

Justification: The Department of Health is currently working to procure Centers throughout the State to train Personal Care Assistants (PCA), Home Health Aides (HHA) and CNAs in order to increase the number of formal caregivers, reducing workforce shortages. This proposal is to make hybrid/virtual training models eligible, which are more easily accessible, to apply for this funding.

Full Proposal:
The Department of Health should procure Centers throughout NYS to increase access and availability to training.

1. The Department of Health would continue to approve Hybrid Virtual Training Programs (HVTPs) under the current application process and HVTPs should be eligible to apply to be Centers alone, or in collaboration with other approved TPs (Training Programs).
2. HVTP would only be provided by the Department of Health-approved PCA or HHA Training Programs (PCATP or HHATP).
3. Local approved Training Programs may recruit and refer potential trainees to the Centers.
4. Centers would train students in a classroom setting or have the option to administer the training virtually, in which instance the HVTP would provide the virtual didactic portion of the training.
5. Centers may contract with approved PCATP and/or HHATP training programs so their nurse instructors can complete the remainder of their HHA certification process.
6. Center Registered Nurse (RN) Instructors would review and sign off on all tests and skills assessments, evaluate final performance and sign off on certificates.
7. Centers would submit all certificates through the Home Care Registry.
8. Centers would send all HHA certificates in accordance with regulations.
9. Training Program graduates would be given a list of all employers in the region and will be referred to employers for interviews to support hiring by their local Licensed Home Care Services Agency (LHCSA) or referred for CNA or other health care training as desired.
10. Trainees would be offered the option of training as a Direct Support Professional in order to serve the Intellectual Disability and Developmental Disability (IDD/DD) population, and Centers will refer trainees accordingly.
11. In addition to the mandated in-service topics, the Center can provide specialty training on various topics depending on the characteristics of the population

being served. This same model applies to other sector certifications and more modules can be added as prerequisites for career advancement. (CNA, Medical Assistant).

Notes: Portions of this proposal are in the process of being enacted.

MPA Council Commentary: *This proposal is categorized as infrastructure. Components of this proposal and proposal 32 are both currently being implemented at the Department of Health through an RFA issued on December 3rd, 2024. The Department of Health will consider the details of this proposal as it proceeds with the procurement process.*

Proposal Presented for the Master Plan for Aging (#44):
Establish the Statewide Caregiver Peer Support System

Summary: Implement statewide caregiver peer support system(s) based on successful peer support programs addressing the needs of caregivers. Successful models to replicate or expand include the Family Essential Care Program (FEP), Pfc. Dwyer Veteran Peer to Peer Program, Alzheimer's Association Peer Support, Living Communities Caregiver Coaching Program, and OPWDDs Family Education Support Groups.

Justification: The goal of the program is to provide user-friendly, personalized, timely and ongoing support, information, and counseling to caregivers to address both their educational and emotional support needs in a culturally appropriate manner across the lifespan. Evidence supports that caregivers rely on others, such as friends, family, and community members, for support and assistance. This will remove silos and duplication of services, allowing for more comprehensive and appropriate programs and services to be provided.

Full Proposal:
Establish or expand statewide caregiver peer support system(s), based on existing

1. The peer support program will match and connect experienced caregivers or former caregivers with caregivers seeking advice, information, and emotional support for their caregiving role.
2. The goal of the program is to provide user-friendly, personalized, timely, ongoing support, information and counseling to caregivers to address both their informational and emotional support needs in a culturally appropriate manner across the lifespan.
3. The program(s) will seek to ensure that culturally appropriate, trauma-informed, equitable, and person and family centered supports and services are available, accessible to all caregivers through equitably conscious administration.
4. Provide funding sufficient to implement this proposal statewide within five years.

MPA Council Commentary: *This proposal is categorized as near term. If implemented, NYSOFA and the Department of Health would convene agencies operating successful peer-to-peer services models to develop a peer-to-peer information and counseling program that would culturally and linguistically support caregivers. Proposed next steps could then include exploring the duplication of services and populations served, determining opportunities for expansion and areas of overlap to develop collaborative programs, as well as developing information and assistance counseling materials on supportive services available for caregivers. Funding allocations would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#28):
Incentivize Geriatric Specialties

Summary: Develop mechanisms to provide incentives that support those interested in entering the fields of geriatrics and geriatric psychiatry, such as scholarships, loan forgiveness, or additional provider reimbursement add-ons for serving specialized populations. The proposal includes incorporating geriatric-specialty-focused elements into existing loan forgiveness programs.

Justification: Existing long-term care shortages are exacerbated by the growing older adult population in New York State. Building upon previously established loan forgiveness programs to include geriatric specialties will effectively attract and incentivize professionals to positions that support the needs of older New Yorkers.

Full Proposal:
Develop mechanisms to provide incentives that support those interested in entering the fields of geriatrics, geriatric nursing, geriatric social work, and geriatric psychiatry, such as scholarships, loan forgiveness, or additional provider reimbursement add-ons for serving specialized populations. Ensure that the base education curriculums for professionals includes working with older adults and incorporating intersectionality in all professional settings.

1. Ensure that Nurses Across New York (NANY) and Doctors Across New York (DANY) specifically provide for a percentage of their grant recipients to be in geriatric specialties.
2. The Social Worker Loan Forgiveness Program should add loan forgiveness eligibility for social workers who practice with a "specific population of older adults and individuals with disabilities requiring long-term services and supports" to the existing eligibility criteria as a qualified Critical Human Service Area Eligibility. This population is not identified as a population Health Professional Shortage Area (HPSA) by the Human Resource & Service Administration (HRSA).
3. Support educational institutions by facilitating private-educational partnerships that would offer joint appointments for clinical educators/faculty or by establishing a NYS-Graduate Nurse Education (GNE) demonstration program similar to the federal one that would support the costs of training and preceptors at clinical sites.
4. Advocate with the existing Boards of Professional Education, licensing boards, and higher education committees to require the inclusion of curriculum on the intersectionality of professional work with older adults.

MPA Council Commentary: *This proposal is categorized as long-term. The State offers a variety of incentives and has many requirements related to the education and training of health care workers and would need to further evaluate the tradeoffs*

associated with incorporating an additional focus on geriatric specialties into these programs. Any additional funding would need to be considered through the annual State budget process and would be subject to the availability of resources.

Proposal Presented for the Master Plan for Aging (#33):
SkillSpring Program to Bolster the Direct Care Workforce

Summary: Recommendation to expand the SkillSpring program to prepare care workers to serve older adults and provide health care jobs to young, low-income New Yorkers. The proposal also includes partnerships with the Department of Health Regional Direct Care Training Centers to certify the program's students.

Justification: The health care workforce crisis continues to impact the State of New York and older adults seeking necessary care. Expansion of health care educational programs such as the SkillSpring program, which is a successful NYC-based program connecting young adults who are disconnected with the workforce with supportive training for health care jobs, would simultaneously improve health outcomes for older adults, challenge workforce crises, and allow young professionals to engage in fulfilling careers. SkillSpring has received past line-item budget funding, and the purpose of this proposal is to scale the program and replicate it in other geographic areas.

Full Proposal:
SkillSpring addresses two urgent economic challenges facing New York: It prepares care workers to serve older adults and it provides good jobs in health care to New York low-income young people.

1. SkillSpring would expand the workforce serving older adults across the state by providing entry into health care jobs with strong career pathways to low-income young adults (ages 18-25) who are disconnected from school and employment.
2. SkillSpring's full-time, 12-week program provides free (to the participant) occupational skills training to low-income young adults (ages 18-25) to attain a New York State credential, such as CNA, HHA or PCA.
3. SkillSpring's rigorous 12-week program encompasses professional workforce development, allied health training, intergenerational programming, and transformational relationship building. Throughout their training, SkillSpring trainees receive wraparound support to complete their training and attain their CNA, HHA or PCA certification. SkillSpring's staff-intensive, high-touch model provides holistic, trauma-informed support to ensure retention and career development for young adult trainees.
4. Once certified, SkillSpring directly connects certified program graduates with employment. SkillSpring identifies, recruits, and trains low-income young adults experiencing barriers to workforce participation to attain certifications (e.g., CNA, HHA, PCA) and then places them in good jobs. Young adults who successfully complete SkillSpring's training and attain CNA certification have been guaranteed a job offer from partnering skilled nursing facilities, certified home health agencies and other employers. SkillSpring creates entry points to career ladder employment opportunities for young adult trainees.
5. SkillSpring would accomplish this system-level change through forging employer-driven workforce partnerships that link low-income community members, nonprofits, institutions, and businesses in the older adult health care sector.

6. SkillSpring's model is designed to promote well-being along with career outcomes for low-income trainees, and it supports social/emotional learning (SEL) opportunities through professional and intergenerational mentoring. SkillSpring uses a trauma-informed approach to youth development and all trainees receive biopsychosocial assessment on intake to ensure identified needs are met through individualized wraparound support.

MPA Council Commentary: *This proposal is categorized as long-term. While job training and pipeline programs are critical to addressing the workforce and staffing challenges of the state, a formal procurement process may be necessary to engage a specific program provider like SkillSpring. Any additional funding would need to be considered through the annual State budget process and would be subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#46):
NYS Working Caregiver Initiative and Pilot

Summary: Establish pilot program supporting working caregivers for up to five businesses with findings used to inform a newly established Caregiver Coordinating Commission (see proposal 63), legislative actions, and dissemination plans beyond the pilot businesses.

Justification: Caregivers are vital to the NYS business economy. However, they may lack resources from their employer and feel unsupported, which may lead them to leave their position. Providing tools, resources, and campaigns, like Any Care Counts, will deliver resources and support to employees, resulting in an immediate, positive, top, and bottom-line economic impact for businesses.

Full Proposal:
Collaborate with the New York State Department of Labor (DOL) to effectively deploy the New York State Office for the Aging's (NYSOFA) Working Caregiver Initiative for up to five pilot businesses (to be identified via collaboration between NYSOFA and DOL) with findings used to inform the newly established Caregiver Coordinating Commission (see proposal 63, above), legislative actions, and dissemination plans beyond the pilot businesses.

1. Findings would also be used to provide ongoing analysis of best practices for the support of caregivers in the workplace.
2. This proposal would also include reviewing and updating the NYSOFA/DOL Businesses Guidebook for Caregivers (e.g., adding more information on kinship caregivers) that has already been passed into law and made available to all businesses on specific websites (previous distribution included a press release with information on where the Guide can be located).
3. This tool would be disseminated to the (up to) five businesses as part of this proposal and made available to all businesses as required by NYS statute (NYS Elder Law Chapter 309- Section 224).
4. This initiative would collect data via the "NY State Employed Caregiver Survey," disseminate data and tool kits to employers via the "Any Care Counts" program and share training and self-identification information for caregivers via "Trualta" and the "CWRC Caregiver Self-Identification" video.

MPA Council Commentary: *This proposal is categorized as near term. Proposed first steps for implementation could include a consultation between the NYSOFA and the DOL regarding the availability of tools and resources for caregivers in the workplace. Proposed metrics for evaluating implementation success could include analysis of the New York State Employed Caregiver Survey and self-reported rates of support. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action to initiate the pilot program. Funding allocations would be subject to the annual budget process and the availability*

of resources.

Proposal Presented for the Master Plan for Aging (#31):
Peer-to-Peer Legacy of Care Mentorship Program

Summary: Institute a demonstration pilot for the peer-to-peer Legacy of Care Mentorship Program within home care service provider agencies statewide, in which seasoned home care staff will mentor newly hired staff over a six-month period, with the aim of boosting retention rates and enhancing job satisfaction. The proposal includes a proposed structure for the program and compensation for the mentors.

Justification: There are high turnover rates and significant staffing shortages statewide across the spectrum of LTSS and home and community-based services (HCBS) that serve the aging and disabled populations. Peer-to-peer mentorship programs increase retention rates, which reduce the cost to replace caregivers, increase job satisfaction and elevate the standard of care provided to patients.

Full Proposal:
A progressive relationship between people with different levels of expertise is called mentoring. In a professional setting, the sharing of practical guidance and implicit organizational knowledge between mentors and mentees helps newcomers to establish professional identities, build career skills, and integrate into their work surroundings. This proposal would institute a demonstration pilot for a peer-to-peer Legacy of Care Mentorship Program within home care service provider agencies statewide, in which seasoned home care staff would mentor newly hired staff over a six-month period, with the aim of boosting retention rates and enhancing job satisfaction.

1. Newly hired home care staff members would be paired with experienced mentors within the first week of their employment. Agencies would choose mentors from existing staff and the program would provide guidance on the traits of successful mentors.
2. The mentorship program would encompass regular biweekly check-ins, hands-on training sessions, and constructive feedback loops. Mentors would meet weekly with their mentor manager to review progress, discuss issues, and receive additional guidance and/or training when needed. Mentors would be provided with training to equip them with mentoring skills and knowledge about effective communication.
3. Mentors would be paid a stipend (or improved hourly rate) to compensate them for their new responsibilities. As such, and to create role stability, Mentors would be afforded eight hours of time per week to participate in the program and to offer mentorship to mentees.
4. The effectiveness of the proposed Legacy of Care Mentorship program would be examined to identify best practices to streamline future implementation.

MPA Council Commentary: *This proposal is categorized as near term. Proposed first steps for implementation could include establishing a new pilot program through the Center for Home and Community-Based Services within the Office of Aging and Long*

Term Care at the Department of Health. Proposed metrics for evaluating implementation success could include staffing turnover rate at participating home care service provider agencies. Funding allocations would be subject to the annual budget process and the availability of resources.

Proposal Presented for the Master Plan for Aging (#54):
Support for Nursing Educators

Summary: Increase the number of nurse educators – school faculty and clinical preceptors – in NYS by expanding scholarship and loan forgiveness programs, consideration of tax incentives for those serving as clinical nurse preceptors and facilitating private-educational partnerships that would offer joint appointments for clinical educators/faculty.

Justification: New York's nursing workforce lacks sufficient age-friendly and geriatric expertise and education. A reason for the reduced numbers of nurses with geriatric expertise is that clinical nursing education opportunities and student capacity are limited due to faculty shortages, due in part, to reduced salaries for the critical educator positions. Scholarships, loan forgiveness opportunities, tax incentives, and private-educational partnerships which offer joint appointments for nurse educators may incentivize improved nursing education, therefore addressing the workforce crisis.

Full Proposal:
Increase the number of nurse educators – school faculty and clinical preceptors – in NYS to ensure the nursing pipeline is robust. Achieve this by:

1. Providing scholarships and loan forgiveness with service obligations for prospective nursing faculty at all education levels, including new eligibility for faculty in Licensed Practical Nurse (LPN) programs, through an expansion of eligibility and an increase in financial awards for the NYS Patricia McGee Nursing Faculty Scholarship Program and the NYS Nursing Faculty Loan Forgiveness (NFLF) Incentive Program.
2. Providing tax incentives for individuals who serve as nurse clinical preceptors in settings that serve older adults and individuals with disabilities requiring LTSS, supporting educational institutions by facilitating private-educational partnerships that would offer joint appointments for clinical educators/faculty, or by establishing a New York State-specific Graduate Nurse Education demonstration project, similar to the federal program, that would partner health care institutions with training programs and support the costs of training and preceptors at clinical sites.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action to incorporate additional nursing titles (if needed) into existing loan forgiveness programs including the New York State Nurses Across New York (NANY) initiative. In addition, further review would be needed to assess the operational and administrative feasibility as well as the fiscal implications of this proposal. Any funding needs would be subject to the annual budget process and availability of resources.*

Proposal Presented for the Master Plan for Aging (#63):
Establish Caregiver Coordinating Commission

Summary: Establish a Governor-Appointed Caregiver Coordinating Commission (Commission) in state law to coordinate statewide planning, development, and implementation of caregiver support services for informal family caregivers. This Commission will incorporate caregiver feedback, conduct analyses of respite programs and review best practices, as well as develop an annual report.

Justification: Caregivers play a crucial role in the lives of older adults but often face obstacles to providing care. The state should establish a Caregiving Coordinating Commission to uplift the important voices of caregivers while also prioritizing cross-sector collaboration to create meaningful change via policies, services, and supports that benefit the well-being of older adults and their caregivers.

Full Proposal:
Establish a Governor-Appointed Caregiver Coordinating Commission led by NYSOFA into state law. The Caregiver Coordinating Commission will coordinate statewide planning, development, and implementation of caregiver support services, including respite care, for informal family caregivers caring for those across the lifespan. The Commission will be charged with:

1. Gathering caregiver feedback and concerns using various approaches and disseminating relevant information about available services, including respite care.
2. Exploring and analyzing effective respite care programs in other states.
3. Creating a caregiver support model consisting of best practices in New York and other states.
4. Providing an ongoing analysis of best practices, including informal caregiver support programs in New York and other states and programs that support caregivers in the workplace.
5. Coordinating activities of existing and proposed informal caregiver support services among State and local units.
6. Continually researching funding opportunities and working with Commission members if the opportunity requires a government applicant.
7. Determining unmet needs and funding priorities.
8. Monitoring and implementing the Commission's recommendations.
9. Providing an annual policy review.
10. Annual strategic planning.
11. Submitting an annual report for the governor.

MPA Council Commentary: *This proposal is categorized as near term. Proposed evaluation metrics include analysis of improved coordination of caregiver supports. This proposal would require funding resources that would need to be considered through the annual State budget process and would be subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#79):
Funding the NYSCRC

Summary: Fund the NYS Caregiving and Respite Coalition (NYSCRC) in order to focus on advocacy, networking, public education, caregiver training, increasing access to respite, and assisting family caregivers in accessing respite care services.

Justification: The NYSCRC has demonstrated success in ensuring respite services that provide necessary relief to caregivers and unnecessary institutionalization for those receiving care. Establishing the NYSCRC as a state-funded initiative will further expand accessibility to respite services and strengthen best practices to meet the dynamic needs of those receiving respite services.

Full Proposal:
Fund the NYSCRC to establish the program as a new state initiative to ensure permanence, strength, future funding opportunities, and the furtherance of its mission. To support all people involved in caregiving and its commitment to quality and accessible respite for all. NYSCRC is an integral part of the New York Lifespan Respite Care System and is a strong collaborative partner. The initiative will ensure NYSCRC supports and strengthens the caregiver network programs with training and technical assistance, innovative approaches to the use of evidence-based approaches for meeting caregiver needs and provides respite services. The success of the initiative will be monitored utilizing data analysis for grant funding, analysis of post-respite program surveys, and include progress reports for outcome results.

1. Fund the NYSCRC to establish the program as a New York State initiative, whose activities focus on advocacy, networking, public education, caregiver training, increasing access to respite, and assisting family caregivers in accessing respite care services.

MPA Council Commentary: *This proposal is categorized as near term. Funding decisions are made in the context of the annual budget process and are subject to the availability of resources. Proposed first steps for implementation could include engagement with the NYSCRC on incorporation into the development of aging and long-term care policy for New York State. Next steps could include identifying grant opportunities to support the program's work with older New Yorkers. Proposed metrics for evaluation would include an analysis of grant funding, access to respite care services, and staffing needs.*

Proposal Presented for the Master Plan for Aging (#29):
Require Alzheimer's Disease and Dementia Care Training

Summary: Improve Alzheimer's disease and dementia care by requiring applicable training for nursing home and assisted living staff. This proposal also includes a series of measures to improve available training in dementia care.

Justification: Cognitive impairment is often misunderstood by health care professionals serving older adults and people with disabilities. Alzheimer's and dementia training would increase awareness among the health care workforce and improve the ability of providers to deliver more comprehensive care and informed detection for those struggling with cognitive impairment. In turn, those facing cognitive impairment will be able to receive the interventions necessary at an earlier point in time, improving quality of life for themselves and their caregivers.

Full Proposal:
To improve detection, diagnosis, treatment, and management for individuals with cognitive impairment, and support prevention and excess disability associated with cognitive decline through the life course, a brain health and dementia-capable workforce must be developed:

1. Require that all nursing home and assisted living staff receive specific training in dementia care practices, such as the opportunities recommended by the Alzheimer's Association that apply to all settings and opportunities that are competency based and training tracked by the Department of Health.
    a. Ensure that training credentials are stackable to prevent barriers to entering the workforce.
2. Leverage and add to the federal Building Our Largest Dementia (BOLD) infrastructure funding currently with the NYS Department of Health Alzheimer's Disease Program and the existing structure of the NYS Centers of Excellence for Alzheimer's Disease (CEAD) and Alzheimer's Disease Community Assistance Program (AlzCap).
3. Implement, expand, and disseminate the use of evidence-based practice inclusive of assessment and evaluation, approaches to connect persons living with dementia and their care partners to community supports and services.
4. Include and promote opportunities for formal accredited training or certification for clinicians and direct care workforce to improve brain health across the life course.
5. Elevate the importance of a dementia-capable workforce at the federal level, aligned with existing federal initiatives and momentum. New York's advocacy promotes the State's leadership in cognitive health care.
6. Develop population health strategies to encourage health care systems and organizations to implement early detection strategies into care processes, particularly those serving underserved regions of NYS.
7. Use evidence-informed training embedded in health systems integrated with

community-based organizations across the state.

8. Continue to support funding that is directed toward brain health initiatives and dementia-capable workforce development.
9. Promote care models that provide an interdisciplinary approach to the early detection, diagnosis, and care of cognitive decline, and the management of chronic diseases that impact brain health.
10. Integrate and adopt training regarding early detection and diagnosis.
11. Focus on whole-person care by promoting the benefits and importance of early detection and diagnosis so families can manage the disease process.
12. Encourage a comprehensive approach combining psychosocial and medical approaches, including use of medications as appropriate, preparing for next stages in the disease course, and ensuring the existence of an Age-Friendly workforce.
13. Address the impacts of cognitive impairment and ensure attention to the challenges in capturing what matters most to the patient/person through the disease course.
14. Include examination of best ways to reimburse for integrated care that supports high-quality brain health.

Notes: Portions of this proposal have been adopted.

MPA Council Commentary: *Components 3, 7, 9, 10, 11, 12, and 13 of this proposal are currently being implemented at the Department of Health. The Office of Aging and Long Term Care's Alzheimer's Disease program continues to engage in its goals of enhancing access to early screening and diagnosis of dementia, expanding the expertise of the health care workforce, and providing access to community-based services for individuals with dementia and their care partners. Area Agencies on Aging (AAAs) continue to provide a range of services that support caregivers, provide training, and aid in early detection of cognitive decline. The Department of Health has acquired BOLD funding and is leveraging it for Alzheimer's Disease programming. The Department of Health is also engaged in the work of making health care across the state Age-Friendly. Component 1, the stackable training credentials and reimbursement for integrated care, is categorized as long-term due to administrative complexity. Continued metrics for evaluation include, but are not limited to, the number of patients diagnosed with a dementia, number of health care professionals trained, and the number of community supports and services accessed by care partners.*

Proposal Presented for the Master Plan for Aging (#36):
Increase Advertising to Recruit More Caregivers

Summary: Consider budgetary actions that would enhance current activities under Workforce Investment Organization (WIO) funding and related programming for the recruitment and retention of health care workers.

Justification: To address the health care and caregiver work shortage that is having adverse effects on the provision of quality care, New York State should revive the previously successful Caring Gene campaign. In the age of digital media, this relatively low-cost investment targeting those with a passion for giving back will increase awareness and interest in caregiving careers that serve older adults and people with disabilities.

Full Proposal:

1. Continue State investment in the successful Caring Gene program which was created through previous WIO funding by The Iroquois Health care Association (IHA), a trade association representing over 50 hospitals and long-term care organizations in upstate New York.
2. This program focused on recruitment and retention of health care workers with state funding made available in previous years. Materials needed for multimedia have already been created and are ready to go with additional investment.
3. The Caring Gene mission is to educate and recruit care industry workers who possess an intrinsic desire to care for others. Their services empower employers to fill open positions with “Caring Gene® Qualified” candidates seeking to make a positive difference where they work. In addition, the campaign seeks to professionalize entry-level positions in this component of the workforce.
4. This statewide recruitment program aimed to grow the workforce by marketing positions in the long-term care sector (CNAs, HHAs, PCAs, and other support positions) to people in lower-paying service jobs or unemployed. Print, video, radio, and digital advertisements were broadcast across New York State to direct job seekers to the Caring Gene website which hosts educational information about types of jobs available in health care and associated training requirements as well as job openings in hospitals and long-term care organizations throughout New York State. The website remains but there is currently no funding for new media buys to direct prospective workers to it.
5. Include recruitment outreach to immigrants and refugees, particularly through the DOS’ Office for New Americans.

MPA Council Commentary: *This proposal is categorized as near term. Funding decisions are made in the context of the annual budget process and the availability of resources. Proposed first steps for implementation could include an assessment of State investment and savings associated with the campaign. Proposed metrics for evaluating implementation success could include staffing recruitment rates.*

Proposal Presented for the Master Plan for Aging (#42):
Statewide Caregiver Engagement Campaign

Summary: Expand the Any Care Counts – NY (ACC-NY) campaign statewide to include the development of engagement kits, training on community access points for obtaining education, and a website for continued engagement of the caregiving population.

Justification: There is a huge disconnect between caregivers and the available resources from which they could benefit, contributing to a lack of caregivers who are able to self-identify. Providing a unified approach to caregiver education, including social media campaigns, community engagement tool kits, and using the storytelling process will allow for an increase in caregiver engagement and better supported caregivers.

Full Proposal:
Expand the ACC-NY campaign statewide. ACC-NY is an existing public/private partnership between NYSOFA and ARCHANGELS (with funding from additional sources such as the Ralph C. Wilson Jr. Foundation and the Association on Aging-NY) that aligns with the proposal for an awareness campaign as outlined in the 2022 National Strategy to Support Family Caregivers via the Recognize, Assist, Include, Support, and Engage (RAISE) Act. Specifically, it is recommended that the expansion of Any Care Counts-NY include the following activities:

1. Continue the ARCHANGELS ACC-NY social media campaign across the state – targeted at unpaid caregivers (anyone caring for a family member, friend, or neighbor). Depending on the channel, up to 10%-40% of caregivers who find out if they are 'in the red', 'yellow' or 'green' through the Caregiver Intensity IndexTM (CII) (ARCHANGELS' proprietary caregiver validation tool) explore resources designed to reduce the intensity, such as those funded by NY State. Caregivers who are engaged by Any Care Counts initiatives and know their own Caregiver Intensity Score engage at significantly higher rates (ranging from 25%-98% increase in engagement in resources). Engage ARCHANGELS to customize and maintain (quarterly updates) its ACC-NY engagement kit to provide each local AAA with content to engage local partners in reaching caregivers in the community.
2. Engage ARCHANGELS to create an engagement kit for community access points including faith-based organizations, health care organizations, retail establishments, and other community hubs.
3. Engage ARCHANGELS to customize and maintain (quarterly updates) its ACC-NY engagement kit to provide all employers in NY state with engagement content by channel, including emails to employees, intranet content, 'Care Cards' to distribute to onsite employees, and website content for each employer.
4. Engage ARCHANGELS to customize and maintain (quarterly updates) its ACC-

NY engagement kit to provide all employers in NY state with engagement content by channel, including emails to employees, intranet content, ‘Care Cards’ to distribute to onsite employees, and website content for each employer.

5. Engage PR and communications partners to create a story gathering and storytelling process as part of statewide awareness activities (e.g., media outreach; publication/media content creation) that will be distributed by the Association on Aging-NY and ARCHANGELS through an ACC-NY story and insights platform maintained by ARCHANGELS.

MPA Council Commentary: *This proposal is categorized as near term. Expansion of the* ACC-NY *partnership may require State funding which would be subject to the annual budget process and the availability of resources. Additional engagement of ARCHANGELS for the development of new materials may require issuance of a Request for Proposals (RFP).*

Proposal Presented for the Master Plan for Aging (#37):
Workforce Development Center for Professional Development in Gerontological and Geriatric Education

Summary: Create a pilot program for schools with an active aging program or specialization in place and create a workforce development center for professional development in gerontological education. This program would include the development of relevant, aging-focused curricula, and it would track learning opportunities, and strive to expand the program into other interested schools.

Justification: There is a lack of age-friendly and geriatric expertise and education among professionals, which contributes to a significant lack of professionals available to work with the population. This is due in part to a lack of curricula relevant to serving older adults. The creation of a pilot program for aging specialization programs and a workforce development center should improve education and awareness about serving older adults, thereby improving the availability of professionals with experience in meeting their needs.

Full Proposal:
Create a PILOT program for schools who already have an aging program or specialization in place. In years 1 & 2, start with schools that already offer substantial aging curriculum (i.e., at least one practice course focused on working with older people and an identified faculty interested in participating).

1. During the first 2 years, track and benchmark learning opportunities for continued expansion while exploring other schools' interest in participation. Use the final year to expand the program to identified additional schools able to participate.
2. The curriculum would be collaboratively developed by the identified faculty and Project Directors (the curriculum team), using their expertise in identified specialty topics such as primary care, specialty medicine (i.e., infectious disease, nephrology, etc.), trauma-informed practice, sexual health, healthy aging, aging in place, end-of-life and palliative care, serving diverse populations, etc.).
3. The curriculum team would identify areas that are most relevant to working with older adults currently, and/or represent emerging and evidenced-based practices, and create a suggested syllabus template for an advanced-year practice class in the field of aging.
4. Create a workforce development center for Professional Development in Gerontological/Geriatric education funded by multiple state agencies and supported by public/private partnerships to engage emerging professionals.
5. The workforce development center would provide a base to recruit and coordinate schools, provide incentive awards for students, provide faculty honoraria to teach courses and hold seminars, collect performance data regarding implementation and outcomes, hold schools accountable, utilize opportunities offered by the 1115 Medicaid workforce initiatives, and collaborate with Workforce Investment Organizations, and identify and develop additional educational and training resources.

6. Set forth the agreement with the schools for the identification of a faculty project director to participate in the development, implementation, and coordination of the project, offer an aging-focused course at least once per year based on the project syllabus template, recruit students to participate in the project, and identify and develop possible internships for students to reflect innovative approaches and a breadth of aging services and learning opportunities which may lead to employment opportunities.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action. Implementation would also likely require the issuance of a Request for Proposals. Any funding associated with supporting the proposed center would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#45):
Develop a Caregiving Toolkit

Summary: Create a caregiving tool kit that promotes caregiver services and supports for leadership of nonprofits, community organizations, and faith-based organizations. This proposal includes collaboration with the Office of Faith and Non-Profit Development Services to disseminate the tool kit, build on the faith-based respite network, engage with the faith-based registry, and expand direct caregiver services delivered by volunteers.

Justification: Due to a lack of respite care providers, there is a heavy reliance on private volunteers to provide support to caregivers. Faith-based communities are well-positioned to help address some of the biggest challenges facing New Yorkers, including the residual impacts of the COVID-19 pandemic such as economic insecurity, adverse mental health conditions, increasing rates of hate crimes and social division, unaffordable housing, and job insecurity. Many New Yorkers are unaware of the resources and services available to them and often do not self-identify as a caregiver. Promoting and engaging caregiver services and supports will help increase self-identification.

Full Proposal:
Create a caregiving tool kit that promotes caregiver services and supports for leadership of nonprofits, community organizations, and faith-based organizations. Proactively assist organizations in implementing the use and dissemination of these resources in collaboration with the Office of Faith and Non-Profit Development Services. This will help increase self-identification and expansion of programs, particularly in under-resourced/marginalized communities. Activities will include, but are not limited to:

1. Recognizing, educating, and partnering with faith-based organizations to build upon the existing faith-based respite network using volunteer-based models, expanding respite services statewide.
2. Engaging the statewide faith-based registry that is managed by the Department of Health. Exploration of current program models that can be replicated (tools, resources, letter templates, etc.).
3. Direct caregiver services, such as caregiver coaching and/or respite care, using volunteers to deliver the service.
4. Growing the peer-to-peer support model.

MPA Council Commentary: *This proposal is categorized as near term and is currently being implemented. The Department of Health is updating its caregiver guide, in consultation with the State Office for the Aging, to integrate the resources documented in separate caregiver guides developed by each agency. Proposed metrics for evaluating implementation success could include utilization of services referenced in the combined guide.*

Proposal Presented for the Master Plan for Aging (#53):
Assess Appropriate Respite Care and Social Adult Day Services Wages

Summary: Through budgetary and regulatory actions, as well as advocacy to the federal government, improve wages received by Respite and Social Adult Services employees.

Justification: The adequacy of respite and social adult day care workers should be reviewed for the possibility of increases to improve quality of care, reduce turnover rates, enhance job satisfaction, and contribute to the professionalization of the field. Fair pay attracts skilled and dedicated caregivers, ensuring high-quality care for clients. Competitive wages attract new talent and improve continuity of care. Raising wages also stimulates local economies, as caregivers spend their earnings on goods and services, benefiting communities.

Full Proposal:
Improve access and utilization of Respite and Social Adult Services by improving wages received by employees delivering these services:

1. Ensure funding for the AAA network, which utilizes the same licensed home care entities for non-Medicaid home care services, so the network can pay wages sufficient in comparison to home care rates.
2. Assess and adjust adequacy of respite care and social adult day service wages to reflect current practices and costs of providing the service, particularly as the need for services to support people to remain in their homes will grow.
3. Urge the federal government to address the Federal Wage Index which disadvantages non hospital Medicare providers.

MPA Council Commentary: *This proposal is categorized as long-term. Governor Hochul has made a commitment to affordability in New York, reinforced most recently by the state's first-ever inflation rebates included in the FY26 Enacted Budget. As part of this commitment, the FY24 Enacted Budget made a historic multiyear commitment to index the minimum wage to inflation. Any next steps on this proposal should include an evaluation of access to, quality of, and demand for Social Adult and respite care services across the state, in order to inform potential investments. Any such investments would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#40):
Antidiscrimination of Caregivers in the Workplace

Summary: Produce a model working caregiver education training program to inform working informal caregivers of their rights and resources in the workplace. This proposal also includes a call to prohibit discrimination based on caregiver status.

Justification: Informal caregivers who maintain employment face challenges accessing health care, supportive services, and knowledge about their rights as a caregiver. Caregiver education will allow working caregivers to better understand and access the resources available to them, ultimately leading to better care and improved health outcomes for caregivers and their loved ones.

Full Proposal:
Consult with the Division of Human Rights and produce a model working caregiver education training program to inform working informal caregivers of their rights and resources in the workplace.

1. Amend Section 292 and 296 of the Executive Law, to prohibit employers from discriminating against individuals based on such individual's status as a caregiver.
2. Develop and distribute educational materials for the general public and update of government media (by DOL, DHR, Office of the Attorney General (OAG), and NYSOFA) to include information about the new legal protection.
3. Collect data on complaints and inquiries based on the new legal protection.
4. Conduct research on the granting of reasonable accommodations under the new law.
5. Collect data on the employment rate vs. the unemployment rate, and also the current employment status of informal caregivers.

MPA Council Commentary: *This proposal is categorized as long-term. A formal review of the impact of different approaches to this type of nondiscrimination protection, and particularly the experience with such protections in New York City, may be necessary to identify the most effective way to create the intended protections.*

Proposal Presented for the Master Plan for Aging (#43):
Education of Informal Caregivers in the Workplace

Summary: Improve education of informal caregivers in the workplace by requiring workplace training on caregiving and caregiver rights. This proposal also includes recommendations to produce a model working caregiver education training program.

Justification: More than half of the U.S. labor force has caregiving responsibilities outside of work, and many do not have access to necessary resources or knowledge to inform them of their rights as a caregiver. Educating caregivers, particularly the "sandwich generation," or those who care for both their children and older loved ones and report higher levels of emotional and financial strain, would allow them to better serve their loved ones and improve overall well-being and service attainment for both parties.

Full Proposal:
More than half of the U.S. labor force has caregiving responsibilities outside of work, and according to federal data, some 37 million Americans can spend an average of nearly four hours a day caring for an older adult. According to AARP,[2] workers in the sandwich generation report even higher levels of emotional and financial strain. Throughout NYS, there are a lack of services and supports for historically marginalized and underserved communities, disproportionally affected communities, including rural communities, youth caregivers, kinship caregivers, caregivers in the sandwich generation who are caring for an older adult, loved one, and/or child, individuals with substance use disorder, behavioral health issues, serious and persistent mental illness, caregivers caring for individuals with developmental disabilities, individuals that cannot qualify for Medicaid, caregivers who are partners but don't have legal status as a spouse, and all New Yorkers (via state budgets, tax revenues, and community impacts).

1. Amend the Labor Law to require workplace training on caregiving, caregiver rights and resources, stress reduction, and other topics, as well as require businesses to post information on caregiver rights and access to resources.
2. Consult with the Division of Human Rights and produce a model working caregiver education training program to inform working informal caregivers of their rights and resources in the workplace.
3. Require every employer in the state with more than 50 full-time-equivalent employees to display the information created pursuant to this proposal in a conspicuous place accessible to employees in the workplace. The information will be translated and made available in the top 12 most commonly spoken non-English languages in NYS, as required per state language access law, § 202-a. Language translation services.

MPA Council Commentary: *Components 1 and 3 of this proposal are categorized as long-term due to administrative complexity and necessary statutory changes. Elements*

[2] Caldera, S. (2023, December). *A Closer Look at Sandwich Generation Caregivers of Medicare Beneficiaries*. AARP. https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/closer-look-sandwich-generation-caregivers-of-medicare-beneficiaries.doi.10.26419-2fppi.00215.001.pdf

of component 1 are currently being implemented by the NYSOFA and DOL through a public-private partnership to survey businesses and employees and provide a guide to best practices for supporting working caregivers. Component 2 of this proposal is categorized as near-term. Proposed first steps for implementation could include an expansion of the existing employee caregiver guide and a partnership between applicable state agency partners. The State offers many benefits for working caregivers that could be promoted through this initiative, including Family Care, a program through which eligible employees can use Paid Family Leave, in certain situations, to care for a close family member such as a parent or grandparent. Proposed metrics for evaluating implementation success could include improved knowledge of caregiver resources.

Proposal Presented for the Master Plan for Aging (#67):
Person-Centered Service Delivery Direct Care Workforce Training

Summary: Revise assessment, care planning, and direct care worker training infrastructure to reflect person-centered principles. Adjustments will include convening experts to identify the comprehensive needs of long-term care service recipients, engaging local authorities and resources, and updating assessment tools to consider inclusivity and psychosocial needs.

Justification: The scope of practice for the direct care workforce is based on a medical model rather than being person-centered with a focus on the psychosocial needs of consumers. However, person-centered services are critical to enhancing quality of life for consumers of long-term care services. To promote person-centered services, the State must adequately prepare and empower direct care workers utilizing a training infrastructure which emphasizes psychosocial needs and prevention best practices. Integrating social determinants of health and cultural competency into the revised assessment system will ensure that all consumer needs are addressed and will allow consumers to move across the continuum of care without issue. Overall, these actions will improve health outcomes through the promotion of health equity and enable direct care workers to provide enhanced care.

Full Proposal:
To promote the delivery of person-centered, equitable services and supports that encourage health, quality of life, and community engagement while also adequately preparing and empowering direct care workers, the State would establish a revised assessment, care planning, and direct care worker training infrastructure emphasizing psychosocial needs of consumers and underlining prevention services.

1. Convene industry experts and consumers and/or their representatives across all settings and populations to identify the current and full needs (clinical, psychosocial, safety, other) of those receiving long-term care services.
2. Engage the range of state, local, and private sector agencies in addition to community-based organizations to contribute to a plan for meeting consumers where they are and maximize (both cost and programmatic) efficiency in providing person-centered services.
3. Revise the current assessment system to reflect person-centered principles and identify all aspects of nonclinical (including psychosocial/Social Determinants of Health) needs of everyone applying for services. Further, implement a universal system that is implemented and facilitates movement across settings and is independent of payment stream.
4. Conduct a review of the revised assessment tool and process to ensure full inclusivity – including language access, cultural competence, and potential biases.

MPA Council Commentary: *This proposal is categorized as long-term. Components of*

this proposal are currently being implemented on an ongoing basis. Relevant State agencies could take further steps to continuously evaluate the comprehensive needs of older adults and engage appropriate stakeholders to identify opportunities for integration of care management to advance person-centered care principles.

Proposal Presented for the Master Plan for Aging (#35):
Support Immigration Reform to Expand the Paid Caregiver Workforce

Summary: Expand the paid caregiver workforce through immigration reform by amending the Immigration and Nationality Act (INA) to recapture unused permanent employment-based visas to fill health care workforce shortages. Modifications include classifying direct care professions as Schedule A shortage occupations, creating a temporary work visa for low-skill workers, and establishing a legalization program for qualifying foreign-born workers.

Justification: With immigration reform, the direct care workforce shortage may be mitigated by permitting immigrants to the United States to assume available jobs. This proposal is for NYS to advocate for Congress to make changes to the visa program such as reserving permanent employment-based visas for direct care workers, creating temporary work visas for low-skill health workers, modifying the au pair program to include caregiving roles for older adults, and classifying direct care professions as Schedule A shortage occupations for at least five fiscal years.

Full Proposal:
Expand the paid caregiver workforce through immigration reform. Congress should amend the INA to recapture permanent employment-based visas (i.e., green cards) previously unused for FY1992 through FY2021 to increase the number of employment-based visas, up to 65,000 visas, available for FY2024 or any subsequent fiscal year to fill health care workforce shortages.

1. Congress should reserve 25,000 of these visas for direct care workers. Congress should not count visas for certain family members to accompany the principal beneficiary of these permanent employment-based visas against the 65,000 cap. New York State should work with our federal delegation to champion the following incremental immigration reform proposals from the Bipartisan Policy Center (BPC) and ensure that NYS is prepared to take advantage of the programs once implemented.
2. Congress should direct the US Labor Department to classify direct care professions as Schedule A shortage occupations for at least five fiscal years, allowing streamlined and simplified visa processing. The State Department should modify the J-1 Visa Exchange Visitor Program's au pair category to increase cultural exchange opportunities while also allowing eligible migrants to legally work in caregiving roles for older adults. Furthermore, it is recommended that the State Department establish distinct training requirements for J-1 au pair recipients who are working with older adults.
3. Congress should amend the INA to create a temporary work visa for low-skill health care workers. The new visa classification would be valid for four years and would be limited to 15,000 visas per fiscal year from FY2025 to FY2027. From FY2028 to FY2030, the cap on the number of visas should be reviewed based on the National Health Care Workforce Commission's evaluation of the direct care

workforce.

4. Congress should establish a legalization program for qualifying foreign-born workers who will help relieve the country's direct care workforce shortage. This program should be available to eligible foreign-born workers who currently reside in the United States and should provide them with the proper authorization to legally remain in the country, work, and pay taxes. Congress should appropriate additional resources to the US Labor Department, United States Citizenship and Immigration Services (USCIS), and other agencies involved in immigration processing to implement the recommended policy reforms.
5. The State will include NYS Department of State's (DOS) Office for New Americans in implementing and communicating any such reforms.

MPA Council Commentary: *This proposal is categorized as long-term. New York State looks forward to discussing changes to federal policy with our federal government representatives.*

II. Modernization and Financial Sustainability of Health care, Residential Facilities and Community-Based Aging Network Service Providers

Proposal Presented for the Master Plan for Aging (#50):
Fund Aging Services

Summary: Increase funding for the network of community-based aging services provided through Area Agencies on Aging (AAA). Such funding could include expanding access to capital programs (such as Statewide funding opportunities) and other ongoing State resources for community-based services, seeking support from Medicaid or other insurers, and exploring innovative financing programs (i.e., social impact bonds) to ensure that all New Yorkers can age in their community of choice.

Justification: New York State's community services are underfunded, hindering their ability to meet the existing and emerging needs of older adults, individuals who are fragile, individuals in need of nursing home care, and those needing primary prevention. The State could reduce costs by expanding home care services and reducing utilization of more costly nursing home care The approximately 98,000 people in Nursing Homes in New York present a particular opportunity to evaluate their needs and preferences, and follow Olmstead principles to examine whether a shift to community-based settings is appropriate.[3]

Full Proposal:
Fund the network of community-based services to ensure that all New Yorkers can age in their community of choice with the necessary community supports. This could be accomplished through advocating for more state dollars and federal funding, designating a focus on community long-term care providers for future "transformations" (VI and up) of the Statewide Health Care Facility Transformation Program and increasing resources for community-based services reforms to enable community-based service providers to obtain funding from Medicaid, Medicare, and private insurers. Exploration of Social Impact Bonds, Tax Credit Financing and public long-term care insurance would also help. This could be accomplished over multiple phases starting upon adoption and spanning 5-10 years.
Funding could specifically be deployed to AAAs for the following purposes:

1. $35 million allocated to:
    a. Reduce waiting lists.
    b. Enhance the home care rate for personal care I and II.
    c. Expand personal care and case management.
    d. Provide additional transportation support.
    e. Combat social isolation.
    f. Increase access to social model adult day services so caregivers are able to have meaningful employment.
    g. Expand health and wellness services and evidenced-based interventions.
    h. Other locally determined needs.
2. Invest in sustainable nutrition support - $43 million.
3. Invest in Aging Services network workforce - $20 million.
4. Expanding eligibility to younger-onset Alzheimer's and to age 50 for caregiver

[3] Internal Department of Health Data

and respite support – $26 million
5. Provide annual appropriation for technology access - $5 million.
6. Provide annual appropriation for New York's Lifespan Respite Care Programs - $1 million
7. Provide annual appropriation for elder abuse education and outreach - $3 million.
8. Provide increased funding for the New York State Health Insurance Program (SHIP), known in New York as the Health Insurance Information, Counseling, and Assistance Program (HIICAP) - $5.5 million
9. Provide an increase in funding for state legal assistance programs - $3 million.
10. Provide an increase in funding for the long-term care ombudsman program - $10 million.
11. Provide an annual appropriation for Aging and Disability Resource Centers - $20 million.
12. Provide reskilling and training for older individuals who wish to return to employment - $2 million.

MPA Council Commentary: *This proposal is categorized as near-term. Components of this proposal are being implemented, including $45 million invested in Governor Hochul's FY26 Enacted Budget to reduce the number of older adults waiting for nonmedical in-home services provided through the State Office for the Aging (similar to Component 1). The Department of Health and the State Office for the Aging have discussed licensing options for the network of community-based service providers as well as innovative financing programs for aging and long-term care services and supports. Funding components of the proposal would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#49):
Medicaid Rate Reform

Summary: Consider reforms to Medicaid reimbursement across long-term service and support providers, including facility-and-home-based providers, through examination and adjustments to SSI/SSP, rate methodology, and episodic payment system policies.

Justification: Many providers who are reliant on Medicaid reimbursement are facing financial distress. Current Medicaid rates may be based on outdated methodologies and may be insufficient to fully cover these providers' costs. Accessing capital for renovation and construction is difficult, but the renovations are necessary to support and improve quality of life for the residents.

Full Proposal:
Preserve the availability of facility-based long-term care in the following ways:

1. Implement Medicaid and Supplemental Security Income/State Supplement Program (SSI/SSP) reimbursement systems, including for skilled nursing facilities (SNFs) and assisted living programs (ALPs), which cover actual provider costs adjusted for inflation, and include targeted adjustments aimed at addressing the higher costs of serving individuals with specialized needs. Examples include: individuals with dementia and other neurobehavioral conditions, mental illness, substance use disorders, intellectual/developmental disabilities, and medically fragile young adults. This should include incorporating incentives to promote desired outcomes.
2. Update the Medicaid rate methodology to include:
    a. Use of the Patient Driven Payment Model (PDPM) for acuity adjustment, rate development and Medicare Upper Payment Limit calculations.
    b. Continuation of the current historical cost model for capital reimbursement with updated per bed construction caps; as well as reimbursement for investments in older buildings currently not reimbursed.
    c. Updated cost base, Wage Equalization Factor (WEF) adjustments and prices, with periodic (i.e., every 1-4 years) updates to all three elements.
    d. Continuation of existing peer groups; with consideration given to creating an additional peer group for small facilities.
    e. Minimum overall system base funding equivalent to 95 percent of total updated reimbursable costs plus the cost of the Nursing Home Quality Initiative program (which should be state funded) and reimbursement for the provider tax.
3. Enhance assisted living program and nursing home Medicaid rates with bridge funding in the budget and include an annual inflation adjustment.
4. Assess LHCSA reimbursement via benchmarking through a transparent stakeholder process to determine provider costs and establish regional hourly benchmark reimbursement rates for Medicaid Managed Care, which would be updated annually. NYS may require payment of these rates or continue with negotiated rates, but such rates shall correspond to the actual cost of care

delivery.

5. Assess Medicaid certified home health agency (CHHA) fee for service rates and update Episodic Payment System with adjustments needed to ensure sustainability of home health agencies and that support agencies' abilities in staffing, training, care management and operations necessary to meet community need. Managed care plans operating in NYS including Essential Plans and Medicaid managed care plans should be examined for alignment.

MPA Council Commentary: *This proposal is categorized as long-term. Decisions about reimbursement of Medicaid services can have significant fiscal implications for the State and happen in the context of the annual budget process and the Medicaid Global Spending Cap and are subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#57):
Interagency Integration of Social and Health care Services

Summary: Establish an interagency office to develop a plan to fully integrate social and health care services for New Yorkers of all ages based on research and available data on positive outcomes. In cross-sector partnerships, state agency members will develop shared goals to assess the effects of ageism and foster sustainable health and social care alignment.

Justification: A focus on "whole person" health has been increasing over the past decade. Recognizing that health outcomes are dependent on both medical and non-medicalized care, major national and international organizations have devoted years of research into the benefits and challenges of aligning public health, social services, and health care to address social determinants of health and to reduce health inequities. The importance of better aligned care for the older population has been recognized by the World Health Organization (WHO). An interagency integration of social and health care services will lead to health care savings and have positive impacts on the lives of older adults and people with disabilities. Cultivated partnerships, integrated health care, and collaboration of government, community and business communities would establish cross-sector alliances that effectively address issues of ageism, health and social care.

Full Proposal:
Establish an interagency office to develop a plan to fully integrate social and health care services for New Yorkers of all ages based on research and available data on positive outcomes.

1. The office would consist of members from the Department of Health including Office of Health Equity and Human Rights and the Statewide Health Information Network for New York; NYS Office for the Aging; County Offices on Aging; NYS Office of the Chief Disability Officer; OPWDD; OASAS; HCR; DOS and could also include other third party organizations (such as Social Care Networks under the Medicaid 1115 Waiver).
2. Members would form an alliance to create shared goals, prioritize cross-sector partnerships, address the effects of ageism, and foster the sustainability of health and social care alignment.
3. Key goals would include:
    a. Enabling organization and financing strategies for sustainable community-based organizations (CBO) network infrastructures.
    b. Developing core competencies for CBO networks.
    c. Encouraging widespread use of existing and proposed social care billing codes.
    d. Ensuring a streamlined contracting process between health systems, payors, and CBOs, which must include a broad-based payment methodology.

e. Ensuring common IT security and interoperability standards, safeguards, and system integrity.
f. Engaging and including planning, community development and building departments to enhance access to and coordination of services through community planning, design, zoning and building code enforcement.

MPA Council Commentary: *This proposal is categorized as long-term. As a proposal to create a new interagency office or body to assess policies and functions at different agencies, it is related to proposal 1, Establishing the Office of Benefits Coordination, and implementation of the two proposals would need to be coordinated. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action. Implementation of this proposal would also likely require additional resources; funding components of the proposal would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#59):
Support PACE Expansion and Enrollment

Summary: Consider regulatory, budget, and programmatic actions to increase Program of All-inclusive Care for the Elderly (PACE) enrollment by increasing accessibility and awareness of PACE.

Justification: PACE is a proven model for the provision of care and services to dually eligible older adults in the setting of their choice, ensuring improved equity to services without the need for long-term care facility placement. Implementing opportunities for PACE enrollment and program expansion may provide more older adults with the care they need without facility placement and its base capitation rates may provide the state with a Medicaid Return on Investment.

Full Proposal:
Implement initiatives to increase Program of All-inclusive Care for the Elderly (PACE) enrollment by increasing accessibility and awareness of PACE:

1. Align the eligibility determination timeline for HCBS with institutional care by developing a standardized, common, conflict-free process to make sure eligibility for Community-based long-term services and supports (CBLTSS) takes the same amount of time as for nursing home care.
2. Promote PACE as a care option during the hospital discharge planning process, within the Conflict Free Enrollment and Evaluation Center (NY Connects), and other “front doors.”
3. Allow PACE organizations to submit enrollments to Medicaid at any time of the month, instead of the current cutoff, which is the 20th of the month.
4. Ensure that PACE centers and related home care agencies are eligible for Statewide Health Care Facility Transformation grants.
5. Have regulations and the streamlined licensure process for PACE under Article 29-EE fully implemented by the final Master Plan on Aging report.

MPA Council Commentary: *To encourage growth of this innovative and successful approach to patient care, the Department of Health would work with the Public Health and Health Planning Council (PHHPC) and PACE industry associations on implementation. Funding components of the proposal would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#7):
Diversifying Long Term Care (LTC) Facility Services

Summary: Diversify long-term care facility services to encourage high quality and person-centered specialized clinical services. This includes expansion of Adult Care Facilities (ACF)/Assisted Living (AL) and Adult Day Care access and expansion of access to, and improved clinical expertise in, psychiatric, mental health, and behavioral health services for long-term services and supports providers.

Justification: Regulatory and programmatic barriers impede access to appropriate providers and person-centeredness in facility-based long-term services and support settings. This limits options for individuals needing LTSS and hinders their ability to optimize their quality of life as their needs change with age. The development of specific mechanisms, such as reviewing operating and payment regulations, expansion of the Expansion for Community Health care Outcomes (ECHO) model, and expansion of availability of specialized workforce training could improve high quality and person-centered specialized clinical services. The goal of this proposal is the elimination of complicated regulatory compliance regarding staffing to assist the diversification of services. The goal is to create an improved person-centered approach that will ensure high-quality and person-centered specialized clinical services are available to persons in long-term care facilities.

Full Proposal:
Develop mechanisms to allow and encourage the provision of high quality and person-centered specialized clinical services to individuals receiving services in facility-based LTSS settings:

1. Explore options to expand access to nursing services for ACF/AL residents.
2. Establish a Department of Health workgroup with stakeholders for issues of nursing within ACFs.
3. Review ACF/AL and Adult Day Health Care (ADHC) payment and operating regulations to ensure that they do not inhibit on-site visits by behavioral health providers (e.g., psychiatrists, psychiatric NPs, psychiatric social workers, substance used disorder treatment).
4. Allow co-location of services within all levels of facility-based LTSS care, including via a more flexible approach to the Home and Community Based Settings (HCBS) Rule [42 CFR Part 441].
5. Promote geriatric behavioral health services partnerships among behavioral health clinicians, hospitals, OMH- and OASAS-licensed providers, and long-term care providers. Expand programs focused on psychiatric needs to a variety of LTC settings. Examine the adequacy of capacity in behavioral intervention units and the extent to which individuals are being admitted in out-of-state facilities or facilities distant from home.
6. Identify and eliminate regulatory and payment barriers that prevent OMH- and OASAS-licensed providers from bringing services on-site to LTSS facilities.

7. Explore payment incentives to encourage these partnerships.
8. Develop a virtual grand rounds platform to connect facility-based LTSS providers with psychiatrists, social workers and family therapists experienced in the management of behavioral, mental, and cognitive health conditions (including PTSD, mental illness, substance use disorders, dementia with challenging behaviors, and developmental disabilities) to provide care consultation.
9. Expand the ECHO model – remote learning/collaboration model – to bring clinical expertise available in ECHO "hubs" to LTC providers. This is a potentially low-cost solution.
10. Expand the use of telehealth for behavioral health, especially in ACFs and Adult Day Health Care (ADHC), and update telehealth Dear Administrator Letter (DAL-DACF 23-27, DHCBS 23-04, and DNH 23-19).
11. Expand availability of specialized workforce training, technical assistance and supports in facility-based LTSS settings.
12. Leverage the Center for Excellence for Behavioral Health in Nursing Facilities – a SAMHSA-funded program.
13. Build an infrastructure for ongoing engagement among OMH, OPWDD, OASAS, and the Department of Health and stakeholders that allows for collaborative problem solving.
14. Conduct a 2-year post implementation evaluation to examine the impact of diversification on quality of care.
15. Develop a Department of Health workgroup to define quality as it relates to the proposed initiatives.

MPA Council Commentary: *This proposal may require an analysis of nursing home coverage across the state to review the availability of OMH providers with interest and experience working with older adults, existing resources, impact of offering these services, and existing service commitments. Components 4 and 9 of this proposal are categorized as long-term. Component 4 would require an assessment of existing federal rules and regulations. Component 9 may include the development of a new State Plan Amendment (SPA) to include Project ECHO GEMH as an education and consultation resource to nursing homes. Further specialization to add-on mental health services may also require an additional SPA and CMS approval. Components 5 and 10 of this proposal are currently being implemented by the Department of Health and state agency partners. The Department of Health could also provide forthcoming guidance to provide clarity regarding the expectations of Component 10. Funding components of the proposal would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#10):
Hospice and Palliative Care Support and Reform

Summary: Improve and preserve the quality and availability of hospice and palliative care. Recommendations include reestablishment of the Hospice and Palliative Care Education and Training Council, development of a Regulatory and Certificate of Need Task Force, funding for a stakeholder statewide coalition, offering an interdisciplinary palliative care benefit for qualifying Medicaid recipients regardless of location, and recognizing Physician Assistants as Hospice Attendings.

Justification: Preserving the quality and availability of hospice and palliative care services requires changes to service delivery, regulation interpretation, and increased knowledge about quality end-of-life services. New York State can better protect the dignity of its residents and improve access to quality end-of-life care by: improving awareness of In improving awareness of culturally and linguistically competent end of life care, improving certificate of need methodology, ensuring appropriate access to services, standardization, oversight, and funding, and ensuring alignment in regulatory and legislative interpretation.

Full Proposal:
Improve and preserve the quality and availability of hospice and palliative care by:

1. Reestablishing the Hospice and Palliative Care Education and Training Council, which would be responsible for reviewing professional training and educational curricula; represent the professions for feedback on curriculum impact and minimum standards for implementation within professions; determine the best method for implementing mandatory education as requirements for health care professional licensure renewal; benchmark utilization of current Medicare Advance Care Planning (ACP) physician billing and encourage expansion; discuss and develop proposals regarding Medicaid reimbursement rates for physician advance care planning conversations; consider claims-based quality metrics Advanced Care Planning codes, and provide input and proposals for improved interoperability of the Medical Orders for Life Sustaining Treatment (MOLST/eMOLST).
2. Creating a Hospice Regulatory and Certificate of Need Task Force within the Department of Health, charged with full review and related proposal for the Certificate of Need Application Process and Hospice Need Methodology. The Task Force should review proposal on hospice consumer safety about fraud, waste, and abuse, review consumer protection policies from other industries; develop a modern need methodology; consider increasing state surveys above the 3-year minimum; consider protections which may be needed within the state contracts to prevent the unbundling of hospice services; and evaluate other means of performance feedback for newly approved hospices. The Task Force should also consider supporting the adequacy of the provision of personal care services.

3. Funding a stakeholder statewide coalition to complete an assessment of the policies, practices, and access to quality palliative and hospice type services for incarcerated and recently released individuals with serious illness. The outcomes will include: An analysis of past data and circumstances surrounding all non-violent deaths within the prison system; compassionate release dispositions prior to death, including location of care; caregivers; hospitalizations; impact of associated timelines for Compassionate Release process, volume of approved vs. denied compassionate release; a health equity analysis of dying while incarcerated; outcomes of compassionately released individuals including medical and parole reports to ascertain issues with, or access to quality end-of-life in the community. This report will be presented to appropriate legislative and Department of Corrections and Community Supervision (DOCCS) leadership.
4. Offering Medicaid recipients an interdisciplinary, palliative care benefit upon identification of a qualified serious illness regardless of location of service or residence via a network of qualified licensed providers approved and registered by the Department of Health.
5. Allowing Physician Assistants to be recognized as Hospice Attendings consistent with federal authorization not requiring additional oversight or signature of the supervising physician.

Notes: Portions of this proposal are enacted.

MPA Council Commentary: *This proposal is categorized as long-term and components of it are currently being implemented. The Department of Health's Center for Hospice and Palliative Care, which was established in 2024, works to ensure New York is positioned to support quality end-of-life choices, better living through routine ACP, and person-centered Hospice and Palliative care services. The Center continues to review recommendations from the Hospice and Palliative Care Education and Training Council and discuss Certificate of Need reform, Hospice Need Methodology, and the creation of a palliative care benefit. An assessment of reforms, scope, and efficacy could be required to implement this proposal. Potential statutory changes and fiscal implications would be evaluated in the context of the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#13):
Cross System Care Coordination Through the 1115 Medicaid Waiver

Summary: Look for flexibilities in the 1115 Medicaid Waiver to incorporate a focus on care transition and navigation needs of the aging population in the procurement process, including Health Equity Regional Organization (HERO) and Social Care Networks (SCNs). Consider reimbursement strategies for community-based organizations, support the growth of Community Benefit Organizations (CBOs), and support full integration of social and medical care throughout the State.

Justification: There is limited access to effective and evidence-based care transition models that successfully incorporate cross-service system care coordination that provide meaningful, holistic navigation for older adults, individuals with disabilities, and their caregivers. Utilizing the 1115 Medicaid Waiver to reimburse CBOs for health promotion through education and class offerings will mitigate adverse health outcomes and decrease the demand for services in the long-term.

Full Proposal:
There is limited access to effective and evidence-based care transition models that successfully incorporate cross-service system care coordination and provide meaningful, holistic navigation for older adults, individuals with disabilities, and their caregivers. To address this barrier, the State would:

1. Within the context of the 1115 Medicaid Waiver, formally incorporate a focus on the care transition and navigation needs of the aging population in the procurement process for new entities, including the HERO and SCNs. The State would also integrate solutions to meet these needs, including with community-based organizations, under the value-based purchasing (VBP) roadmap and seek other funding sources to maintain this focus outside of the Medicaid context.
2. Through the 1115 Medicaid Waiver, reimburse CBOs to engage in health promotion through education and class offerings.
3. Use the 1115 Medicaid Waiver to encourage full integration of social and medical care throughout the State. SCNs would serve as umbrella organizations to help CBOs build capacity, enhance data collection and sharing, and fully integrate with health care organizations.
4. Support the growth of CBOs to support care for older adults, including through data sharing, partnerships between medical and social services providers, and study of the particular benefits generated by CBOs.

MPA Council Commentary: *This proposal is categorized as long-term. The current iteration of the 1115 Medicaid Waiver that has been approved by CMS includes a focus on the integration of social and medical care throughout the state and is currently being implemented. The State is continuously evaluating potential additional changes to the waiver that could be negotiated with the federal government as part of future waiver*

renewals.

Proposal Presented for the Master Plan for Aging (#8):
Expanding Flexibility for Long Term Care Facilities

Summary: Reduce regulatory and programmatic barriers by creating a sustainable, person and quality centric Assisted Living Model for the future; developing one uniform licensure category for assisted living; and increasing financial support for transitioning nursing homes to other care models. Allow ACFs to add Assisted Living Program (ALP) beds.

Justification: Regulatory and programmatic barriers, compounded with financial hindrances, generate gaps in the availability of facility-based LTSS for those who desperately need it. Additionally, individuals who need facility-based LTSS face scarce resources and limited accessibility to other options. Expanding flexibility for facilities will aid in optimizing health at the appropriate level of care and reducing accelerated access of costlier, higher-care levels.

Full Proposal:
Reduce regulatory and programmatic barriers that, in addition to financial barriers, are creating gaps in the availability of facility based LTSS and are limiting options for individuals in need of LTSS, impeding their ability to optimize their quality of life as they age and their needs change.

1. Create a sustainable, person and quality centric Assisted Living Model for the future. Engage internal and external stakeholders, subject matter experts and advocates to create and codify in NYS Public Health Law, one uniform assisted living model that recognizes the deterioration of the old “hospitality model” characterized by an outdated, non-quality driven set of social service laws.
2. Create one uniform licensure category for Assisted Living. This should align with the development of:
    a. A uniform assisted living facility need methodology and should consider the Medicaid funding for existing programs. (Codify language in Article VII submission with the SFY 2026 Budget).
    b. Support innovation by offering Assisted Living Owners/operators local, state, and federal tax incentives and consider directing public subsidies if they increase access for middle- and low-income residents. (Include in SFY 2026 Budget)
3. Allow ACFs to add ALP beds.
4. Review capacity and barriers for adult day health care programs.
5. Study Skilled Nursing Facilities and lower levels of care available for individuals with Severe Mental Illness/Substance Use Disorder/Intellectual/Developmental Disability.
6. Study adequacy of capacity for behavioral intervention units.
7. Increase financial and regulatory support for transitioning nursing homes to other care models: adult day care, assisted living, outpatient services and home care services.

MPA Council Commentary: *Components 1, 2 ,4, 5, 6, and 7 are categorized as long-term. These components would require additional reforms to the business model of Adult Care Facilities as the landscape continues to shift post pandemic. They may also require an assessment of the workforce capacity and availability of specialized services. Policymakers may reference this proposal during the legislative session, as statute and regulations may also be necessary to create a sustainable, person-, and quality-centric model of care. Following the completion of assessment and development of statute and regulations, the Department of Health would continue its pursuit of developing person-centered and sustainable levels of care. Component 3 of this proposal can be categorized as near-term. Proposed first steps for implementation could include an assessment of costs and savings to the State. Funding allocations would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#86):
Elevate Integrated Care Programs

Summary: Create ways to upscale service delivery to the most integrated settings possible. Incorporate enrollees who receive services through provider programs without coordination, and aging individuals receiving OPWDD services, into more comprehensive programs, such as PACE, without disenrollment or automatic exclusion from their current program. These changes ensure more holistic care coordination.

Justification: New York State policy supports enrollment of dually eligible individuals into fully aligned Medicare-Medicaid arrangements such as PACE. However, in practice, New York's delivery system has a path of least resistance to less integrated care options and several barriers exist in enrolling dually eligible individuals into integrated care. These barriers include: the current exclusion from PACE of those enrollees receiving services through the Medicaid Assisted Living Program (ALP) or OWPDD; consumer protections that prohibit automatic enrollment of newly Medicare eligibles into PACE; poor representation of PACE in plan-to-plan transfers; and OPWDD I/DD and OALTC LTC regulations that inhibit the I/DD providers from caring for individuals with I/DD as they age and become more frail.

Full Proposal:
Aging individuals should be enrolled in the most integrated Medicaid-Medicare services available. Many aging dually eligible individuals with LTSS needs are eligible for PACE but are currently enrolled in another program that provides benefits in a piecemeal approach. To better execute on State policy of expanding access to benefits of duals care integration, NYS should create ways to upscale service delivery to the most integrated settings possible. Enrollees who receive services through narrow provider programs without coordination, such as aging individuals in an Assisted Living Program or those receiving OPWDD services, should be guided towards more comprehensive programs, such as PACE, without disenrollment or exclusion from their current program to ensure more holistic care coordination.

MPA Council Commentary: *This proposal is categorized as long-term. The State has taken many steps to promote greater integration of care between Medicaid and Medicare. Policymakers may reference this proposal during the legislative session, as development of a new path for enrollment in integrated care programs could require legislative action. The first step to implement this proposal would be to conduct an evaluation of the range of enrollees negatively affected by current rules and evaluate the fiscal impact of the proposed changes. Decisions about expanding access to Medicaid programs are made in the context of the annual budgeting process and the Medicaid Global Spending Cap are subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#9):
Assisted Living Reform

Summary: Combine accreditation programs and regulatory reforms to drive higher quality care and improved access to specialized services at assisted living residences (ALRs). Encourage integration, including digital systems, into larger network of care providers.

Justification: Accreditation of ALRs through tested and comprehensive quality metrics, and the establishment of enhanced case management programs for ALRs to improve coordination of care, will bolster consumer trust. This will also reduce the risk to ALR operators. Overall, this set of actions will result in improved clinical and social health outcomes.

Full Proposal:

1. All ALRs would begin the process of seeking accreditation from either the Joint Commission, CARF International or the Accreditation Commission for Health Care by 2028. This would provide ample time to focus on quality, secure funding and be actively engaged (after application) to prepare for survey readiness with the accrediting organization. Accreditation would allow for thoughtful building of quality driven organizations and would allow benchmarking of assisted living providers. It would also be considered as a requirement of licensure and re-licensure.
2. Amend state law and regulations that currently prohibit ACFs from meeting the needs of higher-acuity residents that result in inefficient and untimely off-site medical and clinical care, ineffective segregated memory care units, low staffing ratios, and insufficiently trained staff. Ultimately, this will result in a less stressed health care ecosystem and it recognizes the complexity of needs of an aging New York by:
    a. Creating a separate enhanced case management program which coordinates primary care, ancillary services, and therapies on-site at the ALRs.
    b. Requiring in-house contract with social workers, nurses, and physicians to efficiently and timely address acute medical needs, including a repeal of sections of social services law 460-461.
    c. Requiring infection control standards and training for all ACFs that will result in decreased reliance on local health departments.
    d. Requiring all ALRs, as a condition of licensure, to obtain accreditation from a nationally accepted accrediting organization, including the need for dementia certification from such accrediting institution. This is to promote quality and standardization of how ALRs operate, professionalization of the staff employed by these facilities, an overall decrease in reliance on emergency departments.
    e. Requiring and funding, by 2027, electronic health platforms for all nursing

homes and assisted living providers, and recognizing additional support may be needed, especially for those with limited access to broadband.

f. Requiring that all ALRs have agreements in place to partner with other types of providers, including nurse practitioners, physician assistants, registered nurses, care managers, social workers, pharmacists, and others, including mental health providers that ensure residents are offered wraparound services.

MPA Council Commentary: *This proposal is categorized as long-term. Implementation of this proposal would require changes to existing policy and additional resource allocation, which would be subject to the annual budget process and the availability of resources. The Department of Health has already issued several rounds of Transformational Grant and IT Modernization funding to support such initiatives. The Department of Health is currently developing quality metrics and could pursue accreditation in future NYS budget cycles.*

Proposal Presented for the Master Plan for Aging (#60):
Continuing Care Retirement Communities Oversight Reform

Summary: Encourage the growth of Continuing Care Retirement Communities (CCRCs) by consolidating oversight to the Department of Health, updating the priority reservation fee deposit, and reallocating state resources to the Department of Health to support expanded oversight. This proposal includes alternative opportunities to reduce barriers to growth, all of which align with the recommendations to reduce oversight and improve CCRCs' ability to effectively serve their populations.

Justification: Development of CCRCs, a senior housing model which incentivizes the use of retirement funds to pay for care rather than incurring spend-down or estate planning for Medicaid, is hindered by significant barriers. To encourage growth of CCRCs and reduce potential for Medicaid spending, New York should consolidate oversight of CCRCs and eliminate other important barriers to growth.

Full Proposal:
Consolidate oversight of CCRCs to the Department of Health to eliminate barriers that hinder growth.

1. Consolidate oversight of CCRCs into a single State agency – the Department of Health – which would expedite oversight functions, enabling CCRCs to operate more nimbly and be responsive to consumer needs and preferences. It would also shift the CCRC Council to an advisory role consistent with nearly all other councils in the health sector and consolidate the authority of the Council into Department of Health functions.
2. Allow the Department of Health to update the priority reservation fee deposit, which has been capped in statute at $2,000 since 1991. Enabling the Department of Health to update this cap could help ensure that the deposit amount reflects current market conditions and is indicative of a genuine interest in the community.
3. Reallocate existing State resources to the Department of Health to facilitate its expanded oversight functions.

Alternatively:
Encourage growth of CCRCs by:

1. Changing the current structure of the CCRC Board.
2. Eliminating multiagency review and oversight.
3. Overhauling the regulatory process to prevent duplication.
4. Bringing New York CCRCs in line with national CCRC investment strategies
5. Assisting the development of a clinical practice model across all levels of care within the CCRC (including consolidated medical record platform available to all components for the CCRC and eliminating burdensome and bifurcated surveillance functions)
6. Clarifying the purpose of CCRC contracts and that they represent all levels of care within the CCRC.
7. Eliminating duplicative cost reports required of CCRC facilities.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action. The Department of Health and the Department of Financial Services, which both play a role in overseeing CCRCs today, continue to evaluate CCRC regulation on an ongoing basis to identify opportunities for streamlining and encouraging the growth of the model.*

Proposal Presented for the Master Plan for Aging (#85):
Coordination of Home care and Aging Services at OMH Housing Through 1115 Waiver

Summary: Create a demonstration program for individuals being discharged from hospitals participating in the evidence-based care transition demonstration. The demonstration would coordinate home care and aging services for individuals with co-occurring LTC and mental health and/or substance use needs who are transitioning back to, or newly being transitioned to, community-based OMH housing.

Justification: Individuals with co-occurring LTC and mental health and/or substance use needs who are transitioning to community-based OMH housing need immediate access to home care and aging network services. Implementation of a parallel demonstration project, that coordinates home care and aging services for individuals being discharged from hospitals participating in the evidence-based care transition demonstration, will allow for a more seamless transition and better care coordination for this vulnerable population.

Full Proposal:
Building off the Cross System Care Coordination through the 1115 Medicaid Waiver proposal, and adding components of the Supporting Community Housing Models and the Interagency Integration of Social and Health care Services proposals, implement a parallel demonstration project that coordinates home care and aging services with individuals being discharged from hospitals participating in the evidence-based care transition demonstration. The focus of this demonstration would be individuals with co-occurring LTC and mental health and/or substance use needs who are transitioning back to, or are newly transitioning to, community-based OMH housing. Upon discharge, they need immediate access to home care (personal care and/or skilled home health services, medical case management) and aging network services (time-limited review of aging service and managed care enrollment options, social engagement services, food needs, chronic disease self-management classes in local area, etc.). Regardless of payer source and managed care enrollment, individuals and their OMH housing program providers would be required to be plugged into the local SCN of Medicaid and Medicare LTC providers and aging network services based on their needs and preferences.

MPA Council Commentary: *This proposal is categorized as long-term. The current iteration of the 1115 Medicaid Waiver that has been approved by the Center for Medicare and Medicaid Services is in process. While a focus on the care transition needs of individuals moving from inpatient hospital settings to the OMH housing is critical for the provision and parity of care, this demonstration program would need to be developed and proposed for a future iteration of the waiver. The State is continuously evaluating potential additional changes to the waiver that could be negotiated with the federal government as part of future waiver renewals. Accomplishing this proposal*

would require resources that would be subject to the annual budget process and the availability of resources. If the subject demonstration were to be otherwise approved, the Department of Health would work with OMH to integrate the program with existing data systems. New York AAAs may continue to develop relationships with health care organizations and technology companies to keep older adults healthy to support aging in place, and to connect older adults to community-based services to prevent higher levels of care.

Proposal Presented for the Master Plan for Aging (#41):
Adult Day Care Family Caregiver Program

Summary: Increase and incentivize Adult Day Care programs through regulatory reforms that address reimbursement and financing, expanded staffing, and innovative partnerships with other service providers (including with transportation providers), and encourage pilot programs that integrate adult day services.

Justification: For older adults who require supervision during the day, or those who would benefit from more social interactions outside of their homes, adult day care facilities and programs (including both Adult Day Health Care and Social Adult Day Care) offer a safe and secure environment. Local and regional collaborations with key organizations will help ensure that programs are accessible and inclusive for older adults with disabilities (or with unique needs) who are often left unaccommodated and unaccounted. Incentivizing the participating Adult Day Care programs with a program that directly reimburses the facility with up to 50% of the Medicaid rate, will ensure that these critical services will be sustainable for community members who greatly need them.

Full Proposal:
For older adults who require supervision during the day, or who would benefit from more social interaction outside of their homes, adult day care facilities and programs offer a safe and secure environment. Increase and incentivize adult day care programs as an alternative to provide respite and relief to family caregivers so they can work, run errands, or have time to recharge emotionally, psychologically, and physically.
Adult day care programs serve a diverse, predominantly older clientele that is approximately one-third black, indigenous, or of color. Compared with other home- and community-based supports, adult day care programs are among the most racially and ethnically diverse according to a study published by the National Institute of Health.

1. Staff the program with nurses, social workers, health aides, activity professionals, and other health professionals such as occupational and/or physical therapists.
2. Partner with local transportation organizations to provide transportation services to and from the program.
3. Collaborate with organizations like the New York State Adult Day Services Association (NYSADSA) to ensure that the program is accessible and inclusive for seniors with disabilities or unique needs by providing necessary accommodations and equipment.
4. Incentivize participating Adult Day Care programs by initiating a program that subsidizes the cost of Adult Day Care by directly reimbursing the facility with up to 50% of the Medicaid rate based on the client's ability to private pay for these services.
5. Remove MLTC requirements that participants accept mandatory home care services in order to attend Social Adult Day Care programs.

6. Enhance New York's Medicaid Program by reimbursing Adult Day services on a fee-for-service basis under the Medicaid Community First Choice Option (CFCO) in New York State. Note that this would provide additional federal assistance via the 6% Federal Medical Assistance Percentage provided under CFCO.
7. Initiate a pilot program for integrating adult day services under CFCO.

MPA Council Commentary: *This proposal is categorized as long-term. Components of this proposal would require expanded availability and capacity of the workforce and of transportation systems. Other components may require statutory changes. State agency partners may continue to assess workforce challenges and opportunities for improvement regarding transportation challenges statewide. Additionally, decisions about the provision of Medicaid services happen in the context of the Medicaid Global Spending Cap and the annual budget process and must consider the availability of resources.*

Proposal Presented for the Master Plan for Aging (#21):
Adult Care Facility (ACF) Voucher Demonstration

Summary: Create a limited demonstration program modeled on the successful Special Needs Assisted Living Voucher Demonstration Program for persons with dementia aimed at preventing or delaying the need for more costly, higher-level care. The program would provide a sliding-scale subsidy for ACF residents who are at risk of nursing home care due to depleted resources and to individuals not eligible for Medicaid or SSI but in need of Adult Day Care services.

Justification: The "forgotten middle" are individuals who are not eligible for Medicaid or SSI but do not have a large disposable income, those who need Adult Day Health services and do not have access to the services and programs they need which accurately reflect their preferred location of residence or the acuity of care their condition requires. Middle-income populations have limited access to assisted living residence services or memory care, resulting in a decreased quality of care and life. Inclusion of urban, rural, and suburban counties will ensure diversification of the population receiving services.

Full Proposal:
Create a limited demonstration program modeled on the successful Special Needs Assisted Living Voucher Demonstration Program for persons with dementia aimed at preventing or delaying the need for more costly, higher-level care.

1. The program would provide a sliding-scale subsidy for ACF residents who are at risk of nursing home care due to depleted resources and to individuals not eligible for Medicaid or SSI but in need of Adult Day Care services.
2. The program would operate in at least three counties or areas, which would represent an urban, rural and suburban setting.
3. The goal would be to examine whether this approach can reduce or delay the need for nursing home care by assisting seniors to remain living in the community or in their ALR/ACF, while generating a Medicaid savings.
4. In addition, there would be an assessment of the possibility of creating a similar demonstration for individuals who are at risk for Medicaid-funded nursing home placement but would benefit from partially subsidized Adult Day Care services.

MPA Council Commentary: *This proposal is categorized as near-term. Policymakers may reference this proposal during the annual budget process, as creation of a new voucher demonstration program would likely require legislative action and would require funding that would be subject to the annual budget process and the availability of resources. The success of any expansion of Adult Day Care services would be contingent upon sufficient direct care workforce capacity.*

Proposal Presented for the Master Plan for Aging (#11):
Facilitating Nursing Home Reform Efforts

Summary: Create a more home-like environment through the development of the Green House Project model or other small house-type facilities in new and renovated nursing homes. The proposal also includes recommendations to update regulatory requirements to facilitate complementary transformations to the nursing home industry.

Justification: Most nursing home buildings are old, built several decades ago, are institutional in nature and don't fit the population's needs or wants. Nursing home reforms provide modifications such as in-unit dining, additional communal and activity space, environmental and life safety codes, and updated equity contributions. Creating a set of actions to support the development of a facility-based LTC setting, such as the Green House Project model or other small house-type facilities, will create a more home-like environment, improving the quality of life for older adults in residential care.

Full Proposal:
Create a more home-like environment through the development of the Green House Project model or other small house-type facilities. To accomplish this objective, New York would:

1. Revisit certificate of need and equity contribution requirements for new bed construction (see proposal 6) to reduce barriers that may impede the development of innovative nursing home models.
2. Modify safety, building and environmental codes for facility-based care and prevention of infectious diseases.
3. Expand capital financing and revisit capital grant award methodologies for existing grant programs to prioritize support for innovative nursing home models.
4. Exempt nursing home Medicaid capital reimbursement from 70/40 requirements.
5. Review access to capital for not-for-profit facilities.
6. Support streamlining for local planning and zoning facilities to allow for homes and care facilities.

MPA Council Commentary: *This proposal is categorized as long-term. The FY23 enacted budget included $50M in capital funding to support innovative nursing home models, including but not limited to, the Green House Project model. Component 4 of this proposal may require a statutory amendment to change Medicaid capital reimbursement requirements and would be subject to the annual budget process and the availability of resources. The additional components of the proposal would require further discussion by the Department of Health and a continued review of Certificate of Need (CON) methodology and engagement with all relevant State partners.*

Proposal Presented for the Master Plan for Aging (#12):
Reactivate and Modify the Voluntary Residential Health Care Facility Rightsizing Demonstration Program

Summary: Modify and reactivate the Voluntary Residential Health Care Facility Rightsizing Demonstration Program to incentivize facilities to voluntarily give up unneeded beds and ensure appropriate placement through further expansion of alternate levels of service and save Medicaid funds. Proposed modifications would include loosening regulations around reactivation, providing a financial incentive for decertification, and expanding the program.

Justification: Statewide nursing home occupancy has been trending at less than 90% as a result of staffing shortages and availability of alternate care settings, among other factors. Due to the current Medicaid pricing system, facility operators are incentivized to operate a larger number of beds and maintain high occupancy rates. Facilities are reluctant to decertify beds and relinquish the associated economic value. Voluntary rightsizing would incentivize facilities to give up unneeded beds, ensure appropriate placement through further expansion of alternate levels of services and save Medicaid dollars.

Full Proposal:
Modify and reactivate the Voluntary Residential Health Care Facility Rightsizing Demonstration Program to incentivize facilities to voluntarily give up unneeded beds and ensure appropriate placement through further expansion of alternate levels of service and save Medicaid funds. Modification features to the previous Demonstration Program should include:

1. Allowing operators to reactivate temporarily decertified beds at any time after the first year of decertification with prior notice and determination of the facility's peer group assignment for Medicaid reimbursement based on the facility's total certified beds prior to any reductions.
2. Subject to the Certificate of Need process, the Demonstration Program would allow operators to permanently convert generic nursing home beds to specialty service beds, allow operators to permanently decertify beds and receive a one-time payment from the state for doing so, and allow operators to convert existing semi-private rooms to private rooms and receive a supplemental payment from Medicaid for doing so.
3. Increase the 5,000-bed limit.
4. The State would reactivate the program through an open solicitation or periodic time-limited solicitations.

MPA Council Commentary: *This proposal is categorized as near-term. Before implementing this proposal, the State would have to consider metrics for evaluating implementation success -- for example, rates of decertified and converted nursing home beds, remaining availability of and occupancy rates of nursing home beds, and cost*

savings to the State). Decisions about the provision of Medicaid services happen in the context of the Medicaid Global Spending Cap, and any funding implications of this proposal would be subject to the annual budget process and the availability of resources.

Proposal Presented for the Master Plan for Aging (#6):
Nursing Home Capital Assistance

Summary: Recommendation to provide a flexible approach to nursing home capital improvements by a combination of updates to existing regulatory requirements and metrics. The proposal also includes an evaluation of industry interest in developing specialty care units, and a statement of principle regarding grant program utilization.

Justification: Nursing homes, ACFs, and ALRs are heavily reliant on Medicaid and congregate level 3 SSI/SSP reimbursement to sustain operations and maintain physical plants, and existing capital reimbursements may be difficult to access and include limits. Facilities face inadequate financial support for necessary renovations to improve the quality of life and care for residents. Approval of updated reimbursement costs, a reduction in equity contribution from facilities, and the creation of a new reimbursement methodology would make long-term care facility capital improvements more flexible and would improve reimbursement for cost of care.

Full Proposal:
Provide a flexible approach to nursing home capital improvements by:

1. Removing long-standing 25% equity contribution requirement for nursing home capital projects and lowering that contribution to 10% which aligns with all other Article 28 projects and recognizes fiscal constraints for the nursing home providers.
2. Direct the Department of Health, in consultation with subject matter experts, to review and create an updated construction costs reimbursement cap methodology. The cost reimbursement cap was last updated in 2007. The Department could create a permanent methodology to update these caps in a way that appropriately reflects health care cost inflation.
3. Update the decades-old regional nursing home need methodology. In addition to updating the methodology based on current occupancy rates and population statistics, the updated need methodology would consider other factors including regional workforce statistics, public transportation availability, community design and zoning that enhances proximity and access to public spaces, services and other amenities and distances between other nursing homes in a geographical area. Since long-term care needs do not exist in a vacuum, any new nursing home need methodology must be done in conjunction with updating the need methodologies for other long-term care facility and service types, including the demand for and availability of home care, hospice care, adult care and assisted living facilities. Consider long-term care needs as a whole and not as individual spokes in the long-term care continuum.
4. Require the Department to issue a request for information/solicitation of interest for nursing homes interested in establishing specialty care units, which will recognize and address the problem of discharging patients in need of skilled nursing home care that require additional behavioral health intervention and

difficult to serve patients.

5. Amend Public Health Law to account for Department-approved capital cost expenses which will impact resident quality of care.
6. Prioritize long-term care providers in grant programs.

MPA Council Commentary: *Component 3 is categorized as near-term. Components 1, 2, 4, 5, and 6 are categorized as long-term. Implementation steps for components 1, 2 and 4 may include a continued review of Certificate of Need (CON) methodologies to ensure existing processes align with industry needs to maximize quality of care. Changes to Component 2 should take into consideration the availability of other capital funding for nursing homes (e.g., Statewide Health Care Facility Transformation grants). Component 6 is currently being implemented in part at the federal level. Modifications to Medicaid reimbursement methodologies as included in this proposal could have significant fiscal implications for the State and would need to be reviewed in the context of the annual budget process and subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#51):
Improve Nursing Home Quality Incentive Pool

Summary: Strengthen the Nursing Home Quality Incentive Pool through reallocation of funding from the Vital Access Provider Assurance Pool to offset changes to nursing home quality incentive pool. Recommendations for increased investment in improved nursing home quality include collective stakeholder input, additional metrics for staff, and investments in workforce training.

Justification: Many nursing homes, including nonprofits, struggle to provide high quality care in a financially sustainable way. However, these nursing homes would significantly benefit from an improved incentive pool that rewards nursing homes for investment in workforce training and decreased turnover rates, among other quality-based metrics. This would incentivize nursing home providers to invest in these areas.

Full Proposal:
Reallocate funding from the Vital Access Provider Assurance Pool to offset changes to nursing home quality incentive pool. This would involve collective stakeholder input to be reviewed and collated over a period of 120 days, and add metrics related to staff training, consistency in assignment and decreased turnover, and other measures over a period of 4 months, rewards investments in workforce training, forcing all nursing home providers to invest in these areas.

MPA Council Commentary: *This proposal is categorized as long-term. The Nursing Home Quality Incentive Pool is currently a cost-neutral pool funded through payments from the nursing homes based on their quality ratings. Policymakers may reference this proposal during the annual budget process, as adjustments to the Nursing Home Quality Incentive Pool will likely require legislative action and allocation or reallocation of funding for new programs is subject to the availability of resources. Adjustments would likely require a Medicaid State Plan Amendment.*

The following proposals in Pillar 2 are not included in the Advisory Report as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#118):
Strengthen Our Centers Grant Program: Improvements for Community-Based Older Adult Service Organizations

Summary: This initiative, referred to as SOC, aims to provide financial aid to eligible Older Adult Centers (OAC), Adult Day Health Care (ADHC) centers, Social Adult Day Programs (SADs), and Program of All-Inclusive Care for the Elderly (PACE) sites across New York to improve physical infrastructure. The program, aligned with the goals of the New York State Master Plan for Aging, and overseen and administered by NYSOFA, would provide capital assistance to ensure that facilities can be adequately maintained and updated to serve the communities they are in. This program would be modeled after California's Bridge To Recovery initiative.

Justification: The core purpose of this grant program is to ensure our strong network of facilities, programs, and services in New York are able to continue to serve the growing aging population and improve for long-term use by allowing them to make long overdue improvements to their physical infrastructure, technology, and transportation. Supporting these programs helps combat isolation and improve the health, safety, and well-being of at-risk older adults and people with disabilities. It also decreases Medicaid costs by providing funding to ensure safe access to vital in-center congregate services. The necessity for this program stems from several challenges brought to light and exacerbated by the COVID-19 pandemic, which emphasized the importance of programs that prevent or delay the institutionalization of vulnerable individuals while enabling them to receive necessary support in their homes. The pandemic exposed many physical infrastructure challenges these organizations face without adequate funds to address them, such as enhancing ventilation systems and providing increased transportation services.

Full Proposal:
To improve the physical infrastructure of facilities, programs and services that support the aging population, the Strengthen Our Centers Grant Program would offer financial assistance to eligible providers for the following:

1. Building ventilation materials, such as improving existing ventilation systems or adding a new one.
2. Vehicle modification/preservation of existing vehicles used to transport participants, including routine maintenance, repairs to wheelchair lifts, upgrades to upholstery, security fencing, sanitation kits, and surveillance equipment.
3. Medical equipment such as hover lifts, medical exam tables, lift chairs, medical tables/trays, wheelchairs, walkers, and medical recliners.
4. Furniture tables, medical chairs, trays, outdoor patio furniture and umbrellas, and wipeable furniture like vinyl couches and chairs.
5. Technology equipment such as new computers, upgraded security, and other technological enhancements to improve infrastructure and service delivery.

6. Modifying indoor spaces, such as upgrading or replacing HVAC systems, installing air filter or HEPA filtration systems, upgrading ductwork, installing or replacing flooring, and upgrading bathroom fixtures to touchless options (sinks, toilets, paper towel dispensers, etc.).
7. Vehicle purchase of one eligible vehicle per site for transporting participants, including ADA-compliant wheelchair-accessible passenger transportation vehicle capable of transporting more than 10 passengers (including the driver).
8. Indirect costs – costs that are not directly tied to specific project activities but support the overall operation of the facility. Allowable indirect, capped at 10% of the total direct costs requested, include facilities operation and maintenance costs (rent, internet, utilities), depreciation, and administrative expenses.

The ultimate goal is to enable these centers to provide a safe, healthy, and person-centered environment that encourages in-center participation, combats older adult isolation, and improves the overall well-being of vulnerable older adults and individuals with disabilities.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. The MPA recognizes the success of the Statewide Health Care Facility Transformation Program in assisting health care facilities with capital investment to continue providing high quality care. Policymakers may reference this proposal during the annual budget process, as the development of a new capital grant program may require legislative action and would be subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#124):
Expand the Young Adult Unit Demonstration Program

Summary: Update Section 1 of Section 2808-e of the Public Health Law to allow the Commissioner of Health to approve up to 4 units under the Young Adult Unit Demonstration program.

Justification: Appropriate residential & nonresidential services are not widely available for individuals who require specialized services including a growing population of medically complex and fragile young adults. Update the public health law to allow the Commissioner of Health to approve additional demonstration programs for residential services for a growing population.

Full Proposal:
Young adults with medical fragility are defined in PHL 2808-3 as individuals aged 18 to 35 who have a chronic debilitating condition or conditions, are at risk of hospitalization, are technology-dependent for life or health-sustaining function, require complex medication regimens or medical interventions to maintain or to improve their health status and/or are in need of ongoing assessment or intervention to prevent serious deterioration. Two out of only 15 Pediatric Skilled Nursing Facilities serve a growing population of medically complex fragile young adults who require specialized services.

1. Update Section 1 of PHL 2808-e which allows the commissioner to approve 2 units for medically fragile young adults to undergo an expedited CON process to include an additional 2 units. This will give the commissioner of health the ability to approve up to 4 Pediatric Skilled Nursing Units under the Young Adult Unit Demonstration Program.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. In the near-term, the Department of Health will continue to continuously review the Certificate of Need (CON) process for opportunities for administrative improvement. In addition, in 2024, Governor Hochul signed into law bill S5969A/A3674A to allow medically fragile young adults who reside in pediatric specialized nursing facilities to remain at such facilities until the age of 36. Policymakers may reference this proposal during the legislative session and the annual budget process, as this proposal requires legislative action and may have fiscal implications which would be subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#125):
Continuity of Medical Treatment and Medication Access in Short- and Long- Term Care Facilities

Summary: Develop mechanisms for individuals to continue or access consistent medical treatment and medications when entering near term rehabilitation post hospitalization, residential settings, or when admitted to long-term care (i.e., nursing homes).

Justification: Disruptions or changes to medical treatment and medications when patients transfer from the hospital to other near term or long-term facilities or enter residential treatment can have detrimental impact on their health and wellness. Individuals have experienced challenges accessing medications (HIV, cancer, Hepatitis, and addiction-related medications, etc.) or lifesaving treatments (i.e., dialysis) entering alternate care facilities, due to payment/insurance issues (i.e., medication carve outs) and other institutional policies or practices.

Full Proposal:
Provisions must be put in place to ensure that all individuals entering alternate care facilities must be ensured adequate access to consistent medical treatment and medication.

1. Develop a statewide standard of care for all residential, near term and long-term facilities to continue medical care and treatment in collaboration with individuals' primary care or specialty care external providers.
2. Develop universal mechanisms for insurance review and coverage of treatment prior to transfer ensuring consistency of care.
3. Review regulatory procedures statewide and mandate that all facilities, by law, may not deny admission or access to individuals based on their health care needs.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as infrastructure, and is complementary to 6, Integrate Data and Case Management Systems. Policymakers may reference this proposal during the legislative session, as components of this proposal may require legislative action. Proposed first steps for implementation could include the development of interoperable patient and client record systems. This proposal may result in additional State costs which would need to be considered as part of the annual budget process and subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#123):
Expand Licensure for Family Type Home for Adults

Summary: Expand the capabilities of Family-Type Home for Adults (FTHA) under licensure and regulation to enable residents to age in place in the least restrictive level of care setting of their choice.

Justification: FTHAs are the lowest level of adult care facility to meet the needs of dependent adults. Adults enter FTHAs with the expectation of aging in place. Levels of Care definitions in regulation require that residents be discharged to another setting where their increased level of care needs can be met. This does not align with a person-centered approach to allow residents of FTHAs to choose their preferred place to live and aging in place.

Full Proposal:
To ensure a person-centered approach for persons in FTHAs, expand the capabilities of FTHAs to support housing options for older adults and people with disabilities by preventing discharge to a higher level of care. Allow FTHAs:

1. Operators of FTHAs to apply for specialized licenses needed to administer and store controlled substances.
2. Operators with nursing licenses to perform nursing duties including medication administration.
3. Facilities to hire staff to assist residents with mobility challenges.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. Statutory and regulatory reform processes may be required for the administration of additional types of medication and an assessment of workforce availability may be required. The Department of Health, in partnership with relevant state agency partners, may continue to assess the oversight of FTHAs, regulatory reforms needed and workforce challenges across the state on an ongoing basis.*

III. Prevention, Wellness Promotion and Access

Proposal Presented for the Master Plan for Aging (#65):
Evaluate Payor Support for Preventive Services and Supports

Summary: Consider regulatory and programmatic actions to annually analyze policy decisions that affect the delivery of Medicaid LTSS for Medicaid Managed Care, Managed Long Term Care and Fee for Service (FFS) for the consideration of support for LTSS that defer, delay and eliminate the need for Medicaid long-term care. Create an annual report that recommends methods for greater integration of services and payor across the Department of Health and SOFA landscape.

Justification: Spending on long-term care services and supports at all levels and in all settings does not provide equity, efficiency, or financial stability. To develop and promote systems and services at scale, New York should annually analyze policy decisions which affect the delivery of long-term services and supports.

Full Proposal:
Annually analyze policy decisions that affect the delivery of LTSS inclusive of those offered by NYSOFA, Medicaid LTSS for Medicaid Managed Care, Managed long-term care and FFS for considerations of support for LTSS that defer, delay and eliminate the need for Medicaid enrollment or utilization of Medicaid long-term care services.
The objective is to develop and promote systems at scale capable of providing or arranging long-term care services and supports regardless of payor.

1. Develop annual update as to how people are accessing Medicaid funded LTSS to inform efforts to improve service and payor integration.
2. Identify and validate the efficacy of services and supports that defer, delay, or eliminate the need for Medicaid long-term care, including home and community based and facility-based care.
3. Develop a strategic implementation plan for the broad use of services and supports for seniors and individuals with disabilities that encourages integrated programs and services with participants from Medicaid and private pay. Also use sliding fee scales to improve access, availability, and sustainability.
4. Track the use of LTSS through Medicaid as well as other payors.
5. Provide an annual report that recommends methods for greater integration of services and payors across the Department of Health and SOFA landscape.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. State agency partners may continue to evaluate State Office for Aging and Medicaid-funded long-term services and supports to ensure availability and alignment of existing programs for older New Yorkers.*

Proposal Presented for the Master Plan for Aging (#84):
Support Older Adults Aging in Place in OMH-Licensed and Permanent Housing

Summary: Proposes a formal collaboration among OMH, the State Health Department, the Home Care Association of NYS, OMH Housing Providers and Alliance for Rights and Recovery, and other peer advocacy groups to address challenges for accessing needed services in OMH housing.

Justification: As older adults with mental illness age in OMH housing programs, it is apparent that the home care workforce is unequipped to effectively provide services to this population. Knowledge about eligibility and disconnection from family and informal caregivers creates challenges for those living in these housing programs. Cross-agency collaborations will allow a comprehensive understanding of the existing challenges and opportunities in these settings and address the needs of older adults with mental illness.

Full Proposal:
OMH operates almost 50,000 units of housing in NYS, most of these permanent housing, and a significant proportion are older adults. For individuals residing in permanent OMH housing, all will eventually be older adults. As residents of OMH housing programs age, same as many older New Yorkers, they may require access to home care services. However, accessing services is challenged by not only the broad systemic factors limiting access to Home Care services, but also to population-specific factors, and a lack of proximity to services, including, but not limited to:

- Home Care workforce is not well trained in working with older adults with mental illness
- Stigma around adults with mental illness, limiting workers interest in working with these individuals
- Lack of understanding of eligibility for such services for individuals in OMH housing
- Facilities that are physically isolated from surrounding communities.
- Disconnection from families, reducing access to family and other informal caregivers, increases reliance on paid caregivers

Benefits to the larger system of care for older adults to improving access to Home Care services for older adults with serious mental illness, are similar to those of older adults in general: facilitating individuals remaining in their chosen residential setting as long as possible, and reducing burden on other institutional settings (Assisted Living, Nursing Homes, etc.) where they will have to relocate without access to quality home care services.

This proposal suggests a formal collaboration with OMH, the State Health Department, the Home Care Association of NYS, OMH Housing Providers and Advocacy groups (e.g., ACL and SHNNY) and other relevant stakeholders for a robust exploration of the challenges and opportunities to make systemic change to better address the needs of older adults with mental illness in New York.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. Possible first steps for implementation could include engagement with the OMH's housing and provider training (through the existing Geriatric Mental Health and Substance use Disorder Planning Council) and consultation with peers and peer bridgers well versed in the lived experience of trying to maintain community tenure while aging. If successful, the existing Council may propose opportunities for systemic change to ensure the needs of older adults in OMH housing are met. Proposed metrics for evaluating implementation may include improved understanding of OMH services among the workforce, improved service provision, and continued opportunities for systemic change.*

Proposal Presented for the Master Plan for Aging (#14):
More Effective Care Integration Through Plans

Summary: Introduce a care mandate that incorporates mental, behavioral and physical health for managed care plans. The proposal includes a plan to work with CMS for the needed program changes.

Justification: Mental, behavioral, and physical health need to be better incorporated into managed care plans via a care mandate to ensure members are monitored for social isolation, cognitive impairment, and other conditions that are a threat to their health. Social workers play a crucial role in enhancing health systems, particularly in Medicaid Managed Long Term Care, by promoting population health and reducing health inequities, especially for individuals experiencing loneliness, substance abuse, and dementia.

Full Proposal:
Introduce a care mandate that incorporates mental, behavioral and physical health for managed care plans. Have social workers monitoring plan members for social isolation, substance abuse, and dementia, so that treatment for those conditions can be incorporated into care plans. Work with CMS to assess adjustment to rates.

1. The Department of Health to coordinate with CMS and Managed Care Plans to evaluate necessary changes to Managed Long Term Care (MLTC) plans for improved screening and staffing needs for case management.
2. The Department of Health to draft a mandate and determine funding allocation in coordination with CMS.
3. The Department of Health to introduce a care mandate based on conversation with CMS and Managed Care Plans.
4. The Department of Health to coordinate with CMS and Managed Care Plans for plan to address the care mandate.

This proposal is focused on primary and secondary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. While Managed Care Plans are mandated to provide person-centered care planning including connection to necessary treatment, a comprehensive evaluation of the MLTC program may be necessary before the introduction of a care mandate. Following an analysis of the MLTC program, the Department of Health may provide any necessary guidance for modifications to program-mandated person-centered care planning. Medicaid reimbursement methodologies and funding allocations would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#74):
Review and Update of the Patient Review Instrument (PRI)

Summary: Review and engage in an update of the Patient Review Instrument (PRI) Screening Tool in consultation with appropriate partner agencies and stakeholders with the goal of reflecting the current acuity-based Medicaid reimbursement system and an evolving health information technology landscape, increasing efficiencies, and better integration into the State HIT and exchange framework for the aging and LTC services providers.

Justification: The PRI medical evaluation tool meant to assist older adult in their transition between care settings lacks practicality and consistency, does not align with the current Medicaid reimbursement system, and causes delays in long-term care facility admissions and access to necessary services. Updating the PRI may better reflect the current reimbursement system and improve access to and quality of care for older adults.

Full Proposal:
Review and engage in an update of the PRI Screening Tool in consultation with appropriate partner agencies and stakeholders with the goal of reflecting the current acuity-based Medicaid reimbursement system and an evolving health information technology landscape, increase efficiencies and better integrate into the State HIT and exchange framework the aging and LTC services providers. Actions to update the PRI screening may include but are not limited to:

1. Convene a PRI stakeholder group of hospitals, nursing facilities, State Psychiatric Centers, HCBS providers, including housing and homeless/shelter providers, and patients/families, to review a small number of alternative tools and/or processes.
2. Maximize the use of health information technology and exchange.
3. In consultation with OPWDD and OMH, ensure that the SCREEN tool is updated to reflect an updated PRI/patient transfer process, or consider whether any additional updates are needed to consolidate the SCREEN tool or process.
4. In consultation with NYSOFA, ensure the COMPASS tool reflects an understanding of the potential interoperability with the updated PRI.
5. Review the existing State regulations and propose changes needed to reflect an updated PRI process.
6. Propose the updated PRI process to PHHPC and other relevant State bodies, as necessary.
7. Ensure the updated tool is person centered and reflects the interdisciplinary, comprehensive nuances of the patient accurately to minimize the discriminatory medical profiling that delays acceptance within, especially, long-term care communities.
8. Develop a tool that is advanced and informed in areas of trauma, PTSD, psycho-social, and language appropriate.

9. Develop a tool that encompasses a comprehensive data set for rare diseases that are undocumented in history and will continue to be more prevalent.
10. Develop a workforce education plan to educate relevant interdisciplinary staff, including ensuring certified PRI nurses are smoothly transitioned to the new system.
11. Utilize language access programs for immigrants, refugees and others for whom English is not their first language.

This proposal is focused on primary and secondary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. A comprehensive update to the PRI may require regulatory changes and additional State resources. As other MPA proposals governing data infrastructure and continuum of care transitions are implemented, this proposal may continue to be evaluated for feasibility and impact. This proposal may result in additional State costs which would need to be considered as part of the annual budget process and are subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#2):
Community Immunization Program

Summary: Support increasing vaccination rates. The proposal includes a combination of partnerships and studying the most effective ways to encourage vaccination.

Justification: Vaccination is an effective and cost-effective modality of prevention and public health which has a major effect on mortality reduction and population growth. However, vaccination rates are low among older adults, specifically those in underserved and historically marginalized communities. With a focus on health equity, and through partnerships with local health departments, senior centers, pharmacies, and other entities, a Community Immunization Program and a study to learn more about vaccination rates in New York could improve prevention efforts.

Full Proposal:
Pursue a series of initiatives to improve vaccination rates:

1. Engage an external consultant to gain insight into the reasons for the decline in vaccination rates.
2. Partner with local health departments to implement the lessons from the external consultant study for their vaccination programs.
3. Develop public-private partnerships between local health departments that have an existing immunization program with health care service providers to roll out vaccination drives to improve distribution in communities where transportation to a doctor's office/pharmacy for vaccinations may not be accessible. (i.e., The successful coordination between NYSOFA and local health departments to facilitate in-home access to vaccines during the COVID-19 pandemic).
4. Partner with pharmacies and senior centers to extend the reach of vaccination drives.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. Vaccination efforts in coordination with local health departments are ongoing. Engaging a consultant to study declining vaccination rates would likely require a funding allocation, which would be subject to the annual budget process and the availability of resources. Vaccination remains a priority of the State and is a central component of the Department of Health's Prevention Agenda.*

Proposal Presented for the Master Plan for Aging (#5):
Prevention Curriculum

Summary: There is a need for prevention concepts to drive decision making earlier in life to enable older adults to reap the benefits of early investments in health, finances, and relationships. In partnership with the Department of Health's Office of Public Health (OPH) and SED, the Department of Health will engage in curriculum development and school outreach with a coordination effort and commitment to prevention education.

Justification: There is a need for prevention concepts to drive decision making earlier in life to enable older adults to reap the benefits of early investments in health, finances, and relationships. In partnership with OPH and SED, the Department of Health will engage in curriculum development and school outreach with a coordination effort and commitment to prevention education.

Full Proposal:
Develop a Prevention curriculum for elementary, middle and high schools. This proposal responds to the need for prevention concepts to drive decision making earlier in life, so that older adults can reap the benefits of earlier investments in health, finances and relationships. A prevention curriculum should incorporate:

1. Explicit instruction with community engagement.
2. Volunteering opportunities.
3. Information about careers in caregiving and health care.
4. Partnerships with local organizations offering volunteer opportunities.
5. Integration with caregiver career pipeline programs.
6. Incentives, such as credit for a required health course or community service hours.
7. Access to outdoor physical, recreational and social activity through community design (including Governor Hochul's 'Get Offline, Get Outside" children's mental and physical health campaign).

The Prevention curriculum can include year-long support for existing classes, single-event assemblies, and multi-session seminars. Curriculum development and school outreach will be accomplished through collaboration between the Department of Health, particularly OPH, and SED.
This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session and the annual budget process, as development of a curriculum for schools may require legislative action and a substantial funding allocation, which would be subject to the availability of resources. The first step to implement this proposal may be initiating a coordinated effort within the Department of Health and State Education Department to assess options for curriculum development.*

Proposal Presented for the Master Plan for Aging (#47):
Benefits Program Expansion

Summary: Increase and expand a variety of existing benefit programs. This proposal aims to increase the number of enrollees in, and improve the access to, critical health programs.

Justification: Increasing and expanding a variety of existing benefit programs that help older adults maintain good health, for example providing vision, hearing and dental services, may improve access to preventative health services. In addition to improving the lives of many New Yorkers, improving access to preventive health services may decrease long-term costs for more acute health care needs, potentially mitigating some of the heightened costs associated with expanding access to benefits.

Full Proposal:
Increase or expand a variety of existing state benefit programs:

1. Revisit Medicaid eligibility criteria (e.g., income limits, asset tests, lookback periods) to ensure the State's resources are going to support those New Yorkers most in need of services.
2. Increase State Supplement Program (SSP) amounts with an annual Cost of Living Adjustment (COLA) increase and streamline eligibility requirements. Consider shifting back to Social Security Administration for oversight.
3. Utilize public-private partnerships to increase the number of mobile-dental clinics and encourage pathways for Federally Qualified Health Centers (FQHC) to provide dental care for older adults, require private dental plans to be subject to a dental medical loss ratio to ensure dental plans are more valuable for customers, and increase the number of reimbursable dental cleanings in the Medicaid dental program.
4. Require dental plans to be subject to an 83% dental medical loss ratio to make dental plans more valuable for customers.
5. Cover a higher frequency replacement of broken or lost dentures.
6. Increase the number of reimbursable dental cleanings (dental prophylaxis) to four times per year for adults over age 65 with 16 or more teeth and/or problems directly impacting the health of the gums, including evidence of periodontal disease and/or poor home oral hygiene due to inability to properly care for oneself. Dental cleanings for these vulnerable adults should also include oral hygiene education and instructions.
7. Support accessibility to obtain hearing aids through the provision of an up-front subsidy for a portion of the cost of the hearing aid or create a voucher program to provide up-front payment for medically necessary and prior approved hearing aids through Medicaid hearing coverage.
8. Reduce the amount of time for the coverage of replacement glasses under the Medicaid vision program and expand vision assessment coverage under the Medicaid vision program to cover adults 65 and older.

Advocate to increase or expand certain federal benefits:

9. Increase SNAP minimum benefits and ease enrollment requirements; implement the federal SNAP standard medical deduction pilot program.
10. Encourage the federal government to extend Medicare coverage to all expert-recommended vaccinations and encourage all NYS health insurance plans to extend coverage to all expert-recommended vaccinations. Improve provider education and best practices for vaccines and use public-private partnerships to expand Local Health Department immunization programs and drives.

This proposal is focused on primary and secondary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. The State's capacity to expand these benefits may be evaluated in the context of the annual budget process and would be subject to the availability of resources. Portions of this proposal would have substantial costs to the State's Medicaid program. The Departments of Health and Financial Service should continue to review research on the potential impacts of these recommendations, such as changes to existing dental medical loss ratio requirements and expansion of hearing and vision benefits. New York State would have to discuss any changes to federal policy, including as related to SNAP and Medicare, with the appropriate federal officials.*

Proposal Presented for the Master Plan for Aging (#81):
Ecosystem Demonstration Pilot

Summary: Establishes a partnership among NYSOFA, the Department of Health and the DOS to create local teams that would facilitate better coordination across health systems, including those overseen by OPWDD, OMH, OASAS, and Department of Veterans' Services (DVS), local health departments, primary and specialty providers, and AAAs. This would include a requirement that initial demonstrations be located in counties that have at least one health system certified as an Age-Friendly Health System.

Justification: A healthy aging approach seeks to address these factors in a collaborative way across government in order to improve long-term health and wellness outcomes and thus, improve the aging experience. New York has taken the foundational steps to achieve this, but much work remains to integrate medical, public health and community-based care. The Ecosystem Demonstration Pilot is needed to address health service referral, delivery and chronic condition management to establish better coordination of care and referral networks across health systems, local health department, primary and specialty providers, and Area Agencies on Aging. To promote holistic prevention and healthy aging across the lifespan.

Full Proposal:

1. NYSOFA through partnership with DOS and the Department of Health would directly or indirectly arrange for the provision of technical assistance and an educational series for interdisciplinary teams of local government partners to develop an ecosystem of community service and health service referral and delivery promoting holistic prevention and healthy aging across the lifespan. To ensure a high level of engagement and demonstrated capability to sustainably implement, participants would be limited to county-based teams that have a track record of success with the implementation of healthy aging programming including those counties that received funding through the Age-Friendly NY/Smart Growth Community Planning grant program. This will mean that a requirement will be to have teams from counties that have been, or have localities therein that have been, certified as an Age-Friendly State or Community by AARP as well as contain at least one health system that has been certified as an Age-Friendly Health System by the Institute for Health care Improvement.
2. Selected teams would then be tasked with collaboratively fulfilling requirements under Public Health Law (Section 2802B – Health Equity Impact Assessment; Section 2803L – Community Service Plans) to better coordinate and establish referral networks and systems of care among the health systems, local health department, primary and specialty providers, and AAAs to address identified underlying public health and chronic condition management. Additionally, these teams would be responsible for coordinating with and implementing actions that further Master Plan for Aging and Prevention Agenda priorities in their

communities.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. Proposed first steps for implementation could include coordination of the Department of Health and other agency partners to determine messaging and the procurement of resources, subject to the annual budget process and the availability of resources. Next steps could include identifying counties that have a certified age-friendly system. If successfully established, further action may be taken to instill age-friendly and healthy aging approaches into all agency policies. Proposed metrics for evaluating implementation success could include a number of established networks among health systems.*

Proposal Presented for the Master Plan for Aging (#83):
Firearm Retirement Plan

Summary: Provide education and active engagement of older adults to facilitate better firearm safety. Include mental health and suicide prevention in a program of engagement for firearm owners.

Justification: Firearm injury is a major source of preventable injury and death among older adults as they are at an elevated risk of cognitive impairment, serious illness and depression that can cause suicidality. Nationally, those over the age of 50 account for 33% of firearm-associated deaths. About 84% of these are suicides (https://ihpi.umich.edu/news/how-can-we-reduce-firearm-death-toll-older-adults). In New York, white (non-Hispanic) males over the age of 75 are at the highest risk for firearm suicide (https://efsgv.org/state/new-york/). Many older gunowners have not planned for the future in regard to their firearms. The Firearm Retirement Plan will initiate conversations that actively address firearm location and safety concerns.

Full Proposal:
Given the high number of older adults that may have firearms, and the high number of deaths associated with firearms in older adults, there is a need to ensure firearm safety is included throughout the lifespan.
Nationally, those over the age of 50 account for 33% of firearm-associated deaths. About 84% of those are suicides (https://ihpi.umich.edu/news/how-can-we-reduce-firearm-death-toll-older-adults). In New York, white (non-Hispanic) males over the age of 75 are at the highest risk for firearm suicide (https://efsgv.org/state/new-york/).
The Firearm Retirement plan touches on the need to have a conversation with older adults about their firearms, where they are located, and when to remove them if there is a safety concern. Furthermore, given the focus on mental health and suicide prevention throughout the Master Plan for Aging, a conversation around firearms is an important step when addressing those topics across the lifespan.
This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. Proposed first steps for implementation could include convening State Agency partners to determine existing programs and communications on procedures for gun safety, safe-storage, and gun retirement programs. Additional implementation steps could include the development of provider engagement educational and program referral materials and a Technical Assistance Memorandum directing the Aging Services Network on firearm safety for older adults.*

Proposal Presented for the Master Plan for Aging (#82):
Support Services for Older New Americans

Summary: Support older new Americans by funding trusted community benefit organizations in the Older New Americans network. Target organizations would provide case management support, referrals, information, and translation services in a way that overcomes existing linguistic and cultural barriers.

Justification: Older new Americans face significant challenges and restricted access to resources leading to negative health outcomes. Instilling support services to address the specific needs of this rapidly growing population would allow for more coordinated assistance between organizations, increased access to resources, and necessary services that bolster the health and well-being of older new Americans.

Full Proposal:
Older new Americans face significant barriers accessing existing services due to status, cultural and linguistic barriers. Transportation and digital literacy are also barriers that this proposal would address. While federal programs do exist for refugees, these do not apply to other new Americans. The program, by funding trusted CBOs in the DOS Office for New Americans (ONA) network, would provide case management support, referrals, trusted information and translation services along the lines of the Services to Older Refugees Program, operated by the New York State Office of Temporary and Disability Assistance.

MPA Council Commentary: *This proposal is categorized as long-term. Funding allocations would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#80):
Promotion of the Annual Wellness Visit

Summary: Undertake programmatic and educational efforts and consideration of innovative partnerships between community-based and health service providers to provide better awareness and utilization of Annual Wellness Visits with primary care providers to create or update a personalized prevention plan.

Justification: The Medicare Annual Wellness Visit is a yearly appointment with a primary care provider to create a personalized health, prevention, and health monitoring plan, however older adults and physicians lack awareness of the benefit and its usefulness. This benefit improves health care quality and lowers health care costs. New York State should explore ways and opportunities to promote this benefit for the improvement of the health, prevention engagement, and reduction in health care spending.

Full Proposal:
The Annual Wellness Visit (AWV) is a yearly appointment with a primary care provider (PCP) to create or update a personalized prevention plan. It serves as an opportunity to educate the patient on the importance of preventive care, discuss advance directives, track the person's health over time, and ensure the patient is connected to necessary and desired health and social services. The AWV improves health care quality and lowers health care costs utilizing, but not limited to, falls prevention screenings, mental health and cancer screenings, necessary immunizations, nutrition and exercise counseling, diabetes control, cognitive health, vision and hearing screenings, and gait and balance testing. New York should explore ways to promote the AWV.
Potential recommendation requirements include:

1. Require the dual special needs plan to promote and recommend the AWV within their network of providers.
2. Encourage Medicaid managed care plans (that cover older New Yorkers who are ineligible for Medicaid) to promote AWVs for their older and eligible enrollees.
3. Encourage MLTC plans to promote AWVs and their benefits through care coordination, to be covered either by Medicare Parts A and B or a Medicare Advantage Plan.
4. Utilize the AAA Network to explore partnerships with health care systems, plans, and providers for the promotion of the AWV.
5. Leverage key partnerships with associations of professionals who administer the AWV to educate physicians, nurse practitioners and physician assistants on the following: what the AWV entails, how it can be billed, how key recommended vaccinations may be billed, questionnaires and standardized tests to make it simpler and reduce the barriers to coverage.
6. Include AWV materials on the Department of Health website and update recommendations annually based on US Preventive Service Guidelines, CDC and the NIH Advisory Committee on Immunization Practices.

7. The State could create and adequately fund a division within the Department of Health that focuses on Medicare and Medicaid integration to improve health care quality and health outcomes for the dually eligible.
8. Connect the Medicaid patient-centered medical home recipient per-day reimbursement to programs which can provide a patient with necessary and desired health and social services.
9. Encourage private health insurance to offer a similar AWV benefit to beneficiaries.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. To accomplish the proposed components and maintain healthy habits, provide preventative health care, reduce hospitalization rates, and lower health care costs, the State could assess fiscal impact, necessary resources for development, outreach, coordination, and strategies. This proposal would result in additional State costs and funding allocations would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#4):
Multilayered Awareness and Intervention Practices

Summary: Establish multilayered public awareness campaigns and intervention practices based on best public health practices for addressing the following health issues or needs: falls, diabetes, hypertension, The importance of physical activity, sexual health, nutrition benefits (including SNAP, the Elderly Simplified Application Process, and the Restaurant Meals Program), malnutrition prevention and awareness, Advance care planning (ACP) (particularly end-of-life), caregiver education, brain health, adult abuse and scams, mental health, and generalized prevention. Campaigns and other communications should consider health literacy as well as cultural and linguistic competency.

Justification: Risk factors for worsened health and increased health care costs include hypertension, diabetes, and falls, though education and management strategies for these conditions are not widely practiced. Additionally, ACP, the benefits of utilizing SNAP, the identification of caregivers, and the importance of brain health are all issues which may require improved understanding. Education and awareness of these topics may improve health outcomes.

Full Proposal:
Establish multilayered public awareness campaigns and intervention practices based on best public health practices for addressing the following health issues or needs:

1. Falls
    a. Fall risk and risk reduction, educate provider organizations about fall risks and prevention programs, fund, promote, and collaborate with organizations to implement evidence-based programs for falls prevention.
    b. The State of New York should prioritize the following topics in public information campaigns about fall risk and risk reduction, with an emphasis on reaching marginalized populations (delivered at the community level for primary, secondary, and tertiary prevention):
        i. Nutrition education messaging for older adults (e.g., increased protein needs).
        ii. Promoting physical activity to prevent sarcopenia, frailty, and falls.
        iii. Home safety to prevent falls and other accidental injuries.
        iv. Promoting awareness of available programs and services to improve physical activity.
        v. Promoting availability of vision screening and rehabilitation services.
2. Diabetes
    a. Focused on diabetes risk factors, prevention strategies, and healthy lifestyle choices for older adults.
3. Hypertension
    a. Hypertension, or high blood pressure, is a common health condition among older adults that can increase the risk of heart disease, stroke, and

other serious health complications. Implementing specific strategies can help to prevent and manage hypertension among older adults.

4. The importance of physical activity
    a. Educate New Yorkers about the benefits of physical activity for healthy aging, using culturally appropriate messaging and diverse media channels.
5. Sexual Health
    a. Provide information and education to older adults to maintain optimal sexual health and intimacy wellness. This includes information on dating, physical intimacy, and sexually transmitted infections (STI) awareness and prevention efforts (including HIV and Hepatitis C). This includes the importance of ongoing testing, the use of condoms, and information on medications, such as PrEP and Doxy-PEP.
6. Nutrition benefits (including SNAP, the Elderly Simplified Application Process, and the Restaurant Meals Program)
    a. Prioritize targeting outreach efforts to vulnerable and/or low participating groups in SNAP benefits including, but not limited to, older adults and people of color through public-private collaboration, which includes the utilization of existing programs. The outreach should include benefit explanation and education about SNAP benefits with the goal of reducing the participation gap, reducing hunger, and promoting great economic security to those eligible.
7. Malnutrition Prevention and Awareness
    a. Raise awareness and provide education about prevention and treatment of malnutrition and sarcopenic obesity.
    b. Create a Malnutrition Awareness Week with an emphasis on food insecurity, benefits shortage during 5-week months, and impact on community resources.
    c. Create NYS Malnutrition Prevention Committee for Older Adults.
8. Advance care planning (particularly end-of-life)
    a. Fund, develop, and coordinate an equity-based comprehensive statewide public health education campaign on advance care planning as pursuant to Chapter 406 of 2022 to address barriers to making wishes known through the process of ACP and to improve the gap in health equity. Materials will be written in plain language and translations will be available for individuals whose primary language is not English. Video ads will have American Sign Language (ASL) version. All visual materials will meet accessibility guidelines including being assistive reading technology friendly.
9. Caregiver education
    a. Successfully reaching informal caregivers requires identifying and then meaningfully partnering with the individuals and populations that have been marginalized by existing policies. Knowing the gaps and any barriers

for identifying caregivers is a critical first step to developing intentional approaches that best support these populations.

10. Brain health
    a. A public health campaign with targeted strategies for clinicians and the general public to raise awareness about the importance of brain health, the role of prevention in optimizing brain health, and the services that can aid with brain health.
11. Adult Abuse and Scams
    a. A public education campaign conducted by NYSOFA and OCFS on elder abuse built off the 2023 OCFS public awareness campaign to call attention to the issue of adult abuse, which includes advertising across various platforms such as billboards and social media. NYSOFA provides some annual funding to Lifespan of Greater Rochester to conduct education and prevention activities on elder abuse which will also contribute to this campaign.
12. Generalized prevention
13. Mental Health

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. The state is currently implementing multiple public education strategies, programs, and other initiatives. Proposed first steps for implementation could include coordinating impacted state agencies and the governor's Office for order and release of campaigns. Proposed next steps could include engaging relevant programs and agencies for critical information, development, and publication of campaign materials. Proposed metrics for evaluating implementation success could include public engagement with campaign materials and resources. This proposal would result in additional state costs and funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#107):
Training on the needs of Older Adults with Substance Use Disorders

Summary: To better serve older adults with substance use disorders, education, training, and awareness of their specific needs and the impact of stigma and ageism should be improved for NYS OASAS-certified providers. Developing a specialized training curriculum and expanding it to behavioral and physical health providers would enhance care and reduce social stigma.

Justification: Implementing targeted training would equip providers with the skills to address the unique challenges older adults face in substance use disorder treatment, leading to better recovery outcomes. Expanding this curriculum across health care systems would promote comprehensive, stigma-free care and improved collaboration between providers.

Full proposal:
Improve education, training, and awareness about needs, stigma, and ageism for NYS OASAS-certified substance use disorder treatment providers serving older adults with substance use disorders.

1. Develop and implement a training curriculum on substance use disorder treatment and recovery needs of older adults.
2. Expand the curriculum to meet the needs of other provider systems including behavioral and physical health to both improve training, training outcomes and challenge widespread social stigma.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as near-term and has been implemented by the OASAS. Guidance from OASAS was released in late 2024.*

Proposal Presented for the Master Plan for Aging (#3):
Prevention and Geriatrics Continuing Medical Education (CME)

Summary: Establish a blue-ribbon commission (the Commission) to develop Continuing Medical Education (CME) content on prevention and geriatric medicine to increase provider awareness of contemporary best practices and reactivate the Council on Graduate Medical Education. The proposal provides details on the membership of the commission, the target audience for the content, and content distribution.

Justification: Geriatric education ensures that medical professionals are ready to care and advocate for an increasingly diverse and vulnerable population of older adults. The creation of a blue-ribbon commission on CME, with a focus on primary, secondary, and tertiary care for older adults, and the reactivation of an existing Council of experts on Graduate Medical Education, strives to eliminate the gap in provider awareness of best practices with older adults.

Full Proposal:
Establish a blue-ribbon Commission to develop CME content on primary, secondary, and tertiary prevention, geriatric medicine, and sexual health**,** with the goal of bridging the gap in provider awareness of contemporary best practices.

1. The Commission would be composed of leading practitioners (primary and specialty providers) and researchers from public health and geriatric specialties.
2. Content would be designed for practitioners who treat primarily middle-aged and older adults.
3. Content would be distributed in partnership with not-for-profit CME providers.
4. Reactivate the Council on Graduate Medical Education.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. Implementation of this proposal would require discussions and collaboration between the Department of Health and the State Education Department about efforts to enrich professional education in public health and geriatric areas.*

Proposal Presented for the Master Plan for Aging (#73):
Food As Medicine Promotion

Summary: Build an integrated social care delivery system through resource allocation, regulatory and statutory actions with a focus on health equity to enable aging service providers, the existing AAA network, and local health departments to provide Food As Medicine interventions tailored to each community and scaled statewide over a decade. Ensure interventions are culturally appropriate to improve access to nutritious food for high-risk marginalized populations.

Justification: Older adults and individuals with disabilities, particularly individuals of marginalized populations, experience food insecurity, difficulty accessing nutrition benefits, and difficulties accessing healthy food options. These individuals are at an increased risk of poor nutritional diet and worsened medical conditions, which contributes to increased health care costs and strain on the aging services infrastructure that regularly provides home-delivered meals to older adults. An integrated social care delivery system, with Food as Medicine interventions, would improve health equity, reduce health care spending, and enable the AAAs to provide nutrition-based interventions to reduce the trend of malnutrition.

Full Proposal:
To ensure older adults, individuals with disabilities, and marginalized populations in New York State have access to culturally relevant nutritious food, this proposal would build an integrated social care delivery system with a focus on health equity to enable aging service provides, the existing AAA network, and local health departments to provide Food As Medicine interventions tailored to each community. The capacity of this system will be scaled up through 2035 with aging service providers and the AAA network fully able to deliver nutrition-based interventions and be reimbursable through a variety of payors over time.

1. Direct and support aging service providers to identify food insecurity and malnutrition risk and implement Food As Medicine interventions as part of their portfolio.
2. Provide infrastructure, funding, technical assistance, and supports for aging service providers and the AAA network to build capacity to equitably participate in healthy longevity and Food as Medicine health care delivery. Engaging in this initiative can involve partnerships with academic schools and programs which support aging service providers, partnerships with providers and statewide contractors, training for utilization of an evidence-based hunger screening tool, and the creation of a dual-purpose screening for malnutrition and food insecurity which captures nutrition information in both community and health care settings.
    a. The Food As Medicine interventions will meet varied community needs based on cultural, religious, and ethical practices through education, focus groups, and creation of recipe books or videos by each community served.

They will be shared with contractors to create culturally appropriate meals to increase the likelihood of participation by those in underserved areas.
    b. Partner with technology innovators to expand social networks through existing platforms to support wellness checks, healthy days, and promotion of food and nutrition events.
    c. Expand the role of the Registered Dietitian Nutritionist to ensure individuals receiving Food As Medicine interventions have access to an appropriate level of medical nutrition therapy.
    d. Incentivize transportation options for healthy nutrition.
3. Develop and expand regular cooking programs at congregate meal sites, older adult centers, and other community partner settings. Provide supplies under the 1115 waiver as necessary. Train physicians and implement malnutrition and food insecurity screenings to be available to community and health services.
4. Support Aging Service Providers and the AAA Network to expand its capacity to slow and reverse the trends of malnutrition as well as engage in federal advocacy for the creation of pathways for Food As Medicine interventions and reimbursement which do not exist through Medicare.
5. Support access to fresh, local food through community planning, zoning, development and infrastructure, including community gardens and urban agriculture.

This proposal is focused on secondary and tertiary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. Components of this proposal are currently being implemented through nutrition initiatives authorized in New York's most recent federal Medicaid 1115 Waiver amendment, recently expanded Medicaid coverage for nutrition counseling services, funding in the FY24 budget for medical nutrition therapy, expanded funding invested in the FY26 Enacted Budget for services through NYSOFA such as home-delivered meals, and other initiatives. The Department of Health and state agency partners will continue to evaluate accessibility to nutritious food for older New Yorkers and individuals with disabilities. Any additional resources or funding allocations to support this proposal would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#92):
Paid Time Off for Preventative Health care Visits

Summary: Require all employers in New York State to provide sufficient annual time off to engage in an annual preventative health care visit and colon cancer screening.

Justification: About a third of American adults see a health care provider for an annual physical, an appointment meant to engage in preventative health care. However, physicals can include costly examinations and tests, and medical professionals argue that a visit with a focus on establishing relationships, medical history, social situations, and health risk assessments may provide improved engagement with preventative health care. Existing Civil Service Law provides time for cancer screening to prevent cancer for public employees but does not apply to nonpublic employees. All employees in New York State should receive sufficient paid time off to engage in annual preventative and colon cancer prevention health care.

Full Proposal:

New York Civil Service Law section 159b provides all civil service employees named in such section with a period of time not to exceed 4 hours leave to undertake screening for cancer. To address the need for all aging New Yorkers to engage in preventative health care and address the prevalence of colon cancer:

1. All employers in New York State should allow for sufficient paid time off each year to engage in an annual preventative health care visit and a colon cancer screening for prevention of colon cancer.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as this initiative would require legislative action. If successfully included in statute, next steps would likely include the development of materials and guidance to help employers implement such a requirement.*

Proposal Presented for the Master Plan for Aging (#108):
Expand the Wellness Initiative for Senior Education and Screening Brief Intervention Referral to Treatment (WISE-SBIRT) Model

Summary: Expand the Wellness Initiative for Senior Education (WISE)/Screening, Brief Intervention and Referral to Treatment (SBIRT) model to the 10 economic development zones (EDZ) across the state to improve reporting accuracy, increase quality of health information, develop safe spaces for substance use concerns, and provide interventions and referrals.

Justification: Support for older adults experiencing health concerns from substance use and addiction will experience improved health outcomes and quality of life from identification and intervention services and supports.

Full Proposal:
Older adults face additional health risks from substance use and addiction. Support healthy aging, cultural and generational diversity, and identification of substance use and addiction by expanding the WISE-SBIRT model to the 10 economic development zones (EDZ) across the state to:

1. Improve reporting accuracy about substance use in SBIRT.
2. Increase quality health and wellness information.
3. Create safe spaces for concerns about substance use.
4. Provide brief, individualized interventions and referrals.

This proposal is focused on secondary prevention.

MPA Council Commentary: *This proposal is categorized as near-term. This proposal is currently being implemented at the OASAS and in partnership with NYSOFA. Expansion of the nationally recognized model is in development for an additional "train the trainer" iteration and expansion to additional populations for 2025.*

Proposal Presented for the Master Plan for Aging (#89):
Employment Supports for Menopause

Summary: Provide employment supports and benefits for the workforce who experience menopause. Create a public awareness campaign to support improved understanding of menopause including workplace guidance for employers and employees.

Justification: The symptoms of menopause can result in missed work and daily disturbances for the female population of the workforce. Public awareness campaigns, improved guidance, and workplace benefits can better support an aging New York workforce.

Full Proposal:
A significant portion of the female workforce experiences physical symptoms from menopause that result in missed work and disturbances in their daily lives. Tackle the challenges of menopause for workers by providing a range of employment supports and benefits:

1. Implement a menopause-leave allocation of five days per year available to older workers.
2. Develop workplace guidance for employers and employees for understanding and effectively and compassionately managing menopause challenges in the workplace.
3. Create a public awareness campaign normalizing menopause and its potential impact on workers.

This proposal is focused on primary prevention.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as this proposal may require legislative action to require specified time for workers to use menopause-related benefits and leave. If successfully implemented, next steps could include affected agencies engaging with stakeholders and developing guidance and regulations.*

The following proposals in Pillar 3 are not included in the Advisory Report as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#126):
Training on the Sexual Health and Intimacy Needs for Older Adults

Summary: Establish training and materials to better serve older adults related to their sexual health and intimacy needs to prevent sexually transmitted infections (STIs), sexual violence, and to foster healthy communication and relationships.

Justification: Sexual health discussions and prevention related measures are often avoided or ignored with older individuals. Due to provider discomfort, time constraints, or lack of information, older adults often are not provided the necessary information to protect themselves from STIs or other issues that may arise from dating or intimacy seeking when struggling with loneliness, post-menopausal physical relationships, or the loss of a spouse/lifetime relationship. Misnomers about physical-intimacy-seeking and sexual desires on older adults hinder important conversations with health care or supportive service providers.

Full Proposal:
Provisions must be put in place to ensure that older adults have adequate access to information to foster healthy sexual relationships and intimacy.

1. Develop and implement a training curriculum on the sexual health of older adults for medical providers and supportive service providers.
2. Create or expand statewide campaigns to foster discussion on older adult sexual health with caregivers and providers (i.e., public awareness marketing, etc.)
3. Expand current and future curricula and healthy aging materials to meet the needs of other provider systems including long-term care facility staff, behavioral and physical health providers, and others to improve training and training outcomes and challenge widespread ageism and misinformation around the sexual activity of older adults.
4. Support the development of a New York State Sexual Health Bill of Rights. The Bill of rights will guide communication between providers and consumers regarding the assessment of sexual health risk factors, discussion of prevention choices, understanding of treatment options and testing/screening opportunities.
5. Continue and expand awareness and access to sexual health and prevention efforts (i.e., PrEP, Doxy-PEP, hepatitis, intimate partner violence, etc.) to all treatment providers and ancillary staff who can proactively initiate conversations with older adults.
6. Advocate for STI and HIV education and testing for older adults, even those over 65.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as near-term. Exploration may be needed to identify other potential training/resources. The AIDS Institute within*

the Department of Health could work with NYSOFA and all stakeholders to update and develop statewide materials and training, facilitate the development of a statewide standard for dissemination, and create a plan for enforcement and attestation for all training recipients. Any additional resources or funding allocations would be subject to the annual budget process and available resources.

IV. Housing Access and Community Development

Proposal Presented for the Master Plan for Aging (#15):
Addressing Housing Supply

Summary: Address the supply shortage of housing stock. The proposal includes reforms that encourage new construction or adaptive reuse of existing buildings, pilots accessory dwelling units (ADUs), recommends zoning ordinance revisions, and suggests housing models for senior and "missing middle" housing.

Justification: Current zoning in many jurisdictions across NYS limits supply, reducing choices, driving up prices, prohibiting and restricting housing types, and/or making it impossible to provide certain housing types that would be most desirable for some older adults, people with disabilities and their caregivers. Housing supply issues must be addressed by calling upon, funding, and requiring local governments to address their zoning, regulation, and building codes and other related laws. Action is needed to improve access and availability of housing options including ADUs, missing middle housing, and other shared housing models for older adults, people with disabilities and their caregivers.

Full Proposal:
To address the supply shortage of housing stock, initiate the following reforms to encourage new construction:

1. Initiate a pilot with local governments to designate areas where accessory dwelling units (ADUs) can be built for seniors, people with disabilities, and their caregivers as-of-right.
2. Require and fund all local governments, within three years, to audit, and if necessary, revise, their zoning ordinance, subdivision regulations, building code, housing maintenance code and related laws and regulations to ensure that the jurisdiction is allowing sufficient flexibility that new construction or adaptive reuse of existing buildings can meet regional demand for housing that is accessible for older adults and people with disabilities, taking into account the social, transportation, and other needs of these populations.
3. New York State, led by DOS' Office of Planning, Development & Community Infrastructure, shall provide guidance to local governments about how to effectively audit their existing ordinances, codes, and regulations, and potential modifications to them that would address problems the audit reveals, drawing from such sources as the AARP's Livable Communities guides, the NYS DOS/NYSOFA Livable NY Resource manual, and NYS DOS Senior Housing Model Local Laws.
4. Call upon and fund all local governments to allow the development of, "missing middle," housing that could provide affordable, accessible, and safe homes to meet the needs of older adults, people with disabilities and their caretakers while fitting comfortably within existing neighborhoods of single-family detached housing. In developing legislation to require missing middle housing, the State should be guided by AARP's Re-legalizing Middle Housing – A Model Act and

Statewide Guide.

   a. Middle Housing is a range of house-scale buildings with multiple units—compatible in scale and form with detached single-family homes—located in a walkable neighborhood with improved access to transportation, services, public spaces, and social engagement opportunities for people of all ages.

5. Consider the 2022-2023 Plus One ADU program for expansion to other parts of NYS, especially rural areas. Consider expanding the eligibility requirements for the low/no interest rate loans to low- and middle-income older adults, people with disabilities and their caregivers. Consider how the current pilot program will affect older adults in NYS and study its effects. Outcomes and data should be shared with the Department of Health and NYSOFA.
6. The State should consider a statewide loan fund or other financing mechanism, or other ways to increase the ease of building ADUs and increase public acceptance.
7. The State should encourage all local governments to designate areas where senior-only housing, assisted living facilities, and nursing homes can be built for older adults and people with disabilities as-of-right, or with a special permit, subject to only the minimum standards necessary to protect the health and safety of residents of the units and its neighboring properties, and consistent with the federal, state and local fair housing mandates. The state should consider ways that it can help make these facilities more affordable.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session and the annual budget process, as statewide action to review local zoning laws, address "missing middle" housing, expand ADU programs, and create new financing mechanisms may require legislative action--and any funding needs would be subject to the availability of resources. Implementation of the separate elements of this proposal could start with development of legislation to advance the program parameters for the proposed initiatives. Governor Hochul has made increasing the supply of housing a top priority of her administration. As part of the FY25 Enacted Budget, the governor secured a historic agreement to increase New York's housing supply through a variety of measures including incentives that create affordable housing statewide, tools for New York City to generate more housing, $500 million to build up to 15,000 new homes on State land and authority to further strengthen New York's Pro-Housing Communities Program — which was launched by the governor in 2023 and currently includes nearly 300 communities. In addition, as part of the FY23 Enacted Budget, the governor established a five-year, $25 billion Housing Plan to create or preserve 100,000 affordable homes statewide, including 10,000 with support services for vulnerable populations, plus the electrification of an additional 50,000 homes. More than 55,000 homes have been created or preserved to date.*

Proposal Presented for the Master Plan for Aging (#20):
Incorporate Age-Friendly Principles Into Community Design

Summary: Establish an interagency group responsible for the coordination of community design and housing solutions. Incorporate or encourage age-friendly principles into community design by including the following in state procurement and spending policies: (1) planning for enhanced and expanded pedestrian infrastructure and public gathering spaces in and around communities with an aging population, and (2) public engagement of older New Yorkers to live in communities with a higher concentration of jobs, social/medical services, recreational opportunities, and public transit options.

Justification: New York State lacks accessible and comfortable public gathering spaces such as parks, town squares, and other areas to wait for transit and meeting areas within the public realm. Public, accessible spaces promote social engagement, reduce social isolation, promote community engagement, and improve access to services and businesses. The incorporation of age-friendly principles into community design, such as adding more time to pedestrian street crossings for older adults and people with disabilities, will improve safety and promote inclusivity. Additionally, establishing an interagency group responsible for the coordination of community design and housing solutions will help avoid duplication of services and reduce state agency silos.

Full Proposal:
Incorporate or encourage age-friendly principles into community design:

1. Encourage older New Yorkers to live in communities with a higher concentration of jobs, a mix of land uses, social/medical services, accessible and inclusive, recreational opportunities, and public transit options – with these destinations being accessible by walking or bicycling and eliminating reliance on a personal automobile. Such programs could provide incentives for the individual's choice of location and/or for increased housing options in these communities. Enhance access to, and availability of, public gathering spaces for older New Yorkers and those with physical, cognitive or sensory restrictions—in both indoor and outdoor spaces—by making them more age-friendly, intergenerational and inclusive, including both ADA compliance and encouraging amenities that exceed ADA requirements. This not only results in an improved quality of life for the individual but also makes better use of existing services rather than extending them to low-density geographic areas where they are not viable or affordable to provide.
2. Establish an interagency group responsible for the coordination of community design and housing solutions that include social care services, with the intention of reducing state agency silos. The following state agencies are potential candidates for this: DOS, HCR, NYSERDA, and Empire State Development (ESD) from the community planning, development and housing agencies and OMH, the Department of Health, NYSOFA, and OTDA from the services

agencies.

3. Plan for enhanced and expanded pedestrian infrastructure in all communities to allow individuals to walk to nearby services and other destinations. Identify locations and potential funding sources from public and private sector sources to reconstruct deteriorated sidewalks and other streetscape amenities, build new pathways, calm traffic / reduce vehicular speeds, enhance roadway crossings, and ensure ADA compliance—and encourage features that exceed ADA compliance - to allow streets to accommodate individuals who are mobility impaired.
4. Incorporate age-friendly principles into applicable State grant funding opportunities that affect the public realm, as a funding incentive for localities to address this issue.
    a. Recommend reissuance of the New York State Age-Friendly Planning Grant Program RFA or a similar RFA which addresses both Smart Growth Principles as well as the eight (8) domains of Age-Friendly/Livable Communities.
    b. Create a state level resource guide paired with training toward capacity building; building off the previous foundation provided by the Healthy Aging Across All Policies initiative.

MPA Council Commentary: *This proposal is categorized as infrastructure. In addition to the agencies specifically named in this proposal, many other state agencies engage in programming that influences the lives of older New Yorkers. As a result, any implementation of this proposal should take a statewide approach and consider opportunities for implementing age-friendly principles across agencies. Any additional resources or funding allocations necessary to implement this proposal would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#16):
Eviction Prevention

Summary: Ensure people can stay in their homes and avoid eviction. Recommendations include reviewing budgetary opportunities to provide a state-funded housing voucher or a state-funded plan for housing assistance for New York's lowest-income seniors, modeled after the Senior Citizen Rent Increase Exemption, and providing legal assistance to all older adults, individuals with disabilities, and caregivers facing eviction or foreclosure.

Justification: Eviction and foreclosure can be especially devastating for older adults, people with disabilities, and their caregivers. An eviction prevention proposal is needed to both address and improve affordability of rent across NYS and NYC through a state-funded housing voucher or plan. Tenants in NYC can receive free legal representation, advice, and other legal assistance if they are facing eviction or other related housing issues. However, this service is not available statewide. Expanding this service statewide would provide older adults, people with disabilities and their caretakers who may be facing eviction or foreclosure with needed legal assistance to navigate these hardships.

Full Proposal:
To ensure that people are able to stay in their homes and avoid the disruption of eviction:

1. Study the budget, implementation options, policy decisions, and unintended consequences that would be required to provide to the state's lowest income seniors, people with disabilities, and their caregivers with either a state-funded housing voucher and/or a state funded plan for assistance modeled after the locally funded Senior Citizen Rent Increase Exemption/Disability Rent Increase Exemption/Senior Citizen Homeowner's Exemption or similar.
2. Since eviction or foreclosure can be especially devastating for older adults, people with disabilities, and their caregivers, the state could provide funding to provide legal assistance to all such persons facing eviction or foreclosure.

MPA Council Commentary: *This proposal is categorized as long-term. Funding decisions are made in the context of the annual budget process and would be subject to the availability of resources. If the proposal to provide state funding for legal counsel in housing court were to advance, the next step to implement this proposal would be to study the implementation process followed by New York City in its comparable program and identify which components could be implemented at the state level and which components would require partnering with local authorities.*

Proposal Presented for the Master Plan for Aging (#19):
Strengthen Home Modification Programs

Summary: Review, consolidate and direct policy and budgetary actions to implement improvements to current programs that maintain or modify homes to be accessible for older adults and people with disabilities.

Justification: Home modification programs are needed to ensure older adults and people with disabilities can age in place successfully. However, older adults have difficulty navigating through the maze of programs. Reviewing the existing programs that allow older people to maintain or modify their homes to keep them well maintained, safe, accessible, and energy efficient or climate resilient for efficiency, will ensure older adults can age in their homes and avoid unnecessary institutionalization.

Full Proposal:
As an investment in housing equity, review and direct improvements or expansion as necessary for programs that maintain or modify all homes for increased accessibility.

1. Enable the state Chief Customer Experience Officer, along with state agencies administering programs that help older people maintain or modify their homes for maintenance, safety, accessibility, and climate resilience, to review existing programs for efficiency, effectiveness, and overlap. The results of the review will be released in a report that identifies opportunities for consolidation and standardization of such home modifications across the state.
2. Make grants available for the programs that build ramps for renters and homeowners and ensure funding for home repairs.
3. Provide older adults in need of urgent home access for hospital discharge with temporary ramps to help them avoid unnecessary institutionalization.
4. Create a fast-track approval process for home modifications for accessibility. Municipal applications for walk-in showers, grab bar installation, wheelchair ramp installation and doorway widening will be deemed approved within 30 days of submission unless denied for cause.

MPA Council Commentary: *This proposal is categorized as near-term. The first step for implementation of Component 1 would be to organize a planning meeting between the State's Chief Customer Experience Officer (CCEO) and representatives from NYSOFA, HCR, the Department of Health, and Department of Environmental Conservation (DEC) to identify relevant programs. Subsequently, appropriate State resources would need to be identified to collaborate with the CCEO to identify any other State agencies with relevant programs. Components 2 and 3 would require funding and thus be subject to annual budgeting processes and the availability of resources. Policymakers may reference this proposal during the legislative session, as Component 4 may require legislative action.*

Proposal Presented for the Master Plan for Aging (#78):
62+ Housing Exemption for Kinship Caregivers

Summary: Work with the Division of Human Rights to amend waivers for 62+ senior housing developments. The current rules disproportionately impact minority populations. Advocate for the HUD Section 202 Supportive Housing for the Elderly Program age requirement to be eliminated or modified.

Justification: Kinship caregivers living in 62+ housing communities face challenges when minors are in their care. Age-related restrictions prohibit these caregivers from living with a dependent minor and create barriers to remaining in safe and affordable housing. Addressing this restriction with the Division of Human Rights and the HUD will allow caregivers and their dependents to better age in place and foster housing security.

Full Proposal:
Create an exemption for older adults taking on the oversight of a minor when issuing waivers for 62 plus senior housing developments. As described in the federal Fair Housing Act, housing for older adults is exempt from familial status discrimination. Ensure that older adults who are taking in children due to CPS/Family court involvement or parental illness or death can avoid housing loss due to the existing senior housing exemption by:

1. Work with the Division of Human Rights to amend waivers for 62 plus senior housing developments. The current rules disproportionately impact minority populations.

Additionally, the Stakeholder Advisory Committee proposes that the HUD Section 202 Supportive Housing for the Elderly Program age requirement should be eliminated or modified to allow kinship caregivers under the age of 62 to be included.

Stakeholder Advisory Committee Note: This proposal is ranked according to the original proposal. Additional suggestions from the Stakeholder Advisory Committee regarding the HUD Section 202 Supportive Housing for the Elderly Program were added after ranking.

MPA Council Commentary: *This proposal is categorized as long-term. New York State would need to discuss changes to federal policy with Senator Gillibrand, Senator Schumer, and other federal government representatives.*

Proposal Presented for the Master Plan for Aging (#103):
Expand the Empire State Supportive Housing Initiative (ESSHI)

Summary: Empire State Supportive Housing Initiative (ESSHI) funds support the creation and preservation of affordable, supportive housing units for New Yorkers. Expanding ESSHI or similar programs to include rent and services subsidies for older adults in existing housing projects would help serve unhoused, at-risk, and older adults with disabilities.

Justification: Including rent and services subsidies for older adults would provide essential stability to vulnerable populations, reducing homelessness and housing insecurity. By targeting existing housing units, this approach maximizes resources and provides a direct benefit to those in need of supportive services without the time delay of new construction.

Full Proposal:
ESSHI funds create and preserve affordable and supportive housing units for New Yorkers. Expand ESSHI and/or companion programs to provide a rent and services subsidy option for older adults in existing housing projects:

1. Include existing housing units for unhoused, at-risk, and older adults with disabilities.

MPA Council Commentary: *This proposal is categorized as near-term. Policymakers may reference this proposal during the legislative session and the annual budget process, as implementation may require legislative action and would be subject to the availability of resources. Implementation could include the development of a sister program similar to ESSHI, or the expansion of the eligibility requirements for that program, to focus on older adults. Proposed metrics for evaluating implementation success could include rate of accessible supportive housing options and services subsidies to older New Yorkers.*

Proposal Presented for the Master Plan for Aging (#17):
Supporting Community Housing Models

Summary: Support different housing models that provide a range of services. This proposal includes recommendations to create a 5-year Resident Assistant demonstration project, expand the Neighborhood/Naturally Occurring Retirement Community (N/NORC) program and senior housing with services model, expand housing models that benefit people with mental health and substance use disorders and reduce social isolation, and allow for operators of FTHA to apply for special licenses to perform specific duties.

Justification: The N/NORC model is an example of one of many extremely cost-effective (average cost is $423 per participant) senior housing models that include services allowing older adults to age successfully in their homes. These types of community housing models provide older adults with residential options that may include invaluable services and public benefits such as Medicaid, transportation, wellness programs and social engagement. Expanding the following programs and models, Resident Assistant, N/NORC program, Senior Housing with Services model, and other housing models that can reduce loneliness and social isolation, will allow older adults to successfully age in their preferred setting.

Full Proposal:
Support different housing models that provide a range of services:

1. Create a five-year, state-funded demonstration project to support a Resident Assistant to exist in more affordable housing properties with state or city funding, where at least 75% of the population is comprised of older adults. Includes issuance of a Request for Applications (RFA) by NYSOFA for the five-year demonstration project. The goal of this demonstration project is to help low-income older adult residents, 55+, including, but not limited to, those with physical, intellectual, mental disabilities and substance use disorder, age in community – and delay or prevent the need for a higher level of care – by making, at resident request, connections between residents and community programming to combat social isolation, support abilities, strengthen healthy living, and recognize resident choice.
2. Expand the N/NORC program across NYS by an additional $5,000,000 annually; funding $3,000,000 to support N/NORC Nursing/Health Care Professional Costs; and $250,000 to authorize and fund an independent research study regarding the outcome and effectiveness of the N/NORC programs with consideration for additional funding when the report is delivered.
3. Expansion of the senior housing with services model. Senior housing with on-site services or resident assistance can provide invaluable benefits to older adults and their communities at large. For example, resident assistants or service coordinators in affordable senior housing can help older adults to remain healthy and independent and combat social isolation by: (1) providing information and referrals to resources in the community, education on Medicaid and other public

benefits, and assistance with accessing these benefits and preventive programming; (2) assisting with tasks like arranging for transportation and using technology to support telehealth and social visits; and, (3) supporting wellness and social engagement by coordinating on-site programs such as clubs, health fairs, exercise classes, and celebrations (Nursing or care coordinator/manager on site when there are a sufficient number of seniors in a residence or neighborhood).

4. Support the expansion of housing models that can reduce loneliness, particularly beneficial for individuals with mental health and/or substance use disorders:
    a. Multigenerational Village model.
    b. Integrated Supportive Services model.
    c. Lifeforce In Later Years volunteer program bringing services into housing communities.
5. Create housing models for older adults with mental health and substance use disorders and intellectual/developmental disabilities to promote aging in place.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as the proposed RFA for a resident assistant pilot may require legislative action. The fiscal components of this proposal would need to be considered as part of the annual budget process and would be subject to the availability of resources. Encouraging more housing with services, or housing targeted at alternative populations or care models, could be implemented by including relevant provisions in any zoning changes implemented as part of proposal 15.*

Proposal Presented for the Master Plan for Aging (#93):
Increase funding for the Age-Friendly, Accessible, and ADA-Compliant Downtown and Community Revitalization

Summary: Increase funding for the Downtown Revitalization Initiative (DRI), the New York Forward program and the Local Waterfront Revitalization program to increase and expand projects that meet and exceed compliance the Americans with Disabilities Act (ADA) and create healthy, livable, and age-friendly communities for people of all ages and abilities

Justification: New York State lacks accessible and comfortable public gathering spaces such as parks, town squares, and other areas to wait for transit and meeting areas within the public realm. Public, accessible spaces promote social engagement, reduce social isolation, promote community engagement, improve access to services and businesses. Additional funding for existing programs will allow for improved incorporation of age-friendly, accessibility and inclusivity principles into community planning, design and implementation. These principles can support the creation of healthy, livable, climate resilient, and age-friendly communities for all ages and abilities.

Full Proposal:
DOS community planning and development programs support projects that comply with the ADA and support accessibility amenities for older New Yorkers and people with mobility, cognitive, and/or sensory restrictions. Such amenities are often cost-prohibitive, especially when the need for projects within these programs far exceeds the capacity of currently available funding.

1. Provide an additional $10 million for the DRI and New York Forward program funds and an additional $10 million for other DOS community revitalization and development programs including the Local Waterfront Revitalization Program and the Brownfield Opportunity Area program to make them more accessible, inclusive, and intergenerational with a focus on achieving and exceeding ADA Compliance. The provision of increased funding will:
    a. Create healthy livable communities through improving the built and natural environments.
    b. Improve and prolong mental and physical health, contributing to avoidance of health care and institutionalization.

MPA Council Commentary: *This proposal is categorized as near-term. Next steps for implementation would include an assessment of costs and savings to the state. Funding decisions would be made in the context of the annual budgeting process and subject to available resources*

Proposal Presented for the Master Plan for Aging (#98):
Affordable and Accessible Housing for Unhoused People with Disabilities through Medicaid Redesign Team (MRT) Capital and Supportive Housing Opportunity Program (SHOP)

Summary: Create additional capital funding opportunities to construct affordable and accessible housing units around NYS for unhoused people with disabilities.

Justification: New Yorkers with disabilities are at an increased risk for institutionalization. The expansion of Supportive Housing Opportunity Program (SHOP) to fund affordable, accessible housing will allow people with disabilities to leave residential health care facilities and will reduce homelessness for a vulnerable population.

Full proposal:
The Medicaid Redesign Team (MRT) invested funding into the construction of affordable housing projects that set aside units to serve high utilizers of Medicaid. NYS HCR operates SHOP to facilitate construction of housing units for people needing supportive housing who are also homeless or at risk of being homeless.

1. Expand the SHOP to address the housing needs of New Yorkers with disabilities who may:
    a. Be at risk of institutionalization,
    b. Have lost their homes, or
    c. Who have been placed in nursing homes and are otherwise able to be discharged, but do not have housing options that are affordable and accessible.
2. Eligibility for the new funding should be differentiated from other SHOP funding by focusing on unhoused or institutionalized individuals with a disability who may not share the other needs of populations targeted by existing SHOP funding.
3. Review the possibility of renewing the MRT funding for housing high utilizers of Medicaid as a funding source for the SHOP expansion.

MPA Council Commentary: *This proposal is categorized as long-term. The SHOP program is currently a component of the governor's Housing Plan. Reintroducing MRT capital funds may require amending the State's Medicaid 1115 Waiver. Funding decisions would be made in the context of the annual budgeting process and subject to available resources.*

Proposal Presented for the Master Plan for Aging (#102):
Consideration for Older Adults in Local Law

Summary: Direct localities to revise the language in their local (town, village, or city) laws to specifically include the needs of older adults in their comprehensive plans as it relates to zoning and planning regulations.

Justification: Specified inclusion of the consideration of older adults' needs in comprehensive plans raises the profile of meeting the needs of older adults in the local land use planning process. It may also lead to necessary zoning adjustments.

Full Proposal:
Consider older adults in local land use planning. Direct localities to revise the language in Town, Village, and General City Law relating to the development and adoption of Comprehensive Plans to specifically include:

1. References to consider the needs of Older Adults as it relates to zoning and planning regulations.

MPA Council Commentary: *This proposal is categorized as long-term. This proposal is interrelated with proposal 15, which proposes a requirement that local governments conduct an evaluation of their zoning codes to determine if they adequately meet the needs of older adults. Any next steps on this proposal would need to be informed by an evaluation of existing municipality codes, regulations and ordinances across the state, such as that proposed in 15, with a focus on identifying common challenges and opportunities to better address the housing needs of older adults. Policymakers may reference this proposal during the legislative session, as implementation would likely require legislative action.*

Proposal Presented for the Master Plan for Aging (#48):
Funding Infrastructure Upgrades and Investing in Municipalities

Summary: Establish a $2 billion fund for grants to municipalities to make infrastructure upgrades and capital investments. The proposal includes requirements to encourage local support for capital projects and encourage individual action through community governance.

Justification: Grants can be used to fund infrastructure upgrades for older adults, enhancing accessibility in public buildings and transportation systems. These upgrades could include ramps, elevators, wider doorways, and tactile signage. Grants can also support health and wellness initiatives, such as age-friendly outdoor spaces and fitness equipment. Overall, implementing these measures will result in improved safety and inclusivity within communities.

Full Proposal:
Establish a $2 billion fund for grants to municipalities to make infrastructure upgrades, capital investments, and encourage individual action through community governance:

1. Municipalities must provide matching funds up to a percentage of project costs to be determined.
2. Applications must include a narrative detailing why the project targets or disproportionately impacts older adults and/or people with disabilities.
3. Grants must be used for capital expenses; contemplated projects include affordable housing, transportation or digital infrastructure upgrades, senior centers or other similar community facilities and public gathering spaces, such as parks, trails and open spaces.

MPA Council Commentary: *This proposal is categorized as long-term. Multiple state grant programs currently exist for this purpose. The MPA anticipates that the implementation of other proposals would make it easier for applicants to identify those programs for municipal investments. This proposal would have a substantial fiscal impact and any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#104):
Upgrades to the RESTORE Program

Summary: Offer multifamily housing owners the option to implement accessibility and repair upgrades to support older adults and individuals with disabilities in rental units. Establish a rehabilitation or retrofit program for accessibility upgrades in multifamily housing, modeled after the Residential Emergency Services to Offer (Home) Repairs to the Elderly (RESTORE) program.

Justification: Providing a retrofit program would enhance the safety and accessibility of rental units, allowing older adults and people with disabilities to age in place comfortably. By focusing on existing housing, this approach ensures that critical upgrades can be made efficiently and cost-effectively.

Full Proposal:
Provide an option for multifamily housing owners to implement accessibility and repair upgrades to benefit older adults and individuals with disabilities in rental units.

1. Create a rehabilitation or retrofit program for accessibility upgrades in multifamily housing modeled after the RESTORE program.

MPA Council Commentary: *This proposal is categorized as long-term. This proposal is likely more appropriately focused on the Access to Home program than on the RESTORE program. Retrofit programs are currently being implemented to improve housing accessibility throughout the state. The Department of Health and state agency partners could continue to assess the redesign and expansion of programs like Access to Home. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#100):
Expand Co-located Housing Types for Older Adults

Summary: Integrated and versatile housing options allow older adults and individuals with disabilities to live more independently in the community. Revise programmatic and regulatory guidelines to incentivize the development of versatile housing options in the community.
Add additional environmental supports and modifications to housing and development units to provide additional options for New York State's aging population and for those living with disabilities.

Justification: Institutional settings can isolate older adults and individuals with disabilities from communities. Integrated housing options encourage housing to meet the needs of the individual in the setting of their choosing.

Full Proposal:
Provide versatile housing options to meet the changing needs of older New Yorkers on a single site or campus. Encourage expanded development of co-located housing types for older adults to reduce the number of older New Yorkers who are inappropriately housed, underserved, and reluctant to leave housing for a higher level of care. Co-located housing also has the opportunity to develop micro-communities and operational efficiencies.

1. Examine current funding opportunities for establishment of integrated housing settings.
2. Revise programmatic and regulatory guidelines to incentivize the development of settings that contain components of independent living, assisted living, and skilled nursing facilities.

MPA Council Commentary: *This proposal is categorized as long-term. The co-location of ACFs and nursing homes are governed by a variety of regulations, including federal regulations, that make it challenging to locate the two types of facilities in the same building. New York State would need to discuss changes to federal policy with our federal government representatives. Funding allocations would be subject to the annual budget process and the availability of resources.*

The following proposals in Pillar 4 are unranked as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#115):
Maximize Affordable Housing Impact

Summary: Multigenerational housing provides an opportunity to address intersectional concerns including but not limited to social isolation, housing costs, child-care costs, and household costs. Advocate for changes to federal regulations to amend the rules governing affordable housing eligibility, household size, and waiting lists to enable the formation of multigenerational housing.

Justification: Current requirements for applying for affordable housing and the identification of eligibility of unit size discourage multigenerational housing. Multigenerational housing provides an opportunity to address a number of intersectional concerns including but not limited to social isolation, housing costs, child-care costs, and household costs. Separately, the limited stock of affordable housing is further diminished by residents who no longer need a unit to accommodate children.

Full Proposal:
Encourage the state to advocate for changes to federal regulations to accomplish the following:

1. Amend rules governing affordable housing eligibility and household size to facilitate the formation of multigenerational households. Enable the housing of multigenerational families in 2- to 3-bedroom units next to a studio or 1 bedroom unit to better enable multigenerational housing.
2. Give priority to residents of affordable housing units on waiting lists when they seek to downsize to a smaller unit.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. The rules referenced above are largely governed by federal requirements and regulations governing affordable housing tax credits and other federally-funded programs. New York would need to discuss changes to federal policy with our federal government representatives.*

Proposal Presented for the Master Plan for Aging (#116):
Landlord Accessibility Education

Summary: Develop a standard set of resources to educate landlords on their responsibilities and obligations regarding modifications for accessibility. Work with landlord organizations to ensure that their members are aware of those responsibilities and obligations.

Justification: Many landlords across New York State do not have a complete understanding of their legal obligations and responsibilities to provide home modifications for accessibility. They may not know the average cost of a modification such as the installation of grab bars in a shower, or a wheelchair ramp, often resulting in a denial of tenant accessibility requests. Fair housing organizations report that a letter that details the landlords' obligations and the steps they should take around retrofitting or adding modifications is often sufficient to get landlords to address these issues.

Full Proposal:
Develop a standard set of materials to be distributed to landlord organizations, alongside a recorded webinar covering the following topics:

1. Landlord legal responsibilities for accessibility home modifications.
2. Education about reasonable accommodation versus reasonable modification.
3. Understanding costs of retrofitting, such as putting in shower grab bars, wheelchair lifts or wheelchair ramps.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as near-term. Program staff from the MPA team and HCR could work with not-for-profit organizations to identify those obligations and responsibilities that are most frequently the subject of advocacy on behalf of tenants with accessibility needs. There may be a fiscal need attached to the production of training materials for distribution in partnership with landlord organizations, which would be evaluated in the context of the annual budget process and subject to the availability of resources.*

Proposal Presented for the Master Plan for Aging (#117):
Zoning Incentive to Develop Worker Housing

Summary: Provide residential health care facilities and health systems with local zoning code relief to develop housing for health care and direct care workers to address the housing and workforce shortages. Local zoning code shall exempt residential housing built by health care, long-term care, and older adult housing facilities that are intended for employees of the facility.

Justification: A lack of affordable and available housing options throughout the state intensifies shortages of direct care workers and service providers. It is difficult for New Yorkers in low-wage service jobs, including health care and personal care workers, to find affordable housing that is convenient to their work. The systemic intersectional challenges of the housing and workforce crisis could be reduced if home health aides (HHAs), personal care aides (PCAs) and other low-wage health care and personal care service jobs had access to affordable housing provided by their employer.

Full Proposal:

1. Residential units built or converted by health care, long-term care, and independent living facilities that are restricted for use by employees of the facility and their families shall be excluded in the calculation of floor area ratios and shall be exempt from any other zoning or other local code governing the density or quantity of residential housing.
2. Such housing intended for workers may be considered a benefit provided by the employer to the employee, and providing such benefit shall be deemed permissible under any laws otherwise prohibiting housing discrimination on the basis of occupation or employment status.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. Policymakers may reference this proposal during the legislative session, as this proposal may require legislative action.*

Proposal Presented to the Master Plan for Aging (#128): Communication Access in Direct Care, Assisted Living, Nursing Homes, and Memory Care for Deaf, DeafBlind, and Hard of Hearing

Summary: Multi-level approach to improving communication access for Deaf, DeafBlind, Hard of Hearing New Yorkers who are receiving direct care and/or residing in assisted living facilities, nursing homes, or memory care facilities.

Justification: Deaf, DeafBlind, and Hard of Hearing New Yorkers are frequently and severely isolated from peers, staff, and family members by lack of access to effective communication (American Sign Language interpretation, live transcripts, hearing technology, tactile sign language, etc). New York has Tanya Towers in NYC for OMH-specific Deaf, DeafBlind people and HCR recently built a Deaf-focused housing complex in Rochester. The Deaf, DeafBlind, and Hard of Hearing communities have called for more housing in this model to serve their population and to improve communication access across the state with training and "how-to" materials.

Full Proposal: The inability to obtain effective communication isolates Deaf, DeafBlind, and Hard of Hearing people from those around them. Isolation causes significant health deterioration in people and makes for a miserable experience for many. Other states have developed Deaf and DeafBlind specific wings of nursing homes in order to facilitate peer-to-peer communication and centralize staff who are able to communicate to these community members either through their own skills, proficient usage of Video Relay Interpreting (VRI), live transcription, and/or other effective communication approaches. The residents of Tanya Towers in NYC and the Deaf-focused housing complex in Rochester have shown improved health outcomes and there is more demand than there are spaces within these places. The Office of the Chief Disability Officer and the Deaf, DeafBlind, and Hard of Hearing Office can create effective communication guides. NYSOFA can coordinate with these offices to provide resources and training to elder care facilities on how to effectively communicate with Deaf, DeafBlind, and Hard of Hearing New Yorkers. HCR and NYSOFA can work to build and modify homes to be more accessible to Deaf, DeafBlind, and Hard of Hearing people.

MPA Council Commentary: *This proposal contains near-term and long-term components. NYSOFA, the Office of the Chief Disability Officer, the Deaf, DeafBlind and Heard of Hearing Office, and the Department of Health could coordinate to develop and distribute resources and training materials. Any funding needed to develop and distribute training materials or to directly support the building and modification of homes would be evaluated in the context of the annual budget process and subject to the availability of resources.*

V. Affordability of Basic Necessities

Proposal Presented for the Master Plan for Aging (#69):
LTSS Finance Reform

Summary: Consider a new financing system to pay for LTSS in the State, focusing on a long-term care social insurance model. This new program would supplement the existing Medicaid, the Expanded In-home Services for the Elderly Program (EISEP), and private long-term care insurance markets after conducting an actuarial study on LTSS financing model feasibility. This would consider the types of benefits, who should qualify, how it should be funded and other variables and concurrent study of LTSS benefit design which includes cash-only, services-only, and an option between the two. It also covers all LTSS services, including examination of anticipated costs for funding of public education and workforce investments.

Justification: Existing long-term care financing options are insufficient and don't work for many New Yorkers. Many people must spend down their life savings to pay for long-term care. Nationally, there are major problems in the long-term care insurance market due to historic mispricing causing insurers to leave the market and premium rates to become unaffordable. Inability to pay for home care and long-term care has disproportionate effects on under resourced communities and social determinants of health (SDOH). Washington state has instituted a long-term care social insurance program, and several states have conducted, or are in the process of conducting, actuarial studies in consideration of implementation of a similar program that will directly address these issues.

Full Proposal:
Establish a new financing regime to pay for LTSS in the State, focusing on a long-term care social insurance model. This new program would supplement the existing Medicaid, EISEP, and private long-term care insurance markets.

1. Conduct an actuarial study on LTSS financing model feasibility, which would consider the types of benefits, who should qualify, how it should be funded and other variables.
2. Study LTSS benefit design which includes cash-only, services-only, and an option between the two and covers all LTSS services, including examination of anticipated costs for funding of public education and workforce investments (at current scheduled home care minimum versus at 150% of the minimum wage) and to calculate projected Medicaid savings from the program.
3. Convene stakeholders to come to consensus recommendations on a Finance Reform program based on the actuarial study results.
4. Share report with the Legislature and Executive chamber for implementation.

MPA Council Commentary: *This proposal is categorized as long-term. Complex procurement rules preclude New York State from accessing philanthropic funds. The Department of Health and state agency partners can continue to evaluate long-term care financing and insurance options. Medicaid program changes and funding*

allocations must be considered within the context of the annual budget process and are subject to the availability of resources.

Proposal Presented for the Master Plan for Aging (#1):
Establishing the Office of Benefits Coordination

Summary: Establish a Benefits Coordination Office to streamline existing benefits programs across the New York State government. The office would document existing benefits and provider resources, develop a single portal website for benefit identification, and operate a universal benefits application for streamlined application processes.

Justification: Inefficient and inadequate coordination of benefits and services for older adults limits access and leads to poorer health outcomes. The Office of Benefits Coordination aims to streamline the application process for benefits available to New Yorkers through improved collaboration and coordination efforts between state agencies and local social services offices.

Full Proposal:
The State would establish a Benefits Coordination Office with the mission of coordinating all existing benefits programs across New York State government. The Benefits Coordination Office would be responsible for:

1. Documenting all existing benefits programs across State government.
2. Maintaining a single-portal website identifying all State benefits programs, with a staffed phone line for non-digital access.
3. Tracking benefits program funding and performance metrics.
4. Tracking pharmaceutical price negotiation and control efforts at the federal and state level.
5. Maintaining a database of provider resources (e.g., long-term care facilities, home and community-based services providers) and usage/performance data for those providers, where available.
6. Operating a universal benefits application that streamlines applications processes and forms and is available in accessible formats, multiple languages, and submittable online. This application will be administered cross-agency with multiple points of entry in the health care, commercial, nonprofit, and social service system and should be designed with health literacy and other culturally competent concerns tested on diverse cohorts of older adults and individuals with disabilities.

Additional functionality for the portal shall include:

a. Wellness, mental/behavioral health, substance use disorder and social isolation screening tools, including a wellness screening website and mobile application that can also be printed for completion by hand. It includes current, readily available, evidence-based screening tools for mental health, substance use disorder, loneliness, and suicide prevention and it facilitates an appropriate individualized response. Individualized responses will be available in multiple languages in compliance with NYS Language Access Law.
b. A provider-facing portal for providers to assist or evaluate applicants.

c. Tracking data regarding individuals cross-enrolled in multiple benefits.
d. Integration with programs to assist with benefits education and applications (e.g., Health Insurance and Information Counseling and Assistance Program, Facilitated Enrollment for the Aged, Blind, and Disabled Program).
e. A centralized repository for technology resources, trainings and supports.
f. Identifying benefits that an applicant may qualify for, even if they have not specifically applied for them.
g. Integration with transportation coordination applications (e.g., Mobility Management).
h. Expanding outreach, communications, marketing, and assistance for individuals, including increased funding for the Health Insurance and Information Counseling and Assistance Program, FE-ABD, and accessible nonprofit assistors in compliance with Section 508 rules that help people enroll in benefits for older adults that also address the needs as people age such as long-term care/HCBS. A disproportionate amount of funding is spent towards health plan communications and marketing for people under age 65.

Stakeholder Advisory Committee Note: This proposal is ranked according to the original proposal. The Stakeholder Advisory Committee urged consideration regarding different approaches to streamlining benefits access rather than the creation of a new office. They also recommended that this proposal be split in half to address the need to update the back-end technology infrastructure and the front-end user experience in addressing statewide benefits program access.

MPA Council Commentary: *This proposal is categorized as long-term. The creation of a new office would require an assessment of the costs and savings to the State and an assessment of the scope of the proposed office. Any funding allocations would be subject to the annual budget process and the availability of resources. Following these assessments, the creation of a new office is administratively complex and would require extensive statutory and regulatory changes for multiple state agencies. State agency partners are currently working on related initiatives to update technology infrastructure and user experience, streamlining access to a range of benefit programs through the Integrated Eligibility System and making it easier for New Yorkers to apply. New York State agencies can continue to evaluate existing benefits coordination programs and opportunities for improvements in infrastructure and coordination. Following these evaluations, New York State agencies may identify benefits coordination opportunities*.

Proposal Presented for the Master Plan for Aging (#72):
Improving Use of Medicare Savings Program

Summary: Undertake regulatory and budgetary outreach, education and programmatic actions that aim to increase, streamline, and simplify enrollment into the Medicare Savings Program (MSP).

Justification: The MSP can help older adults build health and economic security. However, stubborn barriers to enrollment, access, and retention persist. Accessibility, stigma, lack of adequate outreach, education, and application assistance, all impact MSP enrollment and retention. The elements of this proposal would update and align benefit criteria, streamline application processes, increase outreach and awareness, update technology infrastructure, and maximize benefit enrollment using data matching which may automate enrollments across multiple benefit programs.

Full Proposal:
The MSP assists older adults with maintaining financial and economic security regarding their health costs. Unfortunately, barriers to enrollment, access, and retention persist, including accessibility, stigma, a lack of adequate outreach, education, and application assistance. To better serve older adults, actions should be considered that aim to increase, streamline, and simplify enrollment in the Medicare Savings Program and multiple benefits that result in universal access to comprehensive health coverage.

1. Update and align benefit eligibility criteria that support affordability and whole-body, whole health.
2. Ease the application process for new applicants and prioritize updating information technology immediately.
    a. Consider a guarantee that individuals transitioning from New York State of Health Marketplace Medicaid (MAGI Medicaid and the Essential Plan) can retain comparable health care coverage as they age, and along the continuum of aging and changing health care needs.
    b. Update major information technology infrastructure and eligibility systems with a focus on diverse feedback including race, ethnicity, health literacy, and disability.
3. Streamline application processes and forms by creating a universal benefits application for multiple benefits administered cross-agency with multiple points of entry in the health care, commercial, nonprofit, and social service systems.
4. Maximize benefit awareness and enrollment using data matching that may automate enrollments across multiple benefit programs. This includes exploring flexibility that sustains enrollment in benefits through automated renewal processes across multiple benefits.
5. Expand outreach, communications and marketing, and application assistance, including increased funding for Health Insurance and Information Counseling and Assistance Program (HIICAP) and nonprofit assistors that help people enroll in benefits.
6. Track, measure, and report enrollment data across multiple benefits in a uniform manner to identify gaps and barriers in cross-benefit enrollment.

MPA Council Commentary: *This proposal is categorized as near term. Components of this proposal are currently being implemented by Chapter 585 of the Laws of 2024. Projects currently being developed are working to maintain plan membership as people grow older. Other components of this proposal are categorized as long-term due to logistical and financial complexity. State agency partners can continue to assess costs and savings to the State. Any increases in funding to support this proposal would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#68):
Increase Utilization of the Elderly Pharmaceutical Insurance Coverage Program (EPIC)

Summary: Increase utilization of the Elderly Pharmaceutical Insurance Coverage (EPIC) program by addressing stubborn barriers to enrollment, access and retention through program oversight and transparency, simplify program administration, address stigma, improve a lack of adequate outreach and education, as well as culturally and linguistically competent education and outreach to support application assistance.

Justification: The EPIC program provides seniors with co-payment assistance for Medicare Part D-covered prescription drugs after any Part D deductible is met. EPIC can help older adults achieve better health outcomes through prescription drug savings and build economic security. Unfortunately, stubborn barriers to enrollment, access, and retention persist. Accessibility, stigma, lack of adequate outreach, education, and application assistance, all impact EPIC enrollment and retention. By improving program oversight and transparency, simplifying program administration, and increasing outreach to increase program utilization, older adults will have better access to necessary medications.

Full Proposal:
EPIC provides older adults with co-payment assistance for Medicare Part D-covered prescription drugs after any Part D deductible is met. To increase utilization, recommendations include addressing stubborn barriers to enrollment, access, retention, stigma, lack of adequate outreach and education, as well as application assistance.

1. Improve program oversight and transparency.
    a. Reconvene the EPIC advisory committee and EPIC panel under the Department of Health.
    b. Report any program administrative changes to advisory panel for discussion and feedback prior to implementation.
    c. Outline and communicate any proposed changes to minimize impact on EPIC members.
2. Simplify program administration:
    a. Require disclosure of rebates from drug manufacturers where it may affect consumer decisions and therefore EPIC members, coverage.
3. Education and Outreach:
    a. Conduct a widespread educational and outreach campaign coordinated with community-based organizations to reach diverse communities who would most benefit but are least likely to know about it.
    b. Allocate funding for translated materials, language access, and outreach events that would permit the communities to learn more about EPIC.

MPA Council Commentary: *This proposal is categorized as near-term. Component 3 of this proposal is currently being implemented. The existing EPIC program provides*

educational and outreach services as well as application assistance for federal programs. Program applications are currently available in 10 languages and online enrollment options are available. Component 1 of this proposal is categorized as long-term. State agency partners can continue to assess the viability of reconvening the EPIC advisory committee and its proposed duties. As a State-funded program, any additional EPIC enrollment would have an impact on the State's Financial Plan, and thus discussions on this proposal would be subject to the annual budget process and the availability of resources.

Proposal Presented for the Master Plan for Aging (#101):
Expand STAR Benefits

Summary: Expand the School Tax Relief (STAR) program benefits to help provide eligible aging homeowners with financial relief by providing upfront savings off their tax bills.

Justification: Due to inflation, there has been a steady increase in the cost of living over the past three years. These increases can put a financial strain on homeowners, especially those aging and on a fixed income. This tax credit relief could potentially offer homeowners hundreds, or thousands of dollars, in savings a year.

Full Proposal:
Address the affordability pressure on the high percentage of older adults who are homeowners. The School Tax Relief (STAR) program provides property tax relief that financially benefits older New Yorkers:

1. Expand STAR benefits for older adult homeowners having difficulty maintaining housing.
2. Create incentives for localities to adopt senior citizen STAR enhancements.
    a. Develop incentives through the Pro-Housing Communities and economic development programs.

MPA Council Commentary: *This proposal is categorized as long-term. New York already offers an Enhanced STAR program that provides tax relief specifically to older New Yorkers, providing almost 700,000 people in FY24 with an average benefit of $1,400, and Governor Hochul's FY26 Executive Budget proposed to simplify STAR eligibility determinations to the benefit of older adults. In addition, some localities already offer property tax relief to older adults that may render STAR enhancements less valuable to these older adults; component 2 of this proposal must be evaluated in the context of these alternative forms of tax relief. Tax benefits and other programs with fiscal impact would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#24):
Fund the Office for Older Workers & Expand Workforce Development Initiative

Summary: Consider budgetary and regulatory actions that would expand workforce development services and job training for older adults, building on efforts such as DOL's now concluded Workforce Development Initiative to better maintain and find employment and/or start encore careers.

Justification: Older adults have a specific pattern of disconnection from the workforce that needs to be addressed. Older workers are overrepresented among discouraged workers and workers over 50 who become unemployed. They are more likely to become unemployed long-term. Many older New Yorkers need or want to remain in the workforce and in areas of the state with fewer younger workers, retaining older adults in the workforce is essential in maintaining services and infrastructure. DOL is already creating an office for older adults within their office. It needs to be funded to add staff, and develop and promote programming.

Full Proposal:
Expand workforce development services and job training for older adults through DOL's Workforce Development Initiative so they can maintain and find employment and/or start encore careers. Focus on ensuring existing and future workforce training initiatives work for older adults. Existing and new programs would be promoted to raise awareness and barriers that inhibit promotion.

1. Fund DOL's Office for Older Workers to improve its ability to support older New Yorker's ability to stay engaged, active, working, and volunteering. Utilize existing and future training initiatives through the Office for Older Workers, expand workforce development services, such as those previously supported through DOL's Workforce Development Initiative, to encourage maintenance of employment or creation of second careers, and promote existing and new programs to raise awareness about employment and engagement options.
2. Support DOL with programming and resources to workers to find out what would be helpful in offering skills training and opportunities. Specialized needs training should be designed for current workers and provided in accessible ways to accommodate adult workers, giving them skills to be more competitive in labor force.
3. Employers would be educated on accommodations/flexibility to allow older workers with health needs to continue to work (i.e., the development of flexible roles). Employers would also be educated on caregiver responsibilities and the need for flexibilities. Technology training would be made available to older adults and availability should be promoted.
4. Job developers/recruiters should be inclusive of older adults and build relationships with employers by recommending older adults.

MPA Council Commentary: *While the Workforce Development Initiative at the DOL has concluded, implementation of this proposal could be pursued through a variety of mechanisms (e.g., expanding services through DOL's career centers). Components 1 and 2 of this proposal are categorized as near-term. Implementation of these components might require a State funding allocation for the Office for Older Workers and would benefit from the development of a partnership between NYSOFA and DOL, for example, to inform skills training efforts. Proposed metrics for evaluating implementation success would need to be developed, and could include improved awareness of employment, engagement options, and number of second careers created. Components 3 and 4 of this proposal are categorized as long-term. Policymakers may reference this proposal during the legislative session, as these components would require statutory changes for implementation. Any funding would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#23):
Establish a Lifetime Financial Planning Program

Summary: Create a Lifetime Financial Planning Program responsible for assisting New Yorkers in planning their finances throughout their lifetime, including budgeting, financial literacy, planning for life's milestones (including retirement), dealing with debt, referrals to career counseling, and education about long-term care insurance options. Integrate this program with Secure Choice to ensure fundamental education within the structure of the existing program.

Justification: New Yorkers are not proactively supported to prepare for retirement, in part due to a lack of financial literacy and education. The concept of retirement planning hits too late leading many people without sufficient resources set aside for retirement. There is a gap between Social Security benefits provided and what someone may need to live. The proposed Lifetime Financial Planning Program is needed to assist New Yorkers in planning their finances throughout their lifetimes: including budgeting, financial literacy, planning for life's milestones (including retirement), dealing with debt, referrals to career counseling, and education about long-term care insurance options.

Full Proposal:

1. Create a Lifetime Financial Planning Program responsible for assisting New Yorkers in planning their finances throughout their lifetime, including budgeting, financial literacy, planning for life's milestones (including retirement), dealing with debt, referrals to career counseling, and education about long-term care insurance options.
2. The Program would serve as an information and education resource to support financial literacy and lifelong planning.
3. The materials should also provide information on the limits of public programs and engage with common misconceptions regarding benefits programs.
4. This Program could involve collaboration between agencies such as the Department of Labor, Department of Taxation and Finance, or as SUNY.
5. Integrate this program with Secure Choice to ensure fundamental education within the structure of the existing program.

MPA Council Commentary: *This proposal is categorized as near-term. Implementation would start with engaging DOL, and DTF to determine whether the program materials should be developed internally or acquired through a Request for Proposals (RFP), and to identify a responsible office. Implementation may require funding either an RFP or State staff to develop the materials. Both methods of implementation would be subject to the annual budget process and the availability of resources.*

VI. Access to Services in and Engagement with Historically Underserved Communities

Proposal Presented for the Master Plan for Aging (#18):
Encourage Transportation Network Integration and Growth

Summary: Improve scale, efficiency, and capacity of transportation networks by exploring the expansion of micro-transit services to regions with a high percentage of older New Yorkers, ridesharing technologies such as GoGo Grandparent, expanding the supply of volunteer drivers, encouraging the coordination of rural transit providers into a regional entity that can coordinate services, and establishing local transportation and considerations into existing funding programs and expanded funding opportunities.

Justification: Many older adults and people with disabilities struggle to access affordable and reliable transportation, especially in rural areas. Improving transportation networks, including micro-transit services and volunteer drivers, and coordinating rural transit providers can streamline services across NYS, providing more accessible, affordable, and reliable transportation options.

Full Proposal:
Improve scale, efficiency, and capacity of transportation networks by making the following investments:

1. Explore the expansion of microtransit services to regions with a high percentage of older New Yorkers living in suburban communities, village centers in rural areas, or other mid-density locations where services/destinations are nearby but inaccessible by walking or by conventional public transit. Allow this service to be in addition to existing paratransit service for those individuals who have mobility limitations but are not considered disabled. Research existing micro-transit services in the Capital Region, Rochester area, and Suffolk County to determine how they have accommodated older riders.
2. Expand the supply of volunteer drivers through insurance regulatory clarifications to protect the insurability of volunteer drivers who otherwise maintain a consistent risk profile; prohibit insurance companies from denying or canceling insurance, imposing a surcharge, or increasing rates solely on the basis of serving as a volunteer driver; and make clear that personal auto insurance policies cover volunteer driving.
3. Encourage the coordination of rural transit providers into a regional entity that can coordinate services to avoid duplication, which has the size/capacity to develop and operate new/improved services, and is not limited by county/municipal boundaries but operates in a service area that meets a rural aging populations' travel needs. If establishment of a regional entity is not possible, then ensure a regional partnership is established to align services between separate providers. Reinforce the need for comprehensive Coordinated Public Transit Human Services Transportation Plans and develop mechanisms for their implementation. Such entities or partnerships would service both aging populations and the general public.
4. Encourage the consolidation of rural transit providers – specifically those funded

by 5311 or 5310 (as open door) – into existing or newly established regional entities that can coordinate services to avoid duplication, which have the size/capacity to develop and operate new/improved services, and are not limited by county/municipal boundaries but operate in a service area that meets a rural aging populations' travel needs.

5. Ensure that all publicly supported, county-level and regional transportation programs for older adults and people with disabilities incorporate on-demand, flexible, accessible and cost-effective options to the greatest extent possible within available budgets.
6. Establish grant-supported local transportation pilots: grants for the development of local pilot projects that shuttle older adults to medical appointments and social activities, especially in rural and suburban areas.
7. Update public transportation for ADA compliance; all bus seats should be ergonomic and padded and ADA compliant—consider how some people are unable to use non-compliant ADA mass transit in New York City.
8. To the extent feasible within the 5310 application evaluation process, prioritize applicants who propose to use vehicles in an "open" service in order to align with the coordination emphasis of the Federal Transit Administration (FTA) and address the need for the broader use of vehicles not just for select groups of older adults under a closed model, but rather under an open model to have more capacity to serve older adults unaffiliated with programs.
9. Support and fund Complete Streets land use and transportation funding and policies.
10. Improve the scale, efficiency, and expand the access to technologies such as GoGo Grandparent to enhance access to ridesharing opportunities.

MPA Council Commentary: *Components 1, 2, 5, 6, 7, 8, and 9 are categorized as long-term. The expansion of the Innovative Mobility Initiative would require an assessment of costs and savings to the state. Following this assessment, the New York State Department of Transportation (DOT) would need to determine next steps for program and grant implementation. Component 2 would require changes to insurance regulations, including a review of the market impact of the proposed changes. Components 3 and 4 are currently being implemented with assistance from DOT, rural, and nearby transportation providers. Component 10 is categorized as near-term but would require financial resources that would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#52):
Support Electronic Health Records Adoption

Summary: Budgetary considerations for long-term care providers who were not eligible for federal Meaningful Use funding for electronic health record (EHR) adoption, and policy and regulatory actions to increase efficiency, support workforce and partner with systems across the continuum to ensure seamless care transitions and support technology acquisition and implementation.

Justification: Long term care service and supports providers in all settings experience difficulty providing equitable and quality support and care, particularly during points of transition or shifting care needs because they did not receive meaningful use funding to connect to EHR systems. Allocating funding to allow long-term care service and support providers to modernize their health record systems is likely to result in improved health outcomes and reduced health care spending, a significant return on investment.

Full Proposal:
Integration of information from medical, behavioral, and mixed payer client data systems that did not receive any meaningful use funding are unlikely to be connected to EHR systems.

1. Allocate funds to long-term care providers who were not eligible for federal funding for EHR adoption.
2. Increase efficiency, support a stressed workforce and partner with systems across the continuum to ensure seamless transitions in care through grants to support technology acquisition and implementation.

MPA Council Commentary: *This proposal is categorized as long-term. This proposal would require an assessment of costs and savings to the State. Funding allocations would be subject to the annual budget process and the availability of resources. The Department of Health can continue to evaluate required resources for the coordination and modernization of EHRs across the state.*

Proposal Presented for the Master Plan for Aging (#106):
Improve Retirement Opportunities for People with Intellectual and Developmental Disabilities

Summary: Individuals with intellectual and developmental disabilities have limited access to retirement options as they age, necessitating more support for their post-employment livelihoods. Adapting existing programs and senior centers could expand retirement opportunities for this population.

Justification: Utilizing current resources like senior centers and programs allows for a cost-effective way to create inclusive retirement options for people with disabilities. This approach ensures that individuals can enjoy meaningful and supported retirements without needing entirely new infrastructure.

Full Proposal:
People with intellectual and developmental disabilities have limited access to desired retirement options and Social Security as they age. More retirement opportunities are needed to support post-employment livelihood:

1. Utilize and adapt existing programs and senior centers to provide retirement opportunities for people with intellectual and developmental disabilities.
2. Require businesses operating in New York to provide retirement benefits for individuals with intellectual and developmental disabilities.

MPA Council Commentary: *Component 2 of this proposal is categorized as long-term. This proposal may require statutory changes, and any state support would be subject to the annual budget process and the availability of resources. Component 1 of this proposal is categorized as near-term. Proposed first steps for implementation could include coordination between NYSOFA and OPWDD. This coordination could ensure that existing programs for older adults (such as Social Adult Day Care programs) are able to accommodate individuals with intellectual and developmental disabilities. Proposed metrics for evaluating implementation success could include improved engagement in community programming for individuals with disabilities.*

Proposal Presented for the Master Plan for Aging (#97):
Fund the NYS Adaptive Living Program

Summary: Increase funding for the existing New York State Adaptive Living Program (AP) for Older Individuals who are Blind (OIB) to meet current demand and use AP services to empower older elders to live at home, while increasing reimbursement to much-needed service providers.

Justification: This program is currently working to ensure aging adults can remain at home and is looking to gain more funding to extend these services to more eligible New Yorkers.

Full Proposal:
The New York State Adaptive Living Program (AP) for Older Individuals who are Blind (OIB) administered by the New York State Commission for the Blind (NYSCB) builds access to critical services for individuals 55+ who are legally blind and are not seeking employment. These critical rehabilitative services reduce falls, delay the need for home care or institutionalization, increase independence, improve quality of life, and decrease the burden carried by the public health systems and caregivers.

1. Increase funding to the NYS AP to enable the AP to extend coverage to 1,000 people, allowing these beneficiaries to live at home, as well as to increase reimbursement to service providers to enable inclusion of modern assistive technology.

MPA Council Commentary: *This proposal is categorized as near-term. Funding decisions must be made in the context of the annual budgeting process and are subject to the availability of resources. Proposed first steps for implementation could include an assessment of costs and savings to the State. Proposed metrics for evaluating implementation success could include the number of individuals served by the Adaptive Living Program and length of stay in the setting of their choice.*

Proposal Presented for the Master Plan for Aging (#55):
Loan Forgiveness for Nurses in Medically Underserved Areas

Summary: Expand eligibility for Nurses Across New York (NANY) by including specific considerations for serving older adults or within the LTSS field, consideration of eligibility for other titles, and development of a solicitation of interest related to interest in serving the LTSS population.

Justification: There is a lack of age-friendly and geriatric expertise and education among the nursing discipline, contributing to a workforce crisis among the growing population of aging New Yorkers. Loan forgiveness and reimbursement for specialty certification may incentivize nurses to work with the population, thereby reducing the workforce crisis and improving care rates and quality for older adults.

Full Proposal:
Establish a loan forgiveness/certification support program that builds off of the current NANY (Public Health Law Section 2807-AA).

1. The new program would add practicing with a "specific population of older adults and individuals with disabilities requiring LTSS," (to be more specifically defined) to the existing service obligation in a "medically underserved area." The goal is to engage new nursing professionals in working with the aging population and to also support the development of expertise of current nurses and advanced practitioner nurses by reimbursing the costs of specialty certification.
2. If determined by the Counsel's Office that the NANY Statute requires an amendment to add a specifically defined population that differs from the HRSA designation, eligibility for nurse practitioners (NPs) and clinical nurse specialists (CNSs), and include reimbursement for specialty certification, amend and add an appropriation so the special aging/disability population does not draw resources away from the original medically underserved areas. Since the NANY statute refers to RNs and is not specific as to whether they are advanced practice RNs who may also have an NP or CNS certification, it would not seem that including NPs and CNSs in the NANY Program needs an amendment, however, adding a specific population as an additional option for the service obligation and including specialty certification reimbursement will likely need a change in statute.
3. The Department of Health to develop a solicitation of interest related to the specific population for service obligation related to loan forgiveness and certification reimbursement.

MPA Council Commentary: *This proposal is categorized as long-term. Evaluation of the efficacy of loan forgiveness programs is required. Following this evaluation, this proposal may require statutory changes, or additional funding which would be subject to the annual budget process and the availability of resources. The Department of Health can continue to evaluate the efficacy of existing loan forgiveness programs for recruitment and retention of nursing staff.*

Proposal Presented for the Master Plan for Aging (#95):
Affordable Housing and Support Services for Older Veterans

Summary: Address affordable housing and access to support services for elderly veterans by the establishment of services, utilization of existing programs, and collaboration between programs.

Justification: Older veterans are in need of access to affordable housing that is tailored to their specific needs. Location of residence often determines access to other services. These barriers can be addressed through existing resources while also protecting the interests of this specific population.

Full Proposal:

1. Collaborate with housing authorities, nonprofit groups, community development agencies, educational institutions to establish affordable housing and support services for older veterans in New York State.
2. Obtain support from government housing grants, private foundations, and collaborative efforts with the private sector.
3. Create a system for monitoring the stability of housing, use of services, and the general well-being of veterans.
4. Develop affordable housing units and the construction of new affordable residences tailored to meet the needs of veterans with features which enhance accessibility.
5. Expand programs offering housing vouchers to aid veterans in finding cost-effective housing options.
6. Provide supportive services and case management to assist veterans in navigating housing, health care, and social service systems.
7. Improve transportation accessibility to appointments, grocery shopping and community events.
8. Offer legal aid support on matters relating to housing rights, benefit claims, and estate planning.
9. Partner the existing “Hidden Heroes State” and the existing Elizabeth Dole Foundation to open access to public-private partnerships which leverage respite care offerings and related services for caregivers of veterans.
10. Provide grants or low interest loans for home modifications like ramps, grab bars, and stairlifts to enhance accessibility.
11. Assist in upgrading energy efficient measures to lower utility expenses for veterans.
12. Encourage initiatives which integrate veterans into their communities through social gatherings, volunteering opportunities, and neighborhood watch programs.
13. Create programs that bring veterans and younger community members together for support and enrichment across generations, making offerings on high school and college campuses available as more students become caregivers with fewer

resources or education on aging.

a. Offer “Bridge the Gap” Gerontology educational opportunities at high schools and on college campuses with in-class or assembly speaker sessions, especially during Veterans Month.
b. Provide annual Wellness Seminars including students in health majors with a Gerontology 101 component.
c. Provide physical and mental health resources in a Benefits Checkup for students.
d. Create on-campus Veterans Centers.

MPA Council Commentary: *This proposal is categorized as near-term. This proposal is currently being implemented at DVS. State agency partners can continue to work with supportive services to issue housing vouchers and evaluate potential collaborations for improved access to resources for older veterans. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#96):
Lifelong Learning Program and Employment Support for Older Veterans

Summary: Establish new resources and programs to increase education and employment opportunities for elderly veterans.

Justification: Elderly veterans have limited access to continued education or job opportunities outside of the military due to transferable skills not being accepted, being older in standard educational settings, and/or lack of access to education and employment opportunities.

Full Proposal:

1. Improve the quality of life for veterans through the creation of a Lifelong Learning Program that offers opportunities for learning and employment assistance.
2. Collaborate with schools, job agencies and veteran support groups.
3. Secure funding through state and federal grants for education and employment as well as private and corporate contributions.
4. Monitor program outcomes, overall satisfaction levels, and overall program participation.
5. Provide continuing education courses at college and universities including online options for convenience.
6. Conduct skill development workshops covering topics such as literacy, financial planning, and health management.
7. Aid veterans in obtaining verifications and training for careers or hobbies.
8. Establish services to assist veterans in finding employment that aligns with their skills and interests.
9. Provide entrepreneurship programs, resources, and supports to veterans interested in launching businesses including business planning and accessing funding.
10. Create a network of part-time and flexible job opportunities which cater to the needs of veterans.
11. Establish mentorship programs connecting veterans and other professionals for guidance and support.
12. Organize networking event programming to facilitate connections and job opportunities within the veteran community and beyond.
13. Create a Veterans' Volunteer program available in local communities to enable veteran's to contribute to their communities, engage in governance, community committees, and advocacy associations.

MPA Council Commentary: *This proposal is categorized as near-term and is currently being implemented at DVS. State agency partners can continue to collaborate to successfully implement this proposal. Any additional resources or funding allocations that may be necessary would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#94):
Enhanced Health & Well-Being for Older Veterans

Summary: Create a holistic health and wellness program with a focus on physical and mental health for elderly veterans in New York State. This program should increase access to specialized services, programs and education.

Justification: There is limited access to health and well-being services for elderly veterans in New York State. This proposal would expand access to services and increase overall availability of services, programs and education.

Full Proposal:
Enhance the health and well-being of veterans in New York State through the creation of a holistic health and wellness program. The program should include:

1. Physical health support, including physical health checkups to implement health screenings initiatives for prevention, including the detection of conditions such as diabetes, high blood pressure, and cancer.
2. Specialized access to medical care, including geriatric care, cardiology, oncology, and orthopedics.
3. Access to rehabilitation assistance including physical and occupational therapy services, for the preservation of mobility and independence.
4. Mental health support including counseling/therapy sessions for a variety of mental health concerns such as PTSD, anxiety, depression, access to peer support groups and telehealth options.
5. Health education programs and resources including workshops and seminars on topics such as nutrition, exercise, and managing chronic conditions.

MPA Council Commentary: *This proposal is categorized as near-term and is currently being implemented at DVS. DVS and state agency partners can continue to enhance the wellness of older veterans through health and education outreach and collaborative efforts to successfully implement the components of this proposal.*

The following proposals in Pillar 6 are not included in the Advisory Report as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#121):
Adapt California's CalAIM program to New York through an 1115 Medicaid Waiver

Summary: Implement a program like California's CalAIM program to utilize Section 1115 waiver funds to build on existing services and fill service gaps. This proposal includes a series of recommendations to expand pre-release Medicaid enrollment and health care coverage, provide comprehensive pre-release health care services, and integrate community supports to address SDOH.

Justification: California's CalAIM program leverages Section 1115 waivers to rework Medi-Cal in a way that addresses health care gaps for vulnerable communities, particularly for those transitioning out of incarceration. A core component of CalAIM is the provision of pre-release health care services for incarcerated individuals. Under existing federal rules, Medicaid coverage is suspended during incarceration, which leaves individuals without Medicaid-funded health care while in prison. With Section 1115 waivers, California established a pathway for incarcerated individuals to enroll in Medi-Cal and receive health care 90 days prior to their release. This helps maintain health care service continuity during the transition out of prison. CalAIM also incorporates Community Supports, which include services like housing navigation, medically tailored meals, and sobering centers. Section 1115 waivers allowed these nontraditional supports to be integrated into Medi-Cal. Care coordinators work with individuals before release, helping them plan for continuing their care in the community. Section 1115 waivers make it possible for Medicaid coverage to start before release, reducing interruptions in health care. Another important part of CalAIM is care coordination and data sharing. Setting up a data-sharing infrastructure between correctional facilities, Medicaid, and health care providers helps ensure that health information follows individuals as they reenter their communities. Section 1115 waivers allow Medicaid funds to be used for these coordination efforts, which are essential for successful reentry.

Full Proposal:
Implement recommendations to allow New York State to implement a program like California's CalAIM by using Section 1115 waiver funds to build on existing services and fill service gaps:

1. Expand Pre-Release Medicaid Enrollment and Health care Coverage by establishing a Statewide Pre-Release Enrollment Program
    a. Build on Existing Programs: Expand statewide New York's current 1115 waiver demonstration program that reinstates Medicaid within 30 days prior to release. Currently, Medicaid suspension is reinstated post-release, but this can create delays in access to essential services.
    b. Use an 1115 waiver to ensure that Medicaid is fully activated for all incarcerated individuals at least 90 days prior to release. This will require coordination between the Department of Health, Department of

Corrections and Community Supervision (DOCCS), and local Departments of Social Services (LDSS).

c. Implement a centralized data-sharing system that allows correctional facilities to automatically notify Medicaid offices of impending releases, ensuring a streamlined reenrollment process.

2. Provide Comprehensive Pre-Release Health care Services by establishing Comprehensive Pre-Release Health Coverage
    a. Build on Existing Programs: Use the NYC Department of Health and Mental Hygiene's Bureau of Transitional Health Care Coordination and the Department of Health's Medicaid Health Homes as models for providing pre-release health care to all incarcerated individuals.
        i. This was recommended in 2016 by the governor's Council on Community Re-Entry and Reintegration.
    b. Use Managed Care Organizations (MCOs) to deliver primary health care, behavioral health services, and substance use treatment during the last 90 days of incarceration. This mirrors the managed care involvement under CalAIM.
    c. Expand services offered by Health Homes to ensure continuity of care, including comprehensive physical and mental health assessments, medication management, and care coordination for those with chronic health conditions.
    d. Work with OMH to integrate behavioral health services within this 90-day pre-release window.
3. Integrate Community Supports to Address SDOH by expanding Medicaid to Cover Community Supports
    a. Build on Existing Programs: Utilize the reentry programs of the Fortune Society, Osborne Association, Release Aging People in Prison, and Parole Preparation Project, among other community-based models for providing holistic support (housing, employment, health services, etc.).
    b. Use an 1115 waiver to include Community Supports as Medicaid-covered benefits, focusing on addressing SDOH like housing, employment support, and food security.
    c. Establish housing navigation services for those reentering society, as seen in California's waiver. These services should include housing deposits, tenancy education, and support for finding permanent supportive housing. This can build on partnerships with organizations, such as the Supportive Housing Network of New York (SHNNY).
    d. Collaborate with local nonprofits, Health Homes, older adult centers, home-delivered meals providers, and others to provide medically tailored meals, transportation support, and community health worker services, enhancing the transition into community life.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. In 2022, the Department of Health submitted an 1115 waiver application to CMS seeking approval to provide in-reach services to incarcerated individuals; this application is currently pending CMS, as New York and CMS continue to review the best way to implement such an initiative. In addition, the Department of Health – in partnership with many other state agencies, including DOCCS, the Division of Criminal Justice Services (DCJS), the Commission of Correction, and OCFS, amongst others – are taking many steps to address the health of the justice-involved population. The Department of Health is in the process of implementing targeted in-reach services for justice-involved youth, including physical and behavioral health screenings and targeted case management and referrals, which are designed to improve connections to critical health care services and bolster better health outcomes. As part of the State's recently implemented health-related social need (HRSN) 1115 waiver services, justice-involved adults with serious chronic conditions and juvenile justice-involved youth who are high risk are eligible for enhanced HRSN care management, housing, nutrition, and HRSN transportation services. DOCCS currently offers pre-release discharge planning and provides for health care needs. Any changes to the Medicaid program or additional resources required to implement additional initiatives in this area would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#122):
Facilitate Access to Release Mechanisms for Older Incarcerated Individuals

Summary: Support older incarcerated adults in applying for release mechanisms by utilizing existing community-based programs, engaging with experienced nonprofits in providing application processes for release mechanisms, and expanding access to these nonprofit organizations.

Justification: Incarcerated older adults often experience accelerated aging and poorer health outcomes. As the number of incarcerated older adults increases, partnership with experienced nonprofit organizations can facilitate and provide support for incarcerated older adults seeking reentry and release mechanisms. Such partnerships can additionally ensure more effective community-based health care than that of correctional settings.

Full Proposal:
The state should partner with nonprofits to support older incarcerated individuals in applying for release mechanisms such as parole, gubernatorial clemency, and medical parole. Health care can be delivered much more effectively in community settings compared to correctional settings, especially geriatric care.

1. Build on Existing Programs: Utilize the reentry programs of the Fortune Society, Osborne Association, RAPP, and Parole Preparation Project, among other community-based organizations.
2. Engage nonprofits with experience in providing reentry services to provide support for older incarcerated individuals with the application processes for medical parole, clemency, and other release mechanisms.
3. Facilitate or expand access to correctional facilities for these nonprofits by directing facility directors to allow access.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as long-term. The facilitation of partnerships may require an assessment of existing release initiatives. DOCCS can continue to provide medical parole as applicable and support the use of re-entry services by nonprofit organizations.*

Proposal Presented for the Master Plan for Aging (#120):
Establish a Law Clinic Benefits Coordination Program

Summary: Maximize pre-release support for incarcerated individuals including a Law Clinic Benefits Coordination Program, expansion of nonprofit partnerships for on-site benefit coordination, and coordination with government agencies for on-site and virtual support.

Justification: Individuals who are released from prison have difficulty obtaining essential benefits for survival in the community. Pre-release support to individuals who are incarcerated would provide those individuals with an improved opportunity for increased in-person assistance, expanded access to existing nonprofit services, and reduced bureaucratic hurdles.

Full Proposal:
This proposal brings together law students, nonprofits, and government agencies to maximize the effectiveness of pre-release support for incarcerated individuals.

1. Establish a Law Clinic Benefits Coordination Program
    a. Partner with law schools across New York State to involve law students in reentry efforts. Law students, supervised by clinical professions, would assist incarcerated individuals in applying for benefits like Medicaid, SSI, and Social Security Disability Insurance (SSDI) before release.
    b. Law students could provide in-person support at correctional facilities or virtual support for remote locations. This ensures that individuals in all facilities receive assistance.
    c. Develop a standardized training program to teach law students the steps to help with benefits applications. This would include understanding eligibility, gathering necessary documentation, and navigating application processes.
2. Expand Nonprofit Partnerships for On-Site Benefits Coordination
    a. Formalize partnerships with nonprofits like The Fortune Society, Osborne Association, Parole Preparation Project, RAPP, and Exodus Transitional Community to place benefits coordinators in correctional facilities. These coordinators would guide incarcerated individuals through the process of applying for essential benefits. This would require ensuring that DOCCS directs each correctional facility's director to expand access to facilities to nonprofits, including representatives of those nonprofits who were formerly incarcerated.
    b. Nonprofit coordinators and law students would work collaboratively, sharing expertise to ensure comprehensive support, including help with documentation and resolving any bureaucratic hurdles.
3. Coordinate with Government Agencies for On-Site and Virtual Support
    a. Designate Human Resource Administration (HRA) and Social Security Administration (SSA) staff to work with law clinics and nonprofits, providing expertise and expediting applications. Staff could rotate visits to facilities or provide virtual office hours to assist with applications.

b. Agency staff would help incarcerated individuals obtain identification cards and Social Security cards before release, as these are critical for accessing benefits.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as near-term. Components of this proposal are currently being implemented between DOCCS and nonprofit organizations which coordinate benefits applications. Other components of this proposal are categorized as near-term, utilizing public avenues for implementation and expansion. Proposed first steps for implementation could include engagement with the nonprofit and the private sector for the development of new Law Clinics and support programs. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

VII. Social Engagement of Older Adults

Proposal Presented for the Master Plan for Aging (#70):
Supporting Social Connection with the US Surgeon General's Recommendations

Summary: Support social connection through the implementation of the U.S. Surgeon General's 10 recommendations for government. These recommendations generally propose regulations, government leadership positions and roles, and collaborative governance across federal, state and local functions, to prioritize social connection, which would be connected by newly standardized metrics.

Justification: Socially isolated older adults face negative health consequences and poorer quality of life. Support for social connection via the Surgeon General's ten recommendations will align New York State with federal priorities related to social isolation and loneliness, prioritize connection throughout state policy, and implement best practices to limit loneliness.

Full Proposal:
New York will support social connection through the implementation of the U.S. Surgeon General's ten recommendations for government. New York will accomplish the multiple implementation phases, to start upon adoption and span 5 years:

1. Include social connection as a priority in public health and policy agendas, provision of critical resources, and the creation of strategies to strengthen social connection and community, inclusive of clear benchmarks, measurable outcomes, and periodic evaluation.
2. Establish a dedicated leadership position to work across departments, convene stakeholders, and advance pro-connection policies.
3. Utilize a "Connection-in-All-Policies" approach to examine policies across sectors which look to identify and remedy policies that drive disconnection while advancing those that drive connection. Evaluate and revise as needed.
4. Monitor and regulate technology by establishing transparency, accountability, safety, and consumer protections.
5. Create and implement a standardized measure or set of measures for social connection with the ability to capture granularity needed to guide strategic decision making, planning, and evaluation of strategies.
6. Prioritize research funding based on the impact of social disconnection, loneliness and social isolation, and researchers should be collaborated with to enhance research coordination.
7. Launch comprehensive public education and awareness campaigns, which includes the creation of national guidelines for social connection.
8. Invest in social infrastructure at the local level, including the programs, policies, and physical elements of a community that facilitate bringing the community together.
9. Incentivize the assessment and integration of social connection into health care delivery and public health, achieved through public insurance coverage and other government funding mechanisms.

10. Increase evaluation and oversight of policy and programmatic outcomes from public-institutions, programs, and services, and make the results available through public facing reports and databases, to help improve existing policies and programs, demonstrate transparency, and increase public trust in institutions.

Additionally, the State shall support these recommendations through the implementation of community design principles and programs, such as Smart Growth Community Planning program, DRI and NY Forward as well as AARP's 8 Domains of Livable communities, to foster social engagement through the built and natural environments.

MPA Council Commentary: *This proposal is categorized as long-term. Many components of this proposal overlap with other proposals focused on addressing social connection and reducing isolation amongst older adults. Implementation of this proposal would need to begin with identifying concrete next steps that the State could take to implement the Surgeon General's recommendations Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#66):
Reduction in Social Isolation Through Peer Model Programming Engagement and Expansion

Summary: Conduct a public education campaign on peer-to-peer models and connections available, benefits, and enrollment support. Combine this campaign with the establishment of a wellness screening website that includes a social connections component to provide information on the value of social connection and strategies to strengthen healthy social connections. Strategies could include access to outreach volunteers, peer services, and other resources. State agencies should explore current programs utilizing peer-to-peer models and how to expand access, utilization and consideration of creation programs to target older adults not currently accessing aging services.

Justification: Social isolation and loneliness are key risk factors for the development of mental health and/or substance use disorders and worsening health conditions. Peer model programming and public health education which destigmatizes mental health and promotes engagement can reduce ageism and stigma. It can improve disparities in equity and access to services, supports, housing, and transportation, and provide a return on investment due to reduced medical spending for worsening health conditions.

Full Proposal:
Reduce social isolation among older adults and reduce risk for developing or worsening mental health and/or substance use disorders utilizing:

1. A wellness screening website that includes a social connections component to provide information on the value of social connections, strategies to strengthen healthy social connections such as accessing outreach volunteers, peer services, and other resources, as well as the health benefits and expectations of volunteering and peer mentoring.
2. A public education campaign on the value of peer-to-peer connections and the promotion of an online resource in the form of the wellness screening website for accessing various services provided by volunteers and peer professionals, and the promotion of NYSOFA-championed pathways to access support.
3. A public education campaign on the value of volunteering and peer mentoring for older adults to improve connections for older adults at risk for developing or worsening mental health and substance use disorder, loneliness, and risk of suicide.
4. An expansion of peers working in existing certified programs overseen by OASAS and OMH. Expansion efforts should include:
    a. A public education campaign to target underserved areas, increasing access to Medicaid reimbursable peer services, ensuring Medicaid reimbursement rates to providers incentivize participation in peer models, the creation of a career ladder to incentivize entry into peer services workforce, mandated private third-party insurance coverage of peer services for older adults, and cross-agency training on aging services for integration into peer certification requirements.

5. A collaborative infrastructure between NYSOFA, OASAS, OMH, and community-based organizations to expand programming derived from the Geriatric Demonstration Grants.
6. The creation of a new position, agency, or resource at the state level to implement strategies to target older adults not currently accessing aging services.

MPA Council Commentary: *Components 1, 4, and 6 of this proposal are categorized as long-term. The creation of a wellness website would require an analysis of the costs and savings to the state. Changes to the Medicaid reimbursement rate and mandates for insurance coverage may require statutory and regulatory changes and would be subject to the annual budget process and availability of resources. Components 2, 3, and 5 are categorized as near-term. The State is currently implementing multiple public education initiatives. Proposed first steps for implementation could include coordination with state agency partners and the governor's Office for release of campaigns. Proposed next steps for implementation could include engaging relevant programs for critical information and determination of expansion opportunities. Proposed metrics for evaluating implementation success could include public engagement with campaign materials and expansion of program engagement.*

Proposal Presented for the Master Plan for Aging (#77):
Social Isolation and Loneliness in State Policy

Summary: Require a social connections component embedded across all state policies and programs, including: the design and implementation of a standardized data set and monitoring system for evaluations of social connection interventions statewide; the building of age-friendly social infrastructure within the community that values the assets of older adults and enables opportunities for paid work and volunteering; a focus on the built environment to provide spaces and opportunities to access social engagement; a focus on community-based programming designed to create social connection, meaning, and purpose; and the creation of a, "one-stop-shopping," opportunity for people to obtain a listing of the wide range of opportunities to be engaged with.

Justification: Improving the health of New York requires that social isolation and loneliness be addressed in state policy and programming across all sectors, including the built environment, community programming, the medical environment, as well as crafting a social infrastructure in which older adults are considered, and their strengths are valued. Implementing multi-sectoral policy changes to reduce social isolation and loneliness can improve the health of New Yorkers at all ages.

Full Proposal:
Loneliness and isolation are risk factors for financial loss and its compounding effects. New York State should require a social connections component embedded across all state policies and programs, including: the design and implementation of a standardized data set and monitoring system for evaluations of social connection interventions statewide; the building of age-friendly social infrastructure within the community that values the assets of older adults and enables opportunities for paid work and volunteering; a focus on planning, zoning and developing the built and natural environments to provide proximate and accessible public spaces and other opportunities to access social engagement, including public parks, intergenerational public spaces and walkable streetscapes; a focus on community-based programming designed to create social connection, meaning, and purpose; and the creation of a, "one-stop-shopping," opportunity for people to obtain a listing of the wide range of opportunities to be engaged with.

1. Evaluate state policies and programs across NYS to determine whether it meets the criteria for reduction in social isolation and loneliness.
2. Prioritize funding in the state budget for existing social engagement programs to include the evaluation for the feasibility of programs and the ability to increase access to programs and services (e.g., mental health services). Campaigns should reach marginalized populations and use of diversity of culturally and linguistically appropriate messages.
3. Monitor new and emerging evidence to integrate into the delivery and content of public messaging and programs.

4. Promote social connection through the design of the physical and programmatic infrastructure, including access to transportation, affordable digital access and literacy training, housing and zoning development with access to public transport and within walking distance to needed goods and services, safe and appealing gathering spaces, safe streets for people with disabilities and pedestrians, new recreational facilities/ repurposing of existing spaces, and other public gathering spaces for community connection.
5. Enable the accessible evaluation of social isolation and loneliness utilizing a web-based tool and referral system for improved connection to social engagement opportunities.
6. Surveillance:
    a. Statewide (ideally aligned with other states/federal) standardized instruments and measures for screening and measuring program outcomes; these should ideally be aligned with other states and the federal government.
    b. Consider using the social isolation Behavioral Risk Factor Surveillance System (BRFSS) (https://www.cdc.gov/brfss/questionnaires/index.htm).
    c. Develop a surveillance program to detect and track social isolation and loneliness, including analysis to determine subpopulations at highest risk.

MPA Council Commentary: *This proposal is categorized as near-term. Many state agency partners are currently developing and implementing policies and programs that combat social isolation. Proposed metrics for evaluating implementation success could include improved social isolation and loneliness screening scores and the evaluation of policy and programs. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#34):
Access to Childcare Services Near Long Term Care Settings

Summary: Locate childcare services in the community within close proximity to facility-based long-term care settings. Establish programs to encourage interaction between children and appropriately screened and supervised residents.

Justification: Nursing homes are often challenged in attracting and maintaining sufficient direct care staff to meet patient care needs and state and federal staffing requirements. Lack of childcare is often a barrier that prevents workforce participation by trained caregivers. Closer access to childcare centers at nursing homes will benefit employees who need childcare to be able to work and help reduce nursing home staffing shortages. Childcare services in the community within close proximity to nursing homes has the additional benefit of promoting intergenerational connections and reducing social isolation.

Full Proposal:
Locate childcare services in the community within close proximity to facility-based long-term care settings. Establish programs to encourage interaction between children and appropriately screened and supervised residents.

1. Identify renovations to facilitate this proposal as a preferred use of capital grant programs (e.g., Statewide Transformation).
2. Foster connections between Head Start and Early Head Start programs and facility-based long-term care providers. Head Start and Early Head Start programs are free, federally funded programs designed to promote school readiness for infants, toddlers, and preschoolers from low-income families.
3. Where possible, expand childcare hours within proximally located childcare service settings to provide coverage beyond traditional hours.
4. Consider capping childcare costs to 7% of the family's annual income for facility-based childcare programs. that do not yet have this policy in place – child care programs that use child care subsidies from NYS already have this in place. The U.S. Department of Health and Human Services identifies affordable childcare as a program that costs no more than 7% of a family's income. None of the 50 states meet this criteria.

MPA Council Commentary: *This proposal is categorized as long-term. A formal assessment of the costs and savings to the state may be necessary to determine viability. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

VIII. Combatting Elder Abuse, Ageism, Ableism and Stigma

Proposal Presented for the Master Plan for Aging (#109):
Improve Public Awareness of Financial Scams and Fraud

Summary: Improve comprehensive education efforts and public awareness of financial scams and fraud. This proposal recommends creating a public awareness program to address financial exploitation and stability, a fraud notification program, and promotion of best practices to prevent fraud.

Justification: Financial abuse and fraud negatively impact the lives of older adults and people with disabilities and may result in financial loss. Increased awareness and implementation of best practices may reduce financial crimes against older adults and people with disabilities.

Full Proposal:
Improve comprehensive education efforts and public awareness of financial scams and fraud:

1. Create culturally responsive and evidence-based public awareness programs and campaigns with multiyear strategy to consistently reach as many people as possible, specifically those working with older adults, community "gatekeepers," religious entities, and health care providers.
    a. Campaigns should include information for victims of scams and resources for recouping losses.
    b. Campaigns and educational programs should utilize information from the "2021 Seeking Solutions Summit: Elder Abuse - Creating a Clear Vision of Where We Go from Here,"[4] Person-Centered Education Expansion.
    c. Public awareness programs should encourage conversations about financial wellness and fraud/scam prevention and can be modeled after the existing "Conversation Project."
2. Create a notification program to allow individuals to designate an interdisciplinary team of family, friends, and caregivers to receive notifications of account irregularities and indications of fraud.
3. Promote existing community document shredding days.
4. Create statewide palm cards to be distributed at events and encourage housing providers to share materials on scams and fraud.
5. Expand statewide 'NYS scam watch' and Public Service Announcements on local scams.
6. Expand provider and business-centered approaches to increase awareness about fraud and scams by:
    a. Expanding and funding Enhanced Multidisciplinary Teams (E-MDT)

[4] Lifespan of Greater Rochester. (2022). *Seeking Solutions: Elder Abuse – Creating a Clear Vision of Where We Go From Here.* http://static1.squarespace.com/static/5851b8a715d5db7317addaca/t/63401ca4e1ed44582212dca4/1665146020642/2021+NYS+Elder+Abuse+Summit+Executive+Summary.pdf

statewide and to underserved communities.

b. Expanding statewide reporting of scams and develop a centralized location to report scams.
c. Increasing support for elder abuse specialists in law enforcement.
d. Creating culturally and trauma-informed policy recommendations for handling locally reported scams.

MPA Council Commentary: *Components 1 and 6 are categorized as long-term. A fiscal analysis would be needed to understand the costs and savings to the state. Components 2,3,4, and 5 may require state agency collaboration regarding resources and authorities for the proposed activities.*

Proposal Presented for the Master Plan for Aging (#88):
Address Financial Exploitation of Older Adults

Summary: Build on and increase access to existing comprehensive training on financial exploitation on the identification, prevention, and reporting of financial exploitation for bank staff. Build on existing training programs and funding provided by New York State agencies.

Justification: Older adults may fall victim to financial exploitation resulting in financial loss. Training programs for front line staff may work to prevent elder abuse.

Full Proposal:
Specifically address the financial exploitation of Older Adults:

1. Build on existing and make available additional and more comprehensive training on financial exploitation to front line bank staff on the identification, prevention, and reporting of financial exploitation of older adults.

Build upon and expand funding for existing trainers and/or financial exploitation education and programs provided by NYSOFA and DFS to train local and regional banks on financial exploitation of older adults.

MPA Council Commentary: *This proposal is categorized as near-term and was proposed as part of Governor Hochul's FY26 Executive Budget.*

Proposal Presented for the Master Plan for Aging (#111):
Promote Scam Recovery and Prevention

Summary: Establish public awareness programs regarding best practices and resources for recouping losses from scams and fraud. This proposal includes recommendations for improving scam reimbursement, promoting utilization of fraud prevention software, and increasing the number of prosecutors dedicated to elder abuse and vulnerable adults.

Justification: Older adults and people with disabilities may be disproportionately likely to fall victim to fraud and scams resulting in financial loss. Awareness of existing scams, preventative mechanisms, and initiatives to increase reimbursement may effectively prevent and address scams.

Full Proposal:
Victims of scams and other fraud are often unable to recoup losses and recover. Create public awareness programs about resources for recovering from scams and fraud:

1. Develop awareness programs that are culturally responsive and address feelings of shame and hopelessness that may prevent victims from coming forward.
2. Increase state funding to reimburse victims for financial losses that result from fraud and scams.
3. Promote adoption of software like Fraud Finder for entities working with vulnerable adults.
4. Increase the number dedicated elder abuse and vulnerable person prosecutors across the state.
5. Expand funding and Victims of Crime Act (VOCA) funding for district attorneys and E-MDTs
6. Promote multifactor authentication methods and safe password practices.
7. Implement recommendations from the "2016 Cost of Financial Exploitation Study[5]":
    a. Conduct research on the fiscal impacts of financial exploitation in New York.
    b. Expand state date collection systems to include fields for reporting financial exploitation and associated costs.
    c. Expand training opportunities for Adult Protective Services (APS) workers, law enforcement, financial institutions and fiduciaries.
    d. Expand the use of E-MDTs.
    e. Expand monitoring services to catch fraud early.

MPA Council Commentary: *Components 2, 4, 5, 7d and 7e are categorized as long-term. An assessment of costs and savings to the state would be needed. Components*

[5] Huang, Y., Lawitz, A. (2016, June 15). *The New York State Cost of Financial Exploitation Study.* New York State Office of Children and Family Services. https://ocfs.ny.gov/reports/aps/Cost-of-Financial-Exploitation-Study-2016May.pdf

1, 3, 6, 7a, and 7c are categorized as near-term. This proposal is closely related to proposal 112. A variety of state agencies, including the Office of Victim Services (OVS), NYSOFA, the Department of Financial Services, and others, could play a role in implementation efforts such as developing awareness programs and conducting further financial exploitation research. Component 7b is currently being implemented by OVS through the collection of detailed information regarding financial exploitation reporting. Efforts requiring significant research or development of materials may require additional resources that would be subject to the annual budget process and the availability of resources.

Proposal Presented for the Master Plan for Aging (#61):
Improve Guardianship

Summary: Establish and fund a statewide Article 81 guardianship program to oversee Article 81 guardianship services, including a committee within the NYS Unified Court System (UCS), and pursue a holistic approach to expanding the awareness and availability of guardianship alternatives by focusing on education, planning, and providing supports tailored to each individual's specific need.

Justification: Increased need for Article 81 guardianship will continue to grow with the older adult population in NYS. With no single entity charged with oversight of these programs, New York State should establish an annually funded statewide guardianship program to ensure sufficient management and scale of guardianship services. The collection of relevant data and consistent review of the guardianship process would better ensure that older adults in guardianship situations are protected, and proceedings are constantly adjusted to best serve those involved. Creating awareness to guardianship alternatives would help in reducing the number of those utilizing these programs, limited potential abuse, and save money for impacted families.

Full Proposal:
Improve scale, management, and oversight of guardianship programs:

1. Establish a statewide Article 81 guardianship program, including, at a minimum, $15 million annually. In addition, provide funding to implement proposal and oversee Article 81 guardianship services going forward.
2. The UCS would create a permanent committee that will regularly review and, as necessary, recommend changes to the Article 81 guardianship process. This Committee would issue a report of its findings and proposals and any legislative and regulatory amendments needed to effectuate the proposals to the chief judge, governor, and the appropriate legislative committees within one year of its first meeting and every three years thereafter. The reports would also be available on the UCS' website.
3. The UCS would collect, aggregate, and report on de-identified Article 81 guardianship data in quarterly reports to the governor and the Legislature. The reports would also be posted on the Unified Court System's website so that they are publicly available.
4. Take a holistic approach to expanding the awareness and availability of guardianship alternatives by focusing on education, planning, and providing supports tailored to each individual's specific needs. The goal is to reduce the number of Article 81 guardianships and for individuals to maintain as much autonomy as possible. The designated state oversight office, as part of the proposed Article 81 guardianship program (see Number 1, above), would expand the availability and usage of existing alternatives through:
    a. The development of standards for programs that help individuals access existing alternatives that could be implemented prior to or in lieu of full

guardianship.
    b. Ensuring that such programs are included in a comprehensive benefit resource website containing an up-to-date, searchable index of services.
    c. The development of standards for programs that can provide education about alternatives to community service providers, judges, nonprofit guardianship providers, local offices for the aging, and the public.
    d. Promoting the availability and usage of alternatives on its website, social media, etc.
5. Consider a systematic and integrated approach to accessing available alternatives to guardianship across a variety of New York State programs, systems, and providers when the need for guardianship can be delayed or prevented. Expand the awareness and availability of alternatives to guardianship to reduce the number of guardianships and for individuals to maintain as much autonomy as possible. These include, but are not limited to:
    a. Advance directives (e.g., future care planning, Power of Attorney, health care proxies).
    b. Bill paying assistance.
    c. Encouraging individuals to discuss their wishes with family, friends, and caregivers.
    d. Making medical appointments.
    e. Money management.
    f. One-shot guardianships.
    g. Securing in-home and community-based services.
    h. Supported decision making.
6. Develop standards for the variety of guardianship alternative programs and education about programs to court evaluators, examiners, community service providers, judges, local offices for the aging, nonprofit guardianship providers, and the public. Ensure such programs are included in New York Connects and promote the available of alternatives widely.

MPA Council Commentary: *This proposal is categorized as long-term. This proposal only includes Article 81 guardianship, but does not include Article 17-A guardianship, which is for individuals with intellectual and developmental disabilities. It is important to note that neither the Article 81 nor Article 17-A guardianships are exclusive to the elderly population as there are approximately 4,444 guardianships statewide inclusive of all ages of adults. The creation of any new guardianship infrastructure would require collaboration between NYSOFA OCFS (as well as OMH and OPWDD to support individuals eligible for both types of guardianship described above). State agencies are engaged with the court system and advocacy organizations on an ongoing basis to identify opportunities to strengthen the guardianship system and offer alternatives to guardianship for the protection of older adults and people with disabilities. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#22):
Challenging Ageism, Ableism and Abuse

Summary: Encourages implementing the recommendations contained in the final report of the, "2021 New York State Elder Abuse Summit Seeking Solutions: Elder Abuse - Creating a Clear Vision of Where We Go From Here,[6]"examining opportunities for collaboration among agencies on training and programs addressing ageism, as well as establishing an Elder Justice Coordinating Council consisting of state agency representatives that work on elder justice.

Justification: Financial exploitation, abuse and scams negatively impact the well-being of older adults. Coordination among state agencies and other service providers are working to address elder abuse via the Elder Justice Coordinating Council which will allow for fewer siloed efforts to target solutions to abuse and exploitation affecting older New Yorkers. Mandated ageism and adult abuse trainings are needed to enhance knowledge about adult abuse and ensure that risk factors are widely understood and preventable. To ensure effective service, collaboration, and efficient intervention, an inventory of state programs that address adult abuse should be created by relevant state agencies.

Full Proposal:
Address ageism, ableism and abuse by:

1. Establishing an Elder Justice Coordinating Council (the Council) consisting of state agency representatives working in the realm of elder justice. The Council will also consist of representatives from local governments (including county-based AAAs and APS), aging and human service providers, underserved populations, faith-based organizations, law enforcement, District Attorney's offices, legal service providers, the Association on Aging in New York, stakeholders, advocates, coalition members, researchers, program managers/developers, policy makers, and any other group or entity relevant to its work.
2. Implementing the recommendations contained in the final report of the "2021 New York State Elder Abuse Summit Seeking Solutions: Elder Abuse - Creating a Clear Vision of Where We Go From Here," which focuses on marginalized/underserved populations.
3. Requiring ageism training for all State employees to prevent and address ageism in the administration of public programs.
4. Requiring training on adult abuse for professionals working with older adults (age 60 and over) and vulnerable/dependent adults of any age (e.g., adults who are incapacitated or have a cognitive or physical impairment).
5. Directing NYSOFA and other relevant state agencies:

[6] Lifespan of Greater Rochester. (2022), *Seeking Solutions: Elder Abuse – Creating a Clear Vision of Where We Go From Here.*
https://static1.squarespace.com/static/5851b8a715d5db7317addaca/t/63401ce8e0d93413ec7d77dc/1665146092013/2021+NYS+Elder+Abuse+Summit+Full+Report.pdf

a. Create an inventory of each state agency's programs/initiatives that address adult abuse, scams, neglect, and exploitation, including financial exploitation and perpetration via artificial intelligence (AI).
b. Identify government and community-based programs/initiatives that are effective at serving their clients and include them in the inventory described in 1 above.
c. Develop best practices on:
    i. Effectively serving clients.
    ii. Promoting effective collaboration and client connections between APS, county Offices for the Aging, community-based service providers, domestic violence programs, civil legal service providers, and any other entity the Council deems appropriate.
    iii. Assisting clients who decline or may not be ready to accept recommended services.
    iv. Addressing scams and exploitation perpetrated through AI.

MPA Council Commentary: *This proposal is categorized as long-term. This proposal may require statutory and regulatory changes for the development of the Council and implementation of required trainings. It would require the collaborative development of an appropriate curriculum and training program; NYSOFA could facilitate collaboration between the relevant state agency partners and service providers.*

Proposal Presented for the Master Plan for Aging (#112):
Establish Public Awareness Programs for Scam Recovery

Summary: Establish public awareness campaigns on financial abuse and fraud prevention. Provide training on financial abuse identification to law enforcement and judicial personnel. This proposal recommends utilizing strategies from the "2021 Seeking Solutions: Elder Abuse Summit," to respond to under resourced populations.

Justification: Older adults and people with disabilities may fall victim to financial exploitation resulting in financial loss. Culturally responsive public awareness initiatives, training programs for law enforcement professionals, and targeted outreach to underserved communities may work to prevent elder abuse.

Full Proposal:
Cultural differences are often associated with reporting financial crimes and elder abuse. Establish culturally responsive public awareness campaigns that acknowledge the range of perceptions and experiences of victims of financial crimes and elder abuse:

1. Provide information regarding warning signs of financial abuse/fraud to community gatekeepers, medical providers, financial institutions, retailers, and other non-family members.
2. Provide targeted training for police, prosecutors, judicial and nonjudicial personnel about identifying financial abuse and what to consider if the perpetrator has legal authority over the victim's finances.
3. Expand outreach to under resourced populations to implement culturally responsive strategies outlines in the, "2021 Seeking Solutions: Elder Abuse Summit," report.

MPA Council Commentary: *This proposal is categorized as long-term and is closely related to proposal 111. A variety of state agencies, including the Office of Victim Services (OVS), NYSOFA, and DFS could be involved in implementation of this proposal. OVS is already engaged in initiatives to implement trauma-informed, culturally responsive practices and to expand outreach to under resourced populations.*

Proposal Presented for the Master Plan for Aging (#71):
Elder Abuse and Elder Justice Forum

Summary: Create a permanent, state government-sponsored forum focused on elder abuse and elder justice. This forum would allow a diverse partnership of representatives to share ideas from both academia and the field, provide feedback, and encourage evidence-based and culturally responsive strategies to prevent and intervene in cases of financial exploitation and elder abuse, as well as regularly provide review and feedback on potential updates to operations, programs, and regulations related to elder abuse and justice.

Justification: Older adults may fall victim to elder abuse, exploitation and scams resulting in poorer health outcomes, financial loss, and other negative implications on their overall well-being. Cross-sector collaboration will develop evidence-based and informed strategies that work to prevent and address cases of older adult abuse and exploitation.

Full Proposal:
NYSOFA will create a permanent, state government-sponsored forum (The Forum) that focuses on elder abuse and elder justice. The Forum will be a place where state agency representatives, local governments (including AAAs and APS), aging and human service providers, underserved populations, faith-based organizations, law enforcement and legal service providers, policy makers, and members of the public can and are encouraged to network, share ideas from both academia and the field, provide feedback, and encourage evidence-based and culturally responsive strategies to prevent and intervene in cases of financial exploitation and elder abuse.

1. NYSOFA will develop, implement and publicize the Forum,
2. NYS will provide NYSOFA will the necessary funding to support the Forum, including funding for the necessary staff.
3. NYSOFA will regularly review feedback in the forum and make updates to improve the operations of the Forum, as needed and feasible.
4. The Forum will establish several different methods of communication and networking, including emails, blogs, and in-person and virtual meetings/conferences.

MPA Council Commentary: *This proposal is categorized as near-term. This proposal is closely related to proposal 110. Proposed first steps for implementation could include the establishment of a new Forum derived from existing programs and conferences through NYSOFA. Otherwise funding this Forum would be subject to the annual budget process and the availability of resources. Additional steps for implementation could include the convening of relevant stakeholders and state agency partners to develop an interactive environment encouraging evidence-based and culturally responsive strategies for prevention, intervention, and the creation of a community engaged in elder*

justice. Proposed metrics for evaluating implementation success could include improved and continued recognition of elder abuse and elder justice topics.

Proposal Presented for the Master Plan for Aging (#110):
Elder Abuse Research Forum

Summary: Create a long-term, state government-sponsored forum for networking and research presentations that encourage evidence based and culturally responsive strategies to prevent financial abuse and fraud. This proposal recommends increasing funding for E-MDTs, utilizing existing models and strategies to prevent financial exploitation.

Justification: Financial abuse and fraud negatively impact the lives of older adults and people with disabilities and may result in financial loss. Shared research and networking opportunities can inform the development of policies and programs that work to prevent such crimes.

Full Proposal:
Create a long-term, state government-sponsored forum for researchers to network and present results of research projects to policy makers, program managers/developers, and other researchers to encourage evidence-based and culturally responsive strategies to prevent financial abuse/fraud and other elder abuse crimes.

1. Increase funding and support for statewide adoption and implementation of E-MDTs
2. Follow, "Research to Practice Networking Session," models.
3. Create a NYS Elder Abuse blog to provide information on current events and news.
4. Promote multifactor authentication methods and safe password practices.

MPA Council Commentary: *This proposal is categorized as long-term, though OVS is currently developing resources which could support Research to Practice models. This proposal is closely related to proposal 71. This proposal would require an assessment of existing opportunities and resources. Efforts requiring significant research or development of materials may require additional resources that would be subject to the annual budget process and the availability of resources.*

Proposal Presented for the Master Plan for Aging (#58):
Inclusive Disaster Response and Preparedness

Summary: Enhance and promote New York State's disaster preparedness and response education opportunities. This proposal includes recommendations to promote the Citizens Preparedness Corp trainings and strategies for identifying and developing best practices for assisting older adults and those with access and functional needs during disasters, emergencies, and infectious disease outbreaks.

Justification: Older adults are disproportionately impacted when disaster strikes and often face challenges obtaining necessary resources and assistance. Focused disaster response and preparedness education will better prepare older adults and their caregivers for future disasters and infectious disease outbreaks. New York State should ensure that those with access and functional needs and underserved communities are accounted for in their emergency disaster plans to mitigate adverse outcomes. Timely response may provide lifesaving efforts to those most implicated by disasters.

Full Proposal:
To ensure that disaster response systems consider the particular needs of older adults and people with access and functional needs, this proposal would:
Require the Department of Homeland Security and Emergency Services (DHSES), along with state agency partners, to enhance and promote New York State's disaster preparedness and response education opportunities. Efforts will be focused on educating the public on disaster and infectious disease preparedness, response, and the promotion of the Citizens Preparedness Corp trainings as a resource to the public, communities, governmental, and nongovernmental partners.
Work with local municipalities and emergency managers to ensure they are capturing older adults and those with access and functional needs in their emergency management disaster plans, pursuant to Section 23 of the Executive Law.

1. The state would provide guidance on which individuals are considered to have access and functional needs for the purposes of life saving/sustaining needs during disaster/emergency preparedness and response. This will include:
    a. People who have:
        i. Developmental/intellectual/cognitive disabilities.
        ii. Physical disabilities.
        iii. Chronic conditions or injuries.
        iv. Limited English proficiency/non-English speaking.
        v. To rely on lifesaving medical devices, service animals, and equipment including crutches and wheelchairs.
    b. Older adults.
    c. Children under the age of 18.
    d. People living in institutionalized settings.
    e. People who are:
        i. Low-income.
        ii. Unhoused
        iii. Transportation disadvantaged/dependent on public transit.

iv. Pregnant.
v. Living in multigenerational households.

Ensure that state agencies require their contractors/grantees to develop best practices for older adults and those with access and functional needs and underserved communities during disasters and emergencies.

Engage DOS' Smart Growth Division, Building Codes Divisions and Climate Resiliency Unit to include these elements in municipal and countywide resiliency planning.

MPA Council Commentary: *This proposal is categorized as near-term and is currently being implemented at the DHSES.*

Proposal Presented for the Master Plan for Aging (#113):
Compensation for Victims of Scams and Financial Exploitation

Summary: Streamline compensation and support for victims of financial fraud and scams. This proposal includes recommendations to fund a pilot program using evidence-based approaches to reduce the risk of financial abuse, amend statute to allow compensation up to $2,500 for financial abuse victims, and simplify the definition of "disabled victim."

Justification: Older adults may fall victim to financial exploitation resulting in financial loss. Evidence based approaches to prevent financial abuse and proper compensation efforts may mitigate the impacts of financial exploitation on older adults and people with disabilities.

Full Proposal:
Scams and financial fraud pervasively impact older adults and people with disabilities in New York State. Victims of financial crimes are unable to be appropriately compensated for their losses due to statutory limits on agencies. The inability to recoup losses presents a significant burden on victims, their families, and advocates. Streamline compensation and support for victims of financial crimes:

1. Fund a pilot program to develop and implement an evidence-based approach to reduce the risk of financial abuse and scams for older adults and people with disabilities.
    a. Train adult children and caregivers how to talk to their older or vulnerable loved ones about scams and financial abuse.
    b. Provide implementation progress updates and evaluations of program impacts.
2. Amend existing statute to allow victims of scams and fraud to receive up to $2,500 in reimbursement per claim.
    a. This carve-out would only apply to victims of financial crimes with receipts for transactions.
3. Simplify the definition of, "disabled victim," to include any physical, mental, or medical impairments, as evidenced by medical records, which prevent the exercise of a normal bodily function existing at the time of the crime.

MPA Council Commentary: *This proposal is categorized as near-term. Components 2 and 3 require legislation and were proposed as part of Governor Hochul's FY26 Executive Budget. Component 1 would require funding subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#90):
Combat Ageism in the Workplace

Summary: Create mandatory training on ageism and aging for the New York State workforce which could be expanded to include all employers on a voluntary basis and an ageism public awareness campaign to address ageism in the workplace.

Justification: Ageism negatively impacts aging New Yorkers in the workplace. To reduce the effects of ageism, require workplace training on ageism for the New York State workforce, make the training available to all employers, and create a public awareness campaign to improve awareness of ageism, as well as best practices to avoid ageism in the workplace.

Full Proposal:
Address ageism in the workplace:

1. Create mandatory training on aging and ageism, which outlines its prevalence and most common forms of ageism in the workplace.
    a. For New York State workforce, the training will be required and accessed through the Statewide Learning Management System (SLMS).
    b. The training could be expanded to include all employers on a voluntary or mandatory basis and accessed through existing training platforms.
2. Create a public awareness campaign for employers and employees to improve awareness and knowledge of the signs of ageism in the workplace. The campaign will inform the workforce about avoiding ageist practices and making the workplace more age-affirming.
    a. This campaign should include Know Your Rights messaging for employees.

MPA Council Commentary: *This proposal is categorized as near-term. Proposed first steps for implementation could include the development of an aging and ageism training. If successful, this training would expand the existing work between NYSOFA and DOL. Proposed metrics for evaluating implementation success could include a greater awareness of how ageism may be present in the workplace and avoidance of ageist practices. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#99):
Training Regarding Emergency Preparedness for Individuals with Disabilities

Summary: Develop and provide emergency preparedness training, to all emergency personnel, state employees and staff members, that interact with individuals, of all ages, with developmental disabilities. These training materials must adequately address a plan of action, for individuals with disabilities, in the case of an emergency.

Justification: Aging individuals and individuals with disabilities are more susceptible to harm during an emergency. It is essential that emergency plans are available in residences, living facilities, and communities to account for the needs of individuals aging and of those with disabilities to mitigate harm. This proactive approach will help create safe plans of action, so that all parties involved are informed on what to do during an emergency, to ensure the safety of the target populations.

Full Proposal:
At the peak of an emergency, people with disabilities often face significant challenges and barriers in obtaining appropriate and timely assistance, in some instances life-threatening.

1. Develop and provide emergency preparedness training, materials, and resources focused on ensuring that the needs of people with disabilities of all ages are included in planning and are able to be adequately addressed in emergency situations.
2. Target audience for training to include emergency management personnel, state employ sees working with individuals with disabilities of all ages and staff of community-based organizations which provide services for the disability and aging communities.

MPA Council Commentary: *This proposal is categorized as near-term and is currently being implemented at DHSES. State agency partners can continue to engage with emergency management personnel and build off existing partnerships.*

Proposal Presented for the Master Plan for Aging (#105):
Require Aging and Intellectual and Developmental Training

Summary: Older adults with intellectual and developmental disabilities, including their aging caregivers, face significant barriers in accessing coordinated support from the aging services system and OPWDD provider network. Often people with intellectual and developmental disabilities continue to be cared for by aging family members, resulting in a multifaceted need for support and planning. Improving workforce competency and enhancing coordination between aging services, NYSOFA, the Department of Health, and OPWDD providers is essential to better serve this population.

Justification: Requiring medical professionals to receive specialized training on working with older adults and individuals with disabilities, particularly people with developmental disabilities due to the specificity of their needs, would improve the quality of care and health outcomes for this vulnerable group. Strengthening partnerships and communication between aging services and OPWDD would ensure more coordinated, effective support and service delivery.

Full Proposal:
People with disabilities are living longer and do not have adequate access to health care, health care professionals, or coordinated support from the aging services system nor the OPWDD provider network. Health care professionals are unable to effectively work with this population and the state service systems do not coordinate to serve older adults with disabilities.

1. Improve quality of care, health outcomes and supports for older adults and people with disabilities by increasing health care workforce competency and ensuring workforce employment of best practices. Accomplish this by:
    a. Require medical professionals in hospitals and long-term care facilities to receive training on working with older adults and people with disabilities, with particular attention to intellectual and developmental disabilities.
2. Increase partnerships, coordination, and communication between NYSOFA and OPWDD provider representatives to improve nonmedical service delivery.

MPA Council Commentary: *Component 1 of this proposal is categorized as long-term. Additional training may require regulatory changes and engagement with the medical education community. Component 2 of this proposal is categorized as near-term. Proposed first steps for implementation could include initiating coordination between NYSOFA and OPWDD. Proposed metrics for evaluating implementation success could include improvements in the number of eligible individuals with intellectual or developmental disabilities served by NYSOFA's successful nonmedical services. Additional metrics for success could include an analysis of costs and savings to the State. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

The following proposals in Pillar 8 are not included in the Advisory Report as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#127):
Anti-Stigma and Education Campaigns

Summary: Develop anti-stigma and education campaigns specifically focusing on aging with HIV, the LGBTQ+ aging population and addressing sexual health with aging New Yorkers.

Justification: In 2022, 57% of individuals diagnosed with HIV were over the age of 50 with a significant number much older. Older adults with HIV as well as from the LGBTQ community seek aging services in NYS. Although the new Long Term Care Facility Residents' Bill of Rights for LGBTQIA+ New Yorkers and People Living with HIV was passed as an antidiscrimination law in 2023. Stigma for these communities is significant. HIV stigma and its intersections with other stigmas[1] have been identified as significant barriers to achieving the goals of the National HIV AIDS Strategy, and to quality-of- care outcomes for people with HIV (PWH).[2] Notable barriers to positive health outcomes, such as HIV viral load suppression, include lower medication and visit adherence, higher instances of depression, and lower quality of life.[3] LGBT adults in the U.S. are a growing population who have historically experienced health disparities. Past research shows that LGBT adults face increased challenges when it comes to mental health outcomes and access to care, experiences with serious mental health issues (particularly among trans adults), their physical health (including higher rates of disability among younger LGBT adults), and barriers to accessing and affording needed care.

Full Proposal:

Develop education, training and awareness about HIV and the needs of people with HIV and the LGBTQ+ population, in collaboration with the AIDS Institute, for staff in long-term care facilities, caregivers, and aging related health and community providers.

1. Develop a training curriculum on HIV and the treatment needs of people with HIV.
2. Develop a training curriculum on Sexual Orientation and Gender Identity and provide LGBTQ+ resources.
3. Include topics on HIV-related stigma, discrimination, and policies on confidentiality in curriculum.
4. Include the Long Term Care Bill of Rights for seniors living with HIV and members of the LGBTQIA+ community in curriculum.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as near-term. Development of materials for this campaign could require a Request for Proposals. Funding for this*

proposal would be subject to the annual budget process and the availability of resources. Education to reduce stigma is also a component of proposals regarding substance use disorder and providing care to service recipients through OMH. The AIDS Institute could work with NYSOFA and with other Divisions of the Department of Health to identify the best avenue for developing the proposed materials, in coordination with the other stigma-linked education campaigns.

IX. Technology Access and Development

Proposal Presented for the Master Plan for Aging (#26):
Integrate Data and Case Management Across Care Settings

Summary: Leverage the Statewide Health Information Network for New York (SHINNY) in a series of three pilots to integrate information from medical, behavioral, and mixed payer client data systems to connect to Qualified Entities such as HIXNY or Healthix to facilitate use of electronic information from local provider systems. The pilots would prioritize data sharing to facilitate better transitions across care settings.

Justification: The New York State health care system lacks efficient communication, access to holistic care coordination, knowledge about navigating a fragmented LTSS, and reimbursable or affordable evidence-based care transition programs. This lack of effective care transition service results in avoidable hospitalizations, rehospitalizations, Emergency Room use post discharge, increased medical errors, increased health care spending, and adverse health outcomes. The creation of a pilot which will leverage the SHINNY to integrate critical information from client data systems and facilitate meaningful use of electronic health information in a real-time data exchange using evidence-based care transition models, could contribute to a reduction in avoidable hospital and Emergency Room use, avoidable health care spending, and avoidable adverse health outcomes.

Full Proposal:
Leverage the SHINNY in a series of three pilots to integrate critically needed information from medical, behavioral, and mixed payer client data systems to connect to Qualified Entities such as Hixny or Healthix, to facilitate efficient, meaningful use of electronic information from local provider systems that are experienced in addressing long-term care and aging-related and health-related social needs. These pilots would prioritize real-time data exchange of provider agencies participating in care transitions models shown to be effective and inform decision making through the provision of a concise, actional summary of holistic needs and critical contact information aligned with federal guidance on web accessibility.
The three pilots would be implemented in the following steps:

1. Care Transition: Hospital to facility (Skilled Nursing Facility, ACF/ALR with home care).
2. Care Transition: Hospital/Facility to community-based setting (including independent senior housing, OMH housing, subsidized housing).
3. Community Care Navigation: Post-acute phase, one individual is stabilized after transition, HCBS organizations across the service systems, skilled in utilizing evidence-based care transition models and engagement with aging populations at high risk for losing community tenure, facilitate the individual's connection to community-based services, entitlements, and benefits (includes Aging Network providers, Naturally Occurring Retirement Communities/NORCs, Senior housing and OMH housing, Health Homes and Health Home Plus, and Social Care Networks).

Stakeholder Advisory Committee Note: While the Stakeholder Advisory Committee recognizes the importance of this proposal, they suggest that it would be better accomplished if the first step is a coordinated group of service providers coming to an agreement regarding a uniform set of aligned and required data and questions. This will align the data the proposal's pilots seek to access across the SHINNY. The Stakeholder Advisory Committee also suggests that the proposal should build on the existing work of the Social Care Networks within the 1115 Waiver.

MPA Council Commentary: *This proposal is categorized as infrastructure. The integration of electronic health information systems across health care settings and the community is operationally, administratively, regulatorily, and statutorily complex. Proposed first steps for implementation could include the development of partnerships with key state agency bodies and contractors such as the SHINNY and the Regional Health Information Organizations (RHIOs) as well as representatives from all service systems engaged in transitions across health care settings. Following these discussions, the Department of Health would need to conduct a review of the likely costs and savings associated with this proposal. Any additional resources or funding allocations would be subject to the annual budget process and available resources. Policymakers may reference this proposal during the legislative session, as this proposal may require legislative action.*

Proposal Presented for the Master Plan for Aging (#76):
Meaningful Access to Technology

Summary: Increase efforts to ensure meaningful access to technology for all populations, including access to the hardware, software, and other equipment necessary to meet needs; an internet connection with sufficient bandwidth; and the training, support, and skills necessary to use them delivered in an engaging and culturally component way.

Justification: In the digital age it is now more important than ever to ensure all New Yorkers have the access and technological knowledge needed to use online services and supports. Better understanding challenges to access and providing comprehensive training will allow older New Yorkers to gain the knowledge and resources necessary to obtain the hardware, software, and sufficient broadband that support basic needs and social connectedness.

Full Proposal:
Given the increasing amount of public and private services and programs that are primarily relying on online platforms, New York State must increase its efforts to ensure that all New Yorkers have meaningful access to technology. Meaningful access to technology includes access to the hardware, software, and other equipment necessary to meet ones needs; an internet connection with sufficient bandwidth for the tasks one wants to do; and the training, support, and skills necessary to use them. The COVID-19 pandemic exacerbated the digital divide, leaving older adults and other vulnerable populations without meaningful access to technology, which increased loneliness and challenges in meeting basic needs.
The State should seek to integrate questions about meaningful access into service assessments, program intakes, the COMPASS, wellness checks, person-centered planning processes, etc. The questions should focus on the three components of meaningful access: hardware/software/equipment, internet/bandwidth, and training/support.
If it is found that someone needs one or more of the meaningful access components, the entity working with them should, as appropriate, connect them with programs and resources that provide:

1. Access to hardware, software, and other equipment.
2. Access to broadband.
3. Financial assistance.
4. Engaging and culturally component trainings and ongoing support services. These should include both the “how-to” aspect of using technology as well as discussions of privacy and security (e.g., how to keep your password secure).

This proposal should include expanding access to technology to support caregiving. This proposal works in concert with Proposal 81 (included within Proposal 1) to ensure meaningful access to technology.

MPA Council Commentary: *This proposal is categorized as infrastructure. Policymakers may reference this proposal during the legislative session or the annual budget process, as development of programs to expand access to consumer and provider technologies would likely require legislative action and funding that would be subject to the availability of resources. Policymakers may reference this proposal during the legislative session or the annual budget process, as development of programs to expand access to consumer and provider technologies would likely require legislative action and funding that would be subject to the availability of resources. Many State agencies are engaged in efforts to expand meaningful access to technology. For example, SED has identified libraries as a primary point of internet connectivity and technology support, particularly for people who lack access at home; exploring options for maintaining access to technology through libraries would be a crucial component of successfully implementing this proposal, especially in rural communities.*

Proposal Presented for the Master Plan for Aging (#75):
Statewide Uniform Care Platform

Summary: Develop, launch, and maintain a statewide, uniform Health Insurance Portability and Accountability Act (HIPAA) compliant care platform aiming to empower users to proactively help clients receive the care and services, allowing for benefits and services enrollment based on data analysis, trends, and recommendations generated by the platform. The platform would replace the current use of individual assessment tools and data sheets by various programs and allow users to seamlessly coordinate services and benefits across multiple agencies and programs.

Justification: The establishment of a statewide uniform care platform allows providers to seamlessly assist older adults in receiving care they require. The platform promotes aging in place and accessible, coordinated benefits and services. Timely and efficient enrollments ensure that older adults and people with disabilities can receive necessary services and supports.

Full Proposal:
Develop, launch, and maintain a statewide, uniform HIPAA-compliant care platform (the platform) that will assist service providers in helping older adults and people with disabilities remain in their homes and communities. The platform aims to empower users to proactively help their clients receive the care and services they require. It will allow users to swiftly enroll their clients in benefits and services based on data analysis, trends, and recommendations generated by the platform. Users will be able to seamlessly coordinate services and benefits across multiple agencies and programs. The platform will replace the current use of individual assessment tools and data sheets used by various programs. The state will:

- Issue an RFP for the design, development, launching, and maintenance of the platform.
- Ensure the platform has the most up to date information on all relevant benefits, services, and programs.
- Provide training for how to use the platform to users across NYS.
- The platform will also enable users to identify and report to APS and county-based Offices for the Aging when they suspect their clients are at risk or have been the victim of adult abuse.

MPA Council Commentary: *This proposal is categorized as long-term. State agency partners are currently working on similar initiatives to streamline access to a range of benefit programs through the Integrated Eligibility System. An assessment of existing and in-progress initiatives could be pursued to determine the effectiveness of those services. Following an evaluation of existing initiatives, the relevant State agency partners can determine need for further coordination efforts. Any additional resources or funding allocations would be subject to the annual budget process and available resources.*

Proposal Presented for the Master Plan for Aging (#25):
AgeTech and Assistive Technology Incubator

Summary: Establish a State-sponsored technology incubator focused on, "AgeTech," and assistive technology. The incubator would be a public-private partnership leveraging State opportunities to encourage development of needed technologies.

Justification: AgeTech enhances autonomy and empowers older individuals through assistive technology. This technology, such as voice-activated devices and automated systems, improves the nuances of daily life, including safety and culinary self-sufficiency. It improves quality of life by supporting health-promoting activities like walking and social interactions. Overall, independence and self-reliance via technology will help older adults and people with disabilities live in their own homes, where their sense of well-being is able to flourish.

Full Proposal:
Establish a State-sponsored technology incubator focused on, "AgeTech," and assistive technology.

1. Engage private venture capital to match state funds to support the growth and development of AgeTech and assistive technology companies in New York State.
2. Develop pipelines from universities across the State to facilitate the development of research into marketable technologies.
3. Partner with the Department of Health's Office of Health Insurance Programs to provide feedback on the potential of new technologies and products to be reimbursable by Medicaid.

MPA Council Commentary: *This proposal is categorized as near-term. Policymakers may reference this proposal during the annual budget process, as this proposal may require legislative action and would require new funding subject to the availability of resources. New York State already sponsors or supports a variety of business incubators and accelerators across the state that fund digital health-related ventures. For example, ESD's New York Ventures program is actively deploying over $300 million of capital, and has a large digital health portfolio that is open to new investments in AgeTech. Before establishing an additional incubator, the State would need to develop a clear business case and rationale for how such an incubator would build on and complement these existing efforts. If successful, the creation of an AgeTech Incubator could support the accelerated development of assistive technology to empower older adults, people with disabilities and their caregivers.*

Proposal Presented for the Master Plan for Aging (#87):
Involving the User in the Design and Development of Technology

Summary: Develop policies that encourage the technology sector to involve end users in the design and development of such technology products, trainings, and support services. This includes incentives for companies that include end user in design and development, establishing formalized standards for procurements, involvement of end users in policy development, and implementation of end user feedback.

Justification: Technology is most effective when the intended users are involved in the design and development of the products, trainings, and support services, particularly for older adults, individuals with disabilities, and caregivers. By doing so, the users' desire to engage with the product increases as well as the efficacy of the technology. Implementation of these actions will improve health outcomes, such as with easier utilization of telehealth services, as well as increasing independence through means of empowerment for the individual.

Full Proposal:
New York State should develop a policy that encourages the technology sector to involve end users in the design and development of such technology products, trainings, and support services. The end user includes older adults, people with disabilities, immigrants, refugees and other English language learners (ELL), caregivers, and professionals who work with or utilize telehealth/telehealth remote supports, smart home technology, tools that enable communication with caregivers, and/or tools that protect financial health. To implement this policy, New York State would, at a minimum:

1. Develop and formalize standards to include in procurements, mechanisms for involving end users in policy decisions, and methods to obtain and compile feedback from end users.
2. Prioritize companies and products that involve end users in the design and development of the products, trainings and support services when procuring or designing and building technology.
3. Include end users in policy decisions on how public funding is used to support technology.
4. Involve all state agencies in the implementation of the policy and encourage localities to adapt similar policies.
5. Compile feedback from end users that will be used to inform future procurements and policy decisions.

MPA Council Commentary: *This proposal is categorized as near-term. State agencies across NYS government can look for opportunities to prioritize the consideration of end users in evaluating technology for State procurement.*

Proposal Presented for the Master Plan for Aging (#27):
Improve Cognitive Health Data Accessibility

Summary: Establish a central repository of HIPAA-compliant cognitive health data to inform policymaking and resource prioritization in support of optimizing value, equity, inclusion and effectiveness of cognitive health promotion and care in NYS. The proposal includes an evaluation of existing data sets and of use cases for the repository.

Justification: Existing data sets about cognitive health are not easily accessible or structured to best support cognitive health promotion and disease prevention across the lifespan. The scope, accuracy, and comprehensiveness of the data sets are limited as they do not provide the necessary information for addressing cognitive health, thereby limiting their usefulness for decision making, policy planning and development, and care provision. Having a full range of accurate data will support the understanding of the costs, benefits, and effectiveness of existing cognitive health services.

Full Proposal:
There are currently multiple community and governmental data sets which are not easily accessible or structures to best support cognitive health promotion and disease prevention across the lifespan or reduction of cognitive disease. These data sets do not provide the full scope of information needed to address cognitive health, and the accuracy and comprehensiveness of the data sets vary, limiting usefulness of some data for decision making, policy planning, and care provision.

1. Establish a central repository of HIPAA-compliant cognitive health data to inform policymaking and resource prioritization in support of optimizing value, equity, inclusion and effectiveness of cognitive health promotion and care in NYS.
2. Conduct an initial and ongoing landscape review of existing federal, state and local datasets and systems to create an accessible, comprehensive, data repository to support decision making specific to cognitive health.
3. The data can support an understanding of the costs, benefits, and effectiveness of existing services related to cognitive health, provision of a mapping of available services and programs for providers, policy planners and consumers, support epidemiological surveillance relevant to cognitive health, understand patterns of health care utilization and cognitive health trends in order to improve health care and preparedness planning, support workforce development, and support New York State's existing initiatives in dementia care.

MPA Council Commentary: *This proposal is categorized as long-term. While a robust collection of available data is critical for the development of informed Statewide governmental decision making, the collection of data is administratively complex and may require regulatory changes. Proposed first steps for implementation could include an evaluation of existing the Department of Health resources and the accessibility of other data sources. Following this evaluation, the Department of Health can evaluate*

possible regulatory changes with relevant state agency partners for the continued development of a decision making framework informed by cognitive health data.

The following proposals in Pillar 9 are not included in the Advisory Report as they were submitted at the conclusion of the Stakeholder Advisory Committee meetings.

Proposal Presented for the Master Plan for Aging (#119):
Digital Map of Health for Older New Yorkers

Summary: The digital map of health and service utilization for older New Yorkers will provide a comprehensive look at how aging services are spread throughout New York State - including but not limited to NYSOFA, the Department of Health's Office of Health Insurance Programs (OHIP), and encompassing data as appropriate related to OMH, OASAS, and OPWDD. The data will be maintained and held within an existing data lake at the SHIN-NY with the goal of integration, collaboration and ongoing growth of data analysis.

Justification: Currently, there is no central database for all services - and certainly not by geography. New York State needs to leverage mapping and data capabilities as well as the existing data lake held at the SHIN-NY. If the State is unable to leverage these state resources as well as understand its own data, it will lack a comprehensive view of how to move the State forward and reach older adults.

Full Proposal:
To address these pressing issues, the following key steps need to taken:

1. Through consultation with government and community stakeholders, identify the universe of state and local services and funders that this project can feasibly engage.
    a. Identify stages or phases as needed to begin with more accessible data sources and expand to create a more comprehensive picture.
2. Identify potential policy barriers and advance needed policy changes to advance this project with appropriate concerns for privacy.
3. Geocode all recipients of State service from NYSOFA and OHIP along current census tracks.
4. Coordinate between all agencies serving older New Yorkers to determine common data usage to build upon geocoded data.
5. Build out utilization information from each recipient of each State service.
6. Analyze and make publicly available the information above through a State dashboard.

Stakeholder Advisory Committee Note: This proposal is not included in the Advisory Report as it was submitted at the conclusion of the Stakeholder Advisory Committee meetings.

MPA Council Commentary: *This proposal is categorized as infrastructure because an understanding of health and service utilization is critical for supporting future state decisions. The geocoded mapping of all existing data is administratively, regulatorily, and statutorily complex, but recent developments in language learning models could assist in conforming agency data to a common format. Proposed first steps for implementation might include an evaluation to determine the scope of data for inclusion and an assessment of existing data integration programs. Following these*

determinations, the relevant State agency partners would determine the next steps for data geocoding opportunities. Any additional resources or funding allocations necessary to effectuate these proposals would be subject to the annual budget process and available resources.

Appendix H: Advisory Report

Master Plan for Aging Stakeholder Advisory Committee

Advisory Report, 2025

Prepared by the New York State Department of Health's Office of Aging and Long Term Care and the New York State Office for the Aging

Master Plan for Aging Stakeholder Advisory Committee

Advisory Report, 2025

The Master Plan for Aging (MPA) Stakeholder Advisory Committee met in the autumn of 2024 to do a comprehensive review of the proposals generated in the MPA drafting process, drawing from the efforts of workgroups and subcommittees and from input received from town halls, industry roundtables, and a public survey. Below are the proposals, organized by pillar and ranked according to the scoring provided by the Stakeholder Advisory Committee.

The stakeholders scored each proposal on a 1 to 5 scale for five criteria: return on investment (ROI), consensus/support, urgency, cost and difficulty of implementation. Scores were grouped into two categories – "potential impact" (based on ROI, consensus/support, urgency) and "feasibility" (based on cost and difficulty of implementation). Each proposal received a "high," "medium," or "low" rating in each of the two categories based on the Stakeholders' scoring.

PILLARS	PROPOSAL	PROPOSAL NUMBER	POTENTIAL IMPACT	FEASIBILITY
Prevention, Wellness Promotion and Access	Evaluate Payor Support for Preventive Services and Supports	65	High	Medium
	Support Older Adults Aging in Place in OMH licensed and Permanent Housing	84	High	Low
	More Effective Care Integration Through Plans	14	High	High
	Review and Update of the Patient Review Instrument (PRI)	74	High	Low
	Community Immunization Program	2	Medium	Low
	Prevention Curriculum	5	Medium	Low
	Benefits Program Expansion	47	High	High
	Ecosystem Demonstration Pilot	81	Medium	High
	Firearm Retirement Plan	83	Medium	Low
	Support Services for Older New Americans	82	Medium	Medium
	Promotion of the Annual Wellness Visit	80	Medium	Low
	Multilayered Awareness and Intervention Practices	4	Medium	Medium
	Training on the Needs of Older Adults with Substance Use Disorders	107	Low	Low
	Prevention and Geriatrics Continuing Medical Education (CME)	3	Low	Low
	Food As Medicine Promotion	73	Medium	High
	Paid Time Off for Preventative Healthcare Visits	92	Low	Medium
	Expand the Wellness Initiative for Senior Education and Screening Brief Intervention Referral to Treatment (WISE-SBIRT) Model	108	Low	Low
	Employment Supports for Menopause	89	Low	Medium

PILLARS	PROPOSAL	PROPOSAL NUMBER	POTENTIAL IMPACT	FEASIBILITY
Modernization and Financial Stability of Healthcare, Residential Facilities and Community-Based Aging Network Service Providers	Fund Aging Services	50	High	High
	Medicaid Rate Reform	49	High	High
	Interagency Integration of Social and Healthcare Services	57	High	High
	Support PACE Expansion and Enrollment	59	High	Medium
	Diversifying Long-term Care (LTC) Facility Services	7	High	High
	Hospice and Palliative Care Support and Reform	10	High	Low
	Cross System Care Coordination Through the 1115 Medicaid Waiver	13	High	High
	Expanding Flexibility for Long-Term Care Facilities	8	Medium	High
	Elevate Integrated Care Programs	86	Medium	Medium
	Assisted Living Reform	9	Medium	High
	Continuing Care Retirement Communities Oversight Reform	60	Low	Medium
	Coordination of Homecare and Aging Services at OMH Housing Through 1115 Waiver	85	Medium	Medium
	Adult Day Care Family Caregiver Program	41	Medium	Medium
	Adult Care Facility (ACF) Voucher Demonstration	21	Medium	High
	Facilitating Nursing Home Reform Efforts	11	Medium	High
	Reactivate and Modify the Voluntary Residential Health Care Facility Rightsizing Demonstration Program	12	Low	High
	Nursing Home Capital Assistance	6	Low	High
	Improve Nursing Home Quality Incentive Pool	51	Low	High
Affordability of Basic Necessities	LTSS Finance Reform	69	High	Medium
	Establishing the Office of Benefits Coordination	1	High	High
	Improving Use of Medicare Savings Program	72	Medium	Low
	Increase Utilization of the Elderly Pharmaceutical Insurance Coverage Program (EPIC)	68	Medium	Medium
	Expand STAR Benefits	101	Medium	Medium
	Fund the Office for Older Workers	24	Low	Low
	Establish a Lifetime Financial Planning Program	23	Low	Medium

PILLARS	PROPOSAL	PROPOSAL NUMBER	POTENTIAL IMPACT	FEASIBILITY
Informal Caregiver and Workforce Support and Modernization of Community-Based Aging Network	Support Immigration Reform to Expand the Paid Caregiver Workforce	35	High	High
	Regulatory Reform to Support Direct Care Workforce Recruitment	38	High	Medium
	Support Community-Based Aging Services	114	High	Medium
	Universal Direct Care Worker Model	39	High	High
	Establish Regional Caregiver Support Hubs	32	High	Medium
	Caregiver Tax Credit and Reimbursement Program	56	High	High
	Establish Administrative Infrastructure to Support Kinship Caregivers	62	Medium	Low
	Procurement of Regional Direct Training Centers to Increase Accessibility and Availability of Training	30	High	High
	Establish the Statewide Caregiver Peer Support System	44	Medium	Low
	Incentivize Geriatric Specialties	28	Medium	Medium
	SkillSpring Program to Bolster the Direct Care Workforce	33	Medium	Medium
	NYS Working Caregiver Initiative and Pilot	46	Low	Low
	Peer-to-Peer Legacy of Care Mentorship Program	31	Medium	Medium
	Support for Nursing Educators	54	Medium	Medium
	Establish Caregiver Coordinating Commission	63	Low	Low
	Funding the NYSCRC	79	Low	Medium
	Require Alzheimer's Disease and Dementia Care Training	29	Low	High
	Increase Advertising to Recruit More Caregivers	36	Low	Low
	Statewide Caregiver Engagement Campaign	42	Low	Low
	Workforce Development Center for Professional Development in Gerontological and Geriatric Education	37	Low	Low
	Develop a Caregiving Tool Kit	45	Low	Low
	Assess Appropriate Respite Care and Social Adult Day Services Wages	53	Low	Medium
	Antidiscrimination of Caregivers in the Workplace	40	Low	Medium
	Education of Informal Caregivers in the Workplace	43	Low	Low
	Person-Centered Service Delivery Direct Care Workforce Training	67	Low	Medium

PILLARS	PROPOSAL	PROPOSAL NUMBER	POTENTIAL IMPACT	FEASIBILITY
Housing Access and Community Development	Addressing Housing Supply	15	High	High
	Incorporate Age-Friendly Principles into Community Design	20	High	Medium
	Eviction Prevention	16	High	High
	Strengthen Home Modification Programs	19	High	Medium
	62+ Housing Exemption for Kinship Caregivers	78	High	Low
	Expand the Empire State Supportive Housing Initiative (ESSHI)	103	High	Medium
	Supporting Community Housing Models	17	High	High
	Increase Funding for the Age-Friendly, Accessible, and ADA-Compliant Downtown and Community Revitalization	93	Medium	Medium
	Affordable and Accessible Housing for Unhoused People with Disabilities through Medicaid Redesign Team (MRT) Capital and Supportive Housing Opportunity Program (SHOP)	98	High	High
	Consideration for Older Adults in Local Law	102	Low	Low
	Funding Infrastructure Upgrades and Investing in Municipalities	48	Medium	High
	Upgrades to the RESTORE Program	104	Low	Low
	Expand Colocated Housing Types for Older Adults	100	Low	High
Access to Services in and Engagement with Historically Disadvantaged Communities	Encourage Transportation Network Integration and Growth	18	High	High
	Support Electronic Health Records Adoption	52	High	High
	Improve Retirement Opportunities for People with Intellectual and Developmental Disabilities	106	High	Low
	Fund the NYS Adaptive Living Program	97	High	Low
	Loan Forgiveness for Nurses in Medically Underserved Areas	55	Medium	Medium
	Affordable Housing and Support Services for Elderly Veterans	95	High	High
	Lifelong Learning Program and Employment Support for Elderly Veterans	96	Low	Medium
	Enhanced Health & Wellbeing for Elderly Veterans	94	Low	Medium
Social Engagement of Older Adults	Supporting social connection with the U.S. Surgeon General's Recommendations	70	Medium	Low
	A Reduction in Social Isolation Through Peer Model Programming Engagement and Expansion	66	Medium	Low
	Social Isolation and Loneliness in State Policy	77	Low	High
	Access to Childcare Services Near Long-Term Care Settings	34	Low	Medium

PILLARS	PROPOSAL	PROPOSAL NUMBER	POTENTIAL IMPACT	FEASIBILITY
Technology Access and Development	Integrate Data and Case Management Across Care Settings	26	High	High
	Meaningful Access to Technology	76	Medium	High
	Statewide Uniform Care Platform	75	Medium	High
	AgeTech and Assistive Technology Incubator	25	Low	Medium
	Involving the User in the Design and Development of Technology	87	Low	Low
	Improve Cognitive Health Data Accessibility	27	Low	Medium
Combating Elder Abuse, Ageism and Ableism	Improve Public Awareness of Financial Scams and Fraud	109	High	Low
	Address Financial Exploitation of Older Adults	88	Medium	Low
	Promote Scam Recovery and Prevention	111	Medium	Low
	Improve Guardianship	61	High	High
	Challenging Ageism, Ableism, and Abuse	22	Medium	Medium
	Establish Public Awareness Programs for Scam Recovery	112	Medium	Low
	Elder Abuse and Elder Justice Forum	71	Medium	Low
	Elder Abuse Research Forum	110	Low	Low
	Inclusive Disaster Response and Preparedness	58	Medium	Medium
	Compensation for Victims of Scams and Financial Exploitation	113	Medium	High
	Combat Ageism in the Workplace	90	Low	Low
	Training Regarding Emergency Preparedness for Individuals with Disabilities	99	Low	Low
	Require Aging and Intellectual and Developmental Training	105	Low	Low

Appendix I: Preliminary Report

August 28, 2023

Honorable Kathy Hochul
Governor
State of New York
State Capitol
Albany, New York 12224

Dear Governor Hochul:

As Chair and Vice Chair of the Master Plan for Aging, we are pleased to present this preliminary report offering a progress update on the State's Master Plan for Aging, in accordance with State Executive Order No. 23.

The State's designation in 2017 as the nation's first Age-Friendly state was New York's first step toward helping individuals age with dignity and independence. Through your leadership to advance a State Master Plan for Aging, we are now building on that foundation to elevate our State's status as the most inclusive state for older adults, caregivers, persons with disabilities, and future generations.

The Master Plan for Aging's State Agency Council and Stakeholder Advisory Committee have brought together over 350 experts to address core issues of importance to all New Yorkers as they age. Their work to date is documented in this report and framed by ten thematic, organizing pillars. For each of these organizing pillars, the report presents goals and potential solutions for consideration in later stages of the Master Plan for Aging process. The preliminary solutions put forth herein will continue to take shape and inform short- and long-term strategies that will be documented in future reports for your review.

We thank you for your leadership on this important initiative.

Sincerely,

Adam Herbst, Esq.
Chair, Master Plan for Aging
Deputy Commissioner
Office of Aging and Long Term Care
New York State Department of Health

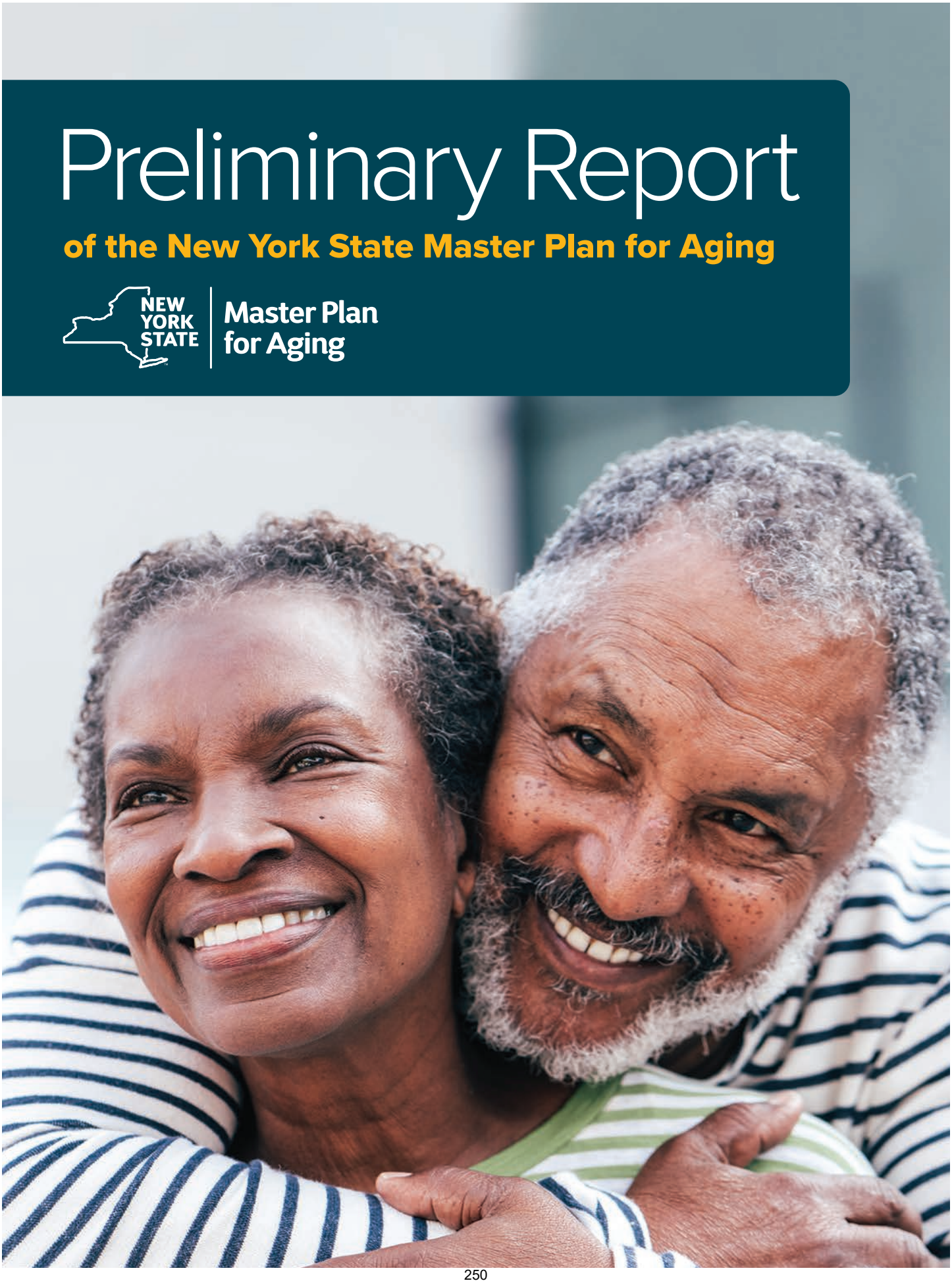
Greg Olsen
Vice Chair, Master Plan for Aging
Acting Director
New York State Office for the Aging

Enclosure

Preliminary Report

of the New York State Master Plan for Aging

NEW YORK STATE | Master Plan for Aging



Executive Summary

This preliminary report is the first progress report on the development of New York State's Master Plan for Aging (MPA). The report summarizes the factors leading to the creation of the MPA, the structure and organization of the MPA, the MPA's procedural milestones and their target completion dates, and the topical foundations (known as "pillars") that will support the ongoing work of and future recommendations from the MPA.

Since Executive Order No. 23 was signed by Governor Kathy Hochul on November 4, 2022, the New York State Department of Health (DOH) in partnership with the New York State Office for the Aging (NYSOFA) have assembled subject matter experts and partners from across the State to advance the important work of the MPA, which is to put forward a comprehensive set of recommended policies and programs that will ensure all New Yorkers can age with dignity and independence.

As of the writing of this report, this undertaking has resulted in:

- assembling **351 total members**, representing experts from the fields of aging, medicine, transportation, technology, housing, organized labor, home care, State and local government, and more. To ensure inclusivity in the MPA's recommendations, these representatives include members from historically disadvantaged or underserved groups including BIPOC (Black, Indigenous and People of Color) communities, rural communities, and the disability community, among others; and

- convening **309 total meetings** as of the writing of this report and scheduled through the end of August 2023. These meetings serve to advance the goals of the MPA and work toward the development of a final set of recommendations. Meetings include:

    - 5 State Agency Council meetings with the MPA's 22 State agency and government partners;

    - 5 Stakeholder Advisory Committee meetings;

    - 36 subcommittee meetings, representing the work of 8 subcommittees discussed herein; and

    - 263 workgroup meetings, representing the work of 32 distinct workgroups.

While much has been accomplished to date, this preliminary report represents only a point in time of the MPA's progress, and recommendation development will continue to take place in regular meetings held by the MPA's members. To that end, the MPA's organizational pillars discussed herein set forth initial ideas to assist members in identifying and articulating the challenges to older adults aging with dignity and independence, centered around the ten pillar themes, and what the keys to resolving those challenges will be. The pillars will continue to

serve as a reference to orient and shape the future policy recommendations arising from the MPA's eight subcommittees and each of their subject-specific workgroups.

Throughout this process, DOH and NYSOFA will continue to provide updates on the MPA's progress. Key milestone dates set forth in Executive Order No. 23 will include an interim report due by January 2024, a final Stakeholder Advisory Committee report due by July 2024, and the final Master Plan for Aging due in January 2025.

Introduction

On November 4, 2022, Governor Kathy Hochul signed Executive Order No. 23 - Establishing the New York State Master Plan for Aging (the "EO"), led by the New York State (NYS) Department of Health ("DOH") and the NYS Office for the Aging ("NYSOFA"). The EO provides a process for drafting guidance for the NYS Master Plan for Aging (the "MPA") and is the first step towards building a comprehensive roadmap for meeting the needs of all New Yorkers as they age.

Building on New York State's status as the first state in the nation to officially receive AARP's age-friendly designation, the MPA aims to help coordinate existing and new state policies and programs for older adults and their families, while also addressing challenges to aging with dignity and independence. Accordingly, the MPA seeks to improve and address: communication, coordination, caregiving, service disparities, wellness, community design, long-term care financing, care models and programs that support healthy longevity and community engagement.

This preliminary report summarizes the factors leading to the creation of the MPA, the structure of the MPA process, and the procedural milestones to be reached by that process. This report concludes with a framework for guiding the development of proposals over the next year and the agendas that the workgroups are developing to engage with their subject issues.

The MPA will provide a comprehensive set of options to be considered by the Governor that could help build and improve systems of services and supports for aging and long-term care. Recommendations will be organized around short-, medium- and long-term goals, and take into account urgency, impact, fiscal implications - including return on investment, and challenges to implementation, as well as the ability to advance key priorities. Recommendations will include legislative and regulatory proposals at the state and local levels, as well as proposals for public-private partnerships. This ensures a commitment at every level to engage society in rising to meet the challenges and opportunities of ensuring New York's future as an outstanding place to grow up and grow old - a community that rises to the moral obligation of caring for its most vulnerable members.

The MPA process is intended to examine and address the experience of aging in New York, including factors in early life that impact a person's physical, mental, financial and social health during later life stages. Governor Hochul's stated goal for the MPA is "to ensure older New Yorkers can live fulfilling lives, in good health, with freedom, dignity and independence to age in place."[1]

The MPA process will accomplish this in two ways: generating policy proposals and serving as a forum for stakeholders to provide input and build consensus around the proposals they are developing. Accordingly, the MPA process has engaged a spectrum of NYS agencies

[1] Exec. Order No. 23, Pg. 2, (2022) https://www.governor.ny.gov/executive-order/no-23-establishing-new-york-state-master-plan-aging

that can be found in Appendix C. The range of non-governmental stakeholders includes, but is not limited to, representatives from organized labor, researchers in medical and non-medical fields, leaders of community organizations, and executives of businesses engaged in home care, real estate services, transportation, and technology; a list of these stakeholders can be found in Appendix B. Extra care has been taken to ensure the MPA process includes voices from BIPOC (Black, Indigenous and People of Color) communities, rural communities, the disability community, and other historically disadvantaged or under-served groups.

In the first six months of its operations, the MPA governing bodies have convened, as directed by the EO, created and populated the eight subcommittees intended to do the bulk of the drafting of the MPA, and began a series of initiatives to solicit public engagement in the process. The subcommittees, in turn, have established workgroups to focus on specific topics recommended by their members. As of the issuance of this preliminary report, the subcommittees and workgroups have developed lists of issues to be reviewed and discussed as a part of this process.

Early on, several topics were repeatedly raised during subcommittee and workgroup discussions – these issue areas have been turned into a series of pillars to guide the next year of MPA work. The subcommittees and workgroups have also begun to generate ideas that will be further developed into formal proposals for inclusion in the final report. The pillars and a selection of associated ideas are discussed in this report. It is important to note, however, that the challenges and possible solutions listed within each pillar represent a snapshot in time of potential, early-stage ideas to support New Yorkers as they age.

Public outreach efforts are underway. A website was created to provide background information and ongoing updates regarding the progress of the MPA. The first Town Hall was held in New York City on June 7, 2023, and additional Town Halls have been held in Albany (July 11) and Plattsburgh (July 12). Community engagement events, including Town Halls, will continue to take place throughout the State as the MPA is developed, including in Long Island, Buffalo, Syracuse and Rochester. An additional set of subject-specific round tables are being planned to engage with specific interest groups and communities. A public survey is planned for later in 2023.

The MPA process will not end with the issuance of the MPA in early 2025. The MPA is organized around 2-year, 5-year and 10-year benchmarks for implementing its proposals and for evaluating its success. Participants from government and stakeholder groups have been asked to continue their commitment to the process past the issuance of the final report, to ensure that the MPA remains dynamic and responsive to ongoing technological, community, social and demographic changes. The MPA website will be adapted to include a dashboard, allowing the public to monitor its progress and implementation.

Factors Leading to the Development of the MPA

Age Friendly Designation and Social Determinants of Health

In 2017, New York was the first state accepted by the AARP into their Network of Age-Friendly Communities, reflecting AARP's evaluation of New York as committed to addressing "the environmental, economic and social factors that affect the health and well-being of older

adults."[2] New York's enrollment followed a 2014 survey by AARP that found that "older New Yorkers would likely stay in the state as they age if improvements were made for them in health, housing, transportation and jobs."[3] Respondents were also concerned with "civic participation, employment and housing."[4]

In an earlier parallel effort, AARP and the World Health Organization (WHO) established the Eight Domains of Age-Friendly Communities, which set eight broad categories of factors defining the age-friendliness of cities. Following the AARP age-friendly designation, in 2018, New York State issued Executive Order 190 – Incorporating Health Across All Policies into State Agency Activities, which directs all state agencies to collaborate on the incorporation of the Prevention Agenda and the Eight Domains of Livability into all planning, procurements, and operations, where possible.

New York's age-friendly designations rested in part on DOH's Prevention Agenda, the State's public health blueprint that emphasizes the impact of non-medical factors on health outcomes. The comprehensive approach of the MPA regarding the holistic experience of aging is rooted in an evolving understanding by the research and caregiver community of the interconnectedness of medical and non-medical factors that drive quality of life and medical outcomes—the social determinants of health.

Extending these concepts, Governor Hochul's mission statement for the MPA directs the process to focus on elements of life driven by factors far beyond medical care. The EO includes references to preventive health care, home care, food and nutrition, human services, housing and transportation.

Prevention and Aging in Place

The Prevention Agenda serves as a conceptual framework for the MPA by drawing connections between early interventions and long-term benefits. With that relationship established, the MPA is able to draw on the recent consensus among medical and service providers: that prevention efforts are effective at both improving quality of life and ensuring efficient resource utilization in aging services and long-term care systems. Despite increasing longevity, recent trends have indicated a reduction of the "health span", or the portion of life spent in good health. Medical advances enable individuals to live longer with diagnoses of terminal and chronic diseases, often while relying on long-term services and supports. However, those advances have stopped significantly extending the period of a person's life without major illness or disability[5].

[2] AARP (February 2018) New York Commits to Being Age-Friendly, AARP Livable Communities, https://www.aarp.org/livable-communities/network-age-friendly-communities/info-2018/new-york-state-joins-aarp-age-friendly-network/

[3] *Id.*

[4] *Id.*

[5] Fried, L.P., Henry, M., Beard, J.R., & Rowe, J.W. (2023). Public Policy and Aging Report. Public health 4.0: Creating health for longer lives. Unpublished Manuscript.

Incorporating these prevention concepts into the MPA has the potential to reverse this trend and increase the number of years that older adults are able to live independently, be engaged in the workforce, and limit or delay costly acute and long-term care. Recent evidence indicates that complementary interventions by the public health system, medical care, and other sectors across society could be highly effective in preventing disease and lengthening health span to match the greater length of our lives.

That opportunity also aligns with what older adults want. New York is fortunate to be engaging in this process at this moment, given the convergence between the preferences of most older adults— to age in place— and the most efficient ways to deploy aging services and long-term care resources. Older adults prefer to age in their homes and communities rather than in facilities. A recent survey conducted by NYSOFA, yielding more than 26,000 responses from older New Yorkers (60+), indicated that respondents overwhelmingly regard their communities as good places to live and work, while a poll by the John A. Hartford Foundation indicates that 70% of older adults are unwilling to live in a nursing home.

Meanwhile, the new consensus across medical and service providers is that providing home care and non-clinical home and community-based services to help people age in place is advantageous for a variety of reasons, including the benefits to the older adults and their communities at large. A community-based approach has been shown to result in savings for health systems by reducing the need for costly acute care. Like aging in place, certain principles of community design and early interventions can improve quality of life, increase productive years, and reduce and delay costly care while aligning with what many older adults want: to live fulfilling lives, in good health, with freedom, dignity and independence, and to age in place for as long as possible.

Supporting the Most Integrated Settings for New Yorkers

The MPA was developed to enhance the lives and wellbeing of all New Yorkers over the continuum of aging. With this framing in mind, the MPA is cognizant of the cross-cutting issues between supports for persons who are aging and supports for persons who currently have, or may acquire in their lifetime, a disability, including the important objective for persons to live as independently as possible and reside in the most integrated settings.

New York State developed a comprehensive Olmstead Implementation Plan in 2013 that addressed four primary domains: housing, employment, transportation, and community engagement. New York's Olmstead Implementation Plan affirmed the State's position as a national leader related to the rights of individuals with disabilities. The oversight body for New York's work under the Olmstead Plan is the Most Integrated Setting Coordinating Council (MISCC), which is focused on four primary priority areas: housing, employment, transportation, and community engagement.

The MPA is building on foundations laid by the MISCC by ensuring that age friendly principles and the eight domains of livability (outdoor spaces and buildings, transportation, housing, social participation, respect and social inclusion, work and civic engagement, communication and information, and community and health services) are incorporated into the MPA's design. The missions of the Olmstead Plan and the MPA are closely aligned, with both sharing the common goals to ensure that older adults and people living with disabilities across the lifespan are afforded the opportunity to live lives of inclusion and work, travel, and engage in their community of choice.

Disconnected Systems

The EO notes that a comprehensive approach is necessary to address, "access to affordable, suitable housing, transportation, the ability to age in place, mental health, isolation, ageism, opportunities for civic engagement and the prevention of elder abuse." The MPA requires a system-wide review to ensure all services and supports are studied and work towards interconnectedness in order to better serve older adults.

The MPA staff undertook a survey of the state offices and agencies that serve and/or interface with older adults. That survey asked participants to provide an inventory of all their programs and regulatory functions that impact older adults.[6] The survey results demonstrate that existing programs, services and regulatory functions for older adults have redundancies, gaps in coverage, and at times do not create a continuum of care across services. This is an area of opportunity that can be addressed via the MPA process.

Demographics

If structural changes are not advanced, current demographic trends will increase the strain on benefits, supports, service systems and community infrastructure, as the average age of the state increases. Currently, New York State has the fourth-largest population of older adults in the United States, with 3.8 million individuals over age 60. New York is also diversifying, with increasing heterogeneity in the older adult population, where 1 in 10 older adults over 65 in New York City were born in a country other than the United States. Older adults in New York are a critical part of the local and state economy, contributing 43% of state GDP ($719 billion), supporting almost 6 million jobs, generating $482 billion in wages and salary, and $72 billion in state and local taxes.

Key demographic trends include:

- By 2030, more than 25% of the population will be over the age of 60 in 51 counties across the state, with approximately 5.5 million New Yorkers aged 60-plus.
- Growth will primarily occur among older adults in communities of color, who are projected to increase by almost 17% for the over-60 population and by 44% for the over-85 population by 2050.
- Meanwhile, 70% of New Yorkers over the age of 65 are likely to need some form of long-term care.
- Long term care expenditures represent ~50% of the Medicaid budget and are the largest cost driver in the state budget.

Governor Hochul established the MPA to ensure that services and support systems are prepared for the impact of approaching demographic changes through prevention and community-based care reform.

[6] The results of the survey have been assembled into a report, with a goal of having the report serve as a continuously updated resource cataloguing all NYS government programs and functions focused on older adults.

Creation of the MPA

Governor Hochul's November 2022 EO designates the DOH Commissioner of Health (or designee) as the chair of the MPA, and NYSOFA Acting Director (or designee) as the vice chair. DOH's designee as chair is Deputy Commissioner of the Office of Aging and Long Term Care, Adam Herbst. NYSOFA's vice chair is Acting Director Greg Olsen, with his designee NYSOFA Chief of Staff, John Cochran, representing the agency.

The EO directs the chair and vice chair to establish two governing bodies for the MPA process. The first is the MPA Council (the "State Agency Council"), which is composed of the leadership of agencies and offices across NYS government. As of the release of this preliminary report, the State Agency Council has 21 members, representing a broad selection of agencies overseeing programs and regulatory functions affecting older adults.

The second governing body is the Stakeholder Advisory Committee (the "Stakeholder Committee"), composed of stakeholders in the aging and long-term care ecosystem outside of government. As of June 2023, the Stakeholder Committee has 29 members, comprised of leaders from the private, not-for-profit, research and advocacy sectors.

The EO further directs the Stakeholder Committee to establish subject-specific subcommittees. The Stakeholder Committee has established the following eight subcommittees:

1. Long Term Services and Supports
2. Home and Community-Based Services
3. Formal Caregivers
4. Informal Caregivers
5. Safety, Security and Technology
6. Health and Wellness
7. Economic Security
8. Housing, Community Development and Transportation

The membership of the subcommittees includes members of the Stakeholder Committee and the State Agency Council, representatives from local health departments and Area Agencies on Aging (AAAs) from across the state, and additional experts and leaders from the aging and long-term care ecosystem. As of June 2023, there are 285 members of the MPA subcommittees. Membership is broad in geographic representation and individuals were invited to self-select into subcommittees and workgroups.

The Association Resource Group (ARG) was established to promote opportunities for older adults to live independently, enhance opportunities for community engagement and advance the age-friendly movement. Participants include, but are not limited to, those representing the aging services network, community based long term care supports providers across the care spectrum, as well as public and private community design professionals. The work done by the ARG aligns with MPA goals by advocating for policies and programs that better support older adults to remain in their communities of choice. For a complete representation of the MPA organizational structure, see **Figure 1**

Figure 1:

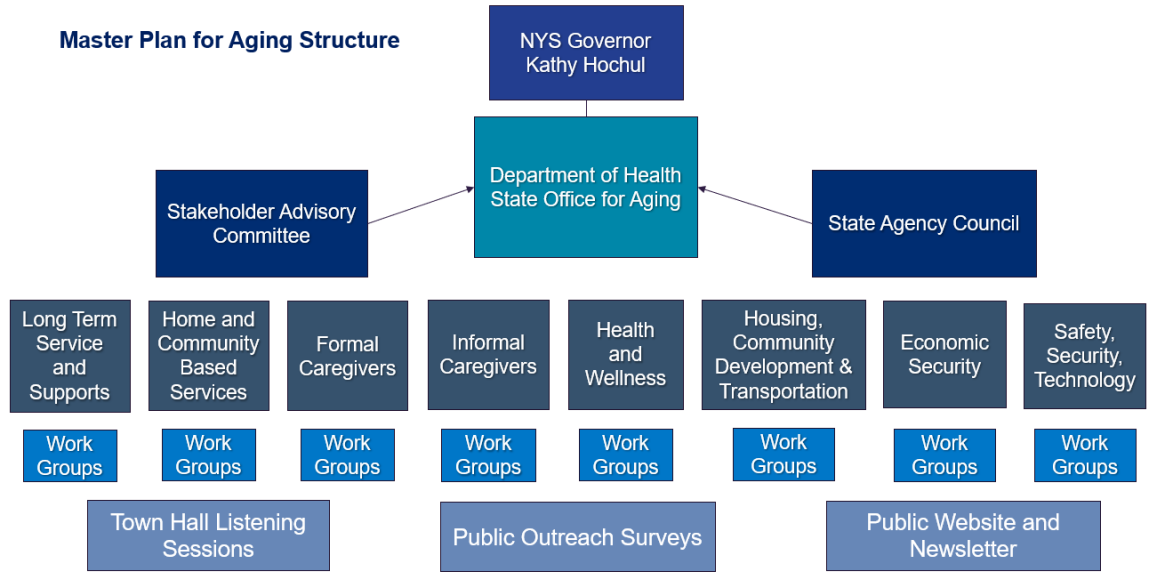


Figure 1: Master Plan for Aging (MPA) organizational structure

MPA Structure and Agenda

Each workgroup has a focus area and will meet regularly until their work is complete. Further, subcommittees are expected to meet at least once per month. Subcommittee meetings are used for workgroups to report on their progress and to discuss overlapping issues or general themes that touch each workgroup's subject matter. The subcommittee chairs meet monthly to coordinate their work.

The following is a list of the workgroups established by each subcommittee. A list of the issues that each workgroup intends to address in the coming year can be found at Appendix A. The full list of participants on the subcommittees and workgroups can be found at Appendix B, and a list of all State Agency Council members can be found at Appendix C.

Housing, Community Development and Transportation

- Housing
- Community Planning
- Transportation

Formal Caregivers

- Recruitment and Training
- Retention, Compensation and Benefits
- Scope of Practice and Job Structure

Informal Caregivers

- Caregiver Supports
- Kinship Caregiving
- Communications
- Finances

Economic Security

- Retirement Financing
- Benefit Programs
- Workforce Engagement

Long Term Services and Supports

- End of Life Care
- Levels of Care
- Person-Centered Navigation and Access
- Payor Structures
- Care transitions
- PACE
- Equitable Facility Transformation

Home and Community-Based Services

- In-Home Services
- In-Community Services
- Critical Partnerships and Systems Building

Safety and Security

- Financial exploitation, scams
- Abuse (physical, sexual, neglect, psychological)
- Guardianship/Alternatives to guardianship
- Technology Development and Access

Health and Wellness

- Promote and sustain physical and mental health, wellbeing and quality of life, including primary and secondary prevention and self-management of chronic disease
- Access to Medicare and Medicaid annual wellness and prevention benefits & communication to improve utilization

- Behavioral health and substance use disorders
- Cognitive health, Alzheimer's disease and other dementias
- Nutrition and food insecurity

Several themes have emerged across the subcommittees as overlapping challenges and solutions have been discussed. While not an exhaustive list, these common themes and the identified challenges therein include:

Addressing the workforce crisis, which encompasses a variety of interrelated issues. Identified problems include facility operating costs, rural and minority community service access, as well as ensuring sufficient training, compensation and professional development opportunities.

Improving communication regarding and coordination of benefits and resources. Programs could be simplified, and communications need to target their intended beneficiaries more effectively**.**

Lowering regulatory barriers to changing services, whether for workers or for healthcare entities. Challenges include enactment of inflexible state and federal rules that make it more difficult to respond to community needs and financial conditions.

Expanding awareness of ageism, ableism, and other biases impacting accessibility, service delivery, and resource inequality.

Targeting zoning and licensing relief for more gradations of independent and supported living. This core theme seeks to address issues of housing affordability, workforce efficiency, cost efficiency, service coordination, and social isolation.

Enhancing funding to support community-based care and services, which aims to bridge gaps between medical and community-based care models, including inadequate discharge planning to community or home settings.

Encouraging a streamlined licensure approach, which seeks to address gaps in opportunity for quality-driven community-based providers and organizations to obtain state licensure to provide health care services.

Target Measures

Subcommittees and workgroups have begun discussing how to measure the impact of implemented proposals. Both objective and subjective measures have been discussed. For example, these data points may include: the number of affordable senior housing units created, number of people employed in formal caregiving roles, workforce turnover rates or the adequacy

of information about benefit programs. To ensure ongoing development of measurable targets, MPA staff have provided subcommittees and workgroups a discussion framing tool to focus deliberations on producing proposals.

MPA staff are preparing an overview of potential metrics to track and serve as a resource for subcommittees and workgroups as proposals are formalized. These potential metrics reflect research addressing age-friendly principles. They also include proposals to collect data not currently available as well as data on hand.

MPA Timeline

The State Agency Council initially convened on December 7, 2022, and the first meeting of the Stakeholder Committee was on January 9, 2023.

Further meetings of the State Agency Council took place January 11, February 22, May 8, 2023, and August 8, 2023, and the Stakeholder Committee met February 22, April 20, June 6, 2023, and August 8, 2023. The subcommittees and workgroups also met on the dates indicated on the table in Appendix D.

The timeline for submission of the required reports for the MPA was triggered by the first meeting of the Stakeholder Committee. Accordingly, this preliminary report is due six months after the first meeting of the Stakeholder Committee (July 9, 2023). An interim report is due one year after that first meeting (January 9, 2024). The final report from the Stakeholder Committee is due eighteen months after the first meeting (July 9, 2024). The Master Plan for Aging is due two years after the first meeting of the Stakeholder Committee (January 9, 2025).

See **Figure 2** below for a complete timeline.

Figure 2

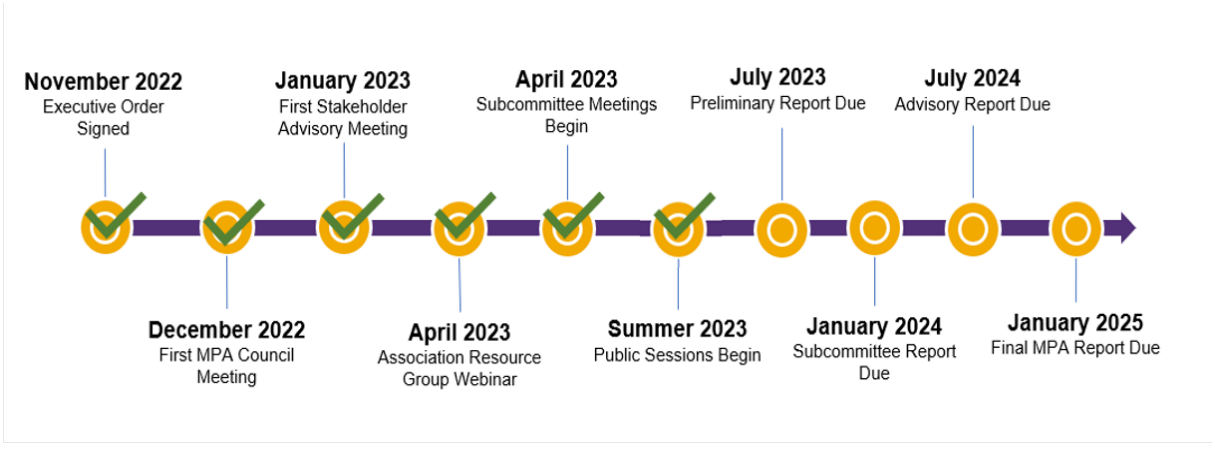


Figure 2: MPA timeline

The Pillars of Support for the MPA

In the first two months of subcommittee and workgroup meetings, a set of foundational pillars arose. Those pillars are listed below and will be used to focus conversations to ensure that the MPA process develops proposals to improve aging in New York. The pillars are:

1. Housing access and community planning

2. Informal caregiver and workforce support

3. Affordability of basic necessities for older adults

4. Access to services in and engagement with historically marginalized communities

5. Modernization and financial sustainability of healthcare, residential facilities, and community-based aging network service providers

6. Social engagement of older adults

7. Promoting health and access to services and supports in rural communities

8. Combating elder abuse, ageism, and ableism

9. Technology access and development

10. Prevention and wellness promotion and access

Looking forward, the subcommittees, through each of their workgroups, will work to develop a set of specific recommendations that are linked to each of these pillars.

Each pillar is summarized below, including outlines of **preliminary** proposals, which will be refined over the coming year. While some of the pillars align closely with specific subcommittees, most reflect issues that are being discussed across multiple subcommittees.

Organizing Pillar:
Housing Access and Community Development

Challenge: *Assuring access to affordable, secure housing, in a community with needed services, enabling older adults to age in place in the setting of their choice in the least restrictive, most integrated environment possible*

Who is affected: Older adults with limited mobility and/or other disabling conditions; older adults with low to moderate income; renters; families of older adults needing housing assistance; older adults who are constrained in their access to the community and services by virtue of restrictive community design; and communities with limited housing options for older members, particularly BIPOC communities (Black, Indigenous and People of Color).

Goals: A sufficient supply of accessible, affordable and middle-income housing in all communities reflective of the continuum of care needs; offering financial assistance necessary to enable low- and moderate-income individuals to access available housing; creating a clear, navigable process to access housing and supportive services if and when needed to maintain independence and dignity; community design that is human scale, people-oriented, and accessible for all members of the community inclusive of all abilities; and a process to connect older adults to their housing opportunities; and establishing integrated and contemporary community planning models, including those that take into account a changing environment and emergency preparedness needs

Keys to resolution: Zoning relief; construction financing; regulatory review; infrastructure development; expansion and replication of best practices from Downtown Revitalization Initiative efforts around collaborative planning to improve livability; transit-oriented development; transportation networks; and Fair Housing Act compliance

Potential solutions:

- Maximize utilization of existing supply, increase housing supply, and provide subsidies for efficient housing options
- Expand programs that combine zoning relief with the development of senior affordable housing, including market rate units to facilitate private sector subsidizing of affordable housing
- Grant zoning relief and as-of-right use approval for residential continuum of care communities

- Long term capital gain tax relief on sale of primary residence if moving to smaller primary residence
- Expand access to services and supports for older adults residing in senior housing – models include the federal Housing and Urban Development Section 202 Supportive Housing for the Elderly Program and the Naturally Occurring Retirement Community (NORC) model
- Consider other affordable housing options such as microhomes, long-term home sharing programs, accessory dwelling units, and expansion of models like the Village to Village Network sites and Downtown Revitalization Initiatives
- Programs that modify and adapt existing housing stock to enhance accessibility
- Rental and operating subsidies
- Planning support to encourage community design principles consistent with the 8 Domains of Age-Friendly Communities
- Design affordable and accessible housing for health with connection to others in order to decrease loneliness and isolation

Figure 3 demonstrates the need to support older New Yorkers regardless of their housing situation

Figure 3

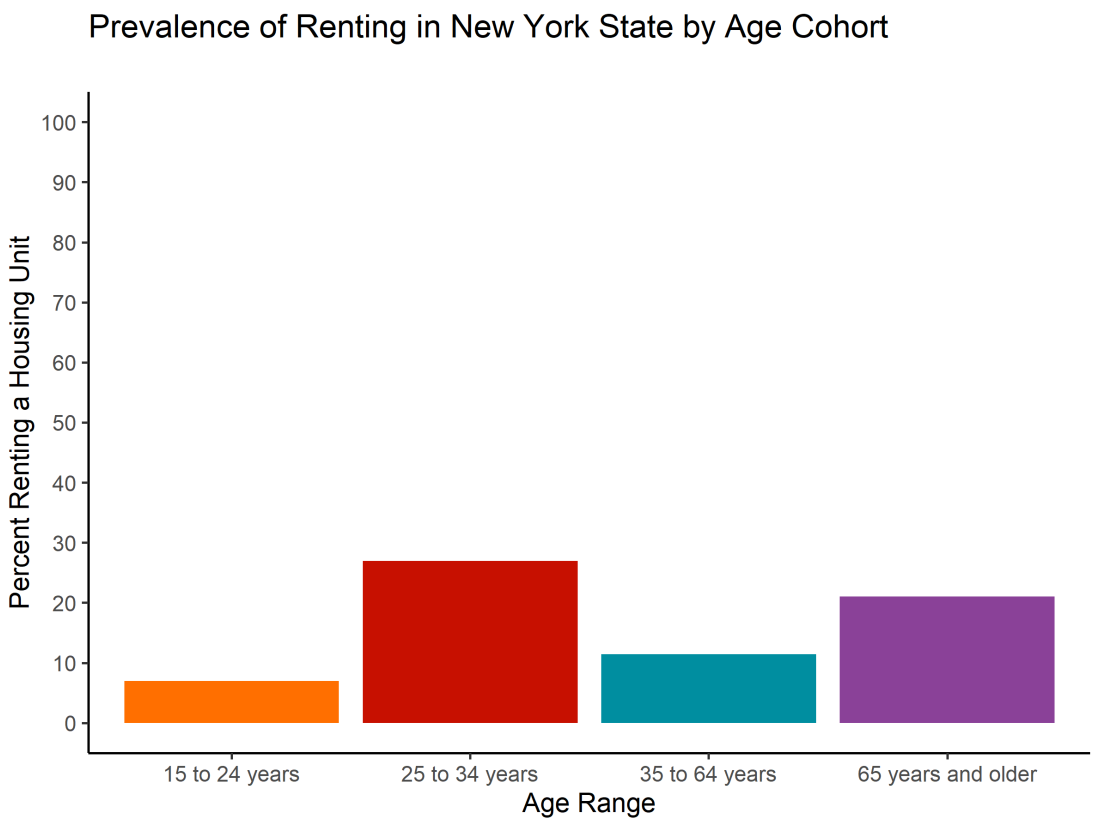


Figure 3: 21% of adults over 65 are renters, the second largest group of renters in New York State. This figure was generated from American Community Survey data, which is collected by the United States Census Bureau.

Organizing Pillar:
Informal Caregiver and Workforce Support

Challenge: *A shortage of workers in caregiving roles has led to services and supports becoming more expensive and less accessible.*

Who is affected: Older adults and others with disabling conditions who cannot find and obtain the services of home care aides; providers unable to recruit and retain qualified staff; willing workers who are unable to obtain the compensation, benefits and employment conditions necessary to meet their needs, and families under the financial and logistical pressures of caregiving.

Goals: Availability of skilled workers and paraprofessionals for all care settings; employment opportunities that meet the needs and expectations of willing workers; supports and systemic rules that facilitate informal caregiving, including the provision of training and programs to assist caregivers.

Keys to resolution: More flexible licensing, including need methodologies and certificate of need processes; expanded scope of practice; stackable credentialing and workforce development pipelines; establishing career ladders and other opportunities for advancement; mentoring programs; public-private partnerships linking education and training institutions to needed employment sectors; readily available training for certification or licensure; improved compensation and conditions of employment; programs of support for informal caregivers; legal systems and benefit programs supporting kinship caregivers.

Potential solutions: Optimize the current workforce with technology while making jobs more attractive with higher wages and expanded benefits in order to increase supply:

- Ease attainment of multiple certifications, e.g., Personal Care Aide (PCA), Home Health Aide (HHA), and Certified Nursing Assistant (CNA), to facilitate flexible employment options
- Support programs to improve the recruitment and retention of direct care workers
- Promote the creation of case-managed multidisciplinary teams that include non-medical supportive services to assist older adults to remain in their communities of choice for as long as feasible
- Increase the opportunities for Area Agencies on Aging (AAAs) to hire personal care aides directly to enable aging in place while preventing Medicaid costs
- Establish dedicated home care aide training for asylum seekers

- Empower informal caregivers by expanding NYSOFA's public campaign focused on self-identification and education about existing supports
- Enhance employers' understanding of the challenges faced by working caregivers and the linkages to supports and services available by expanding NYSOFA's Help for Working Caregivers initiative outside of government
- Streamline access to information regarding public benefits
- Identify opportunities within the continuum of care to support informal caregiving

Organizing Pillar:
Affordability of Basic Necessities

Challenge: *Older adults unable to afford basic necessities due to underemployment or unemployment and inadequate safety net programs.*

Who is affected: Older adults who cannot afford the basic requirements of daily life; older adults unable to work due to disability; older adults ineligible for public benefits; lack of appropriate training, ageism, and/or lack of opportunities; older adults who have depleted their savings due to costs of care; older adults without savings or insurance to pay for their basic needs.

Goals: Enhanced employment opportunities for older New Yorkers; financial assistance for older adults unable to afford the expenses of meeting their essential needs for housing, food, health care, transportation or other requirements of daily living.

Keys to resolution: Training opportunities; employment assistance; retirement planning education; improved benefit programs; affordable broadband access; information about programs and benefits that is accessible and easily navigated, and streamlined benefit program implementation.

Potential solutions: Support training opportunities and provide workplace protections to extend working years, and close gaps in safety net programs:

- Incentivize and facilitate training programs linked to employment for older adults
- Ensure access to community-based services and supports through the aging services network by eliminating waiting lists and facilitating service delivery to prevent further impoverishment
- Improve NYConnects as a one stop portal for all benefits and entitlements that individuals may be eligible for
- Create a public education campaign to promote the benefits and entitlements portal
- Eliminate the need for the recertification of benefits for older adults when their income status has not changed
- Develop a plan to support the long-term care needs of individuals who do not qualify for Medicaid
- Work with companies that are known for hiring older workers to formalize and replicate their programs as well as their recruitment and retention policies and practices

- Develop an employer “age friendly workplace” designation (e.g., Age Smart Employer Awards), for companies that are known for hiring older workers
- Simplify the benefit application processes and waive recertification for benefits, programs and supports for older adults so they do not lose benefits they are deemed eligible for and are receiving
- Develop strategies designed to assist older adults from impoverishing themselves as they seek access to supportive services provided through state and federally funded programs

Figure 4 shows that there are concentrated pockets of poverty for older New Yorkers both upstate and downstate.

Figure 4:

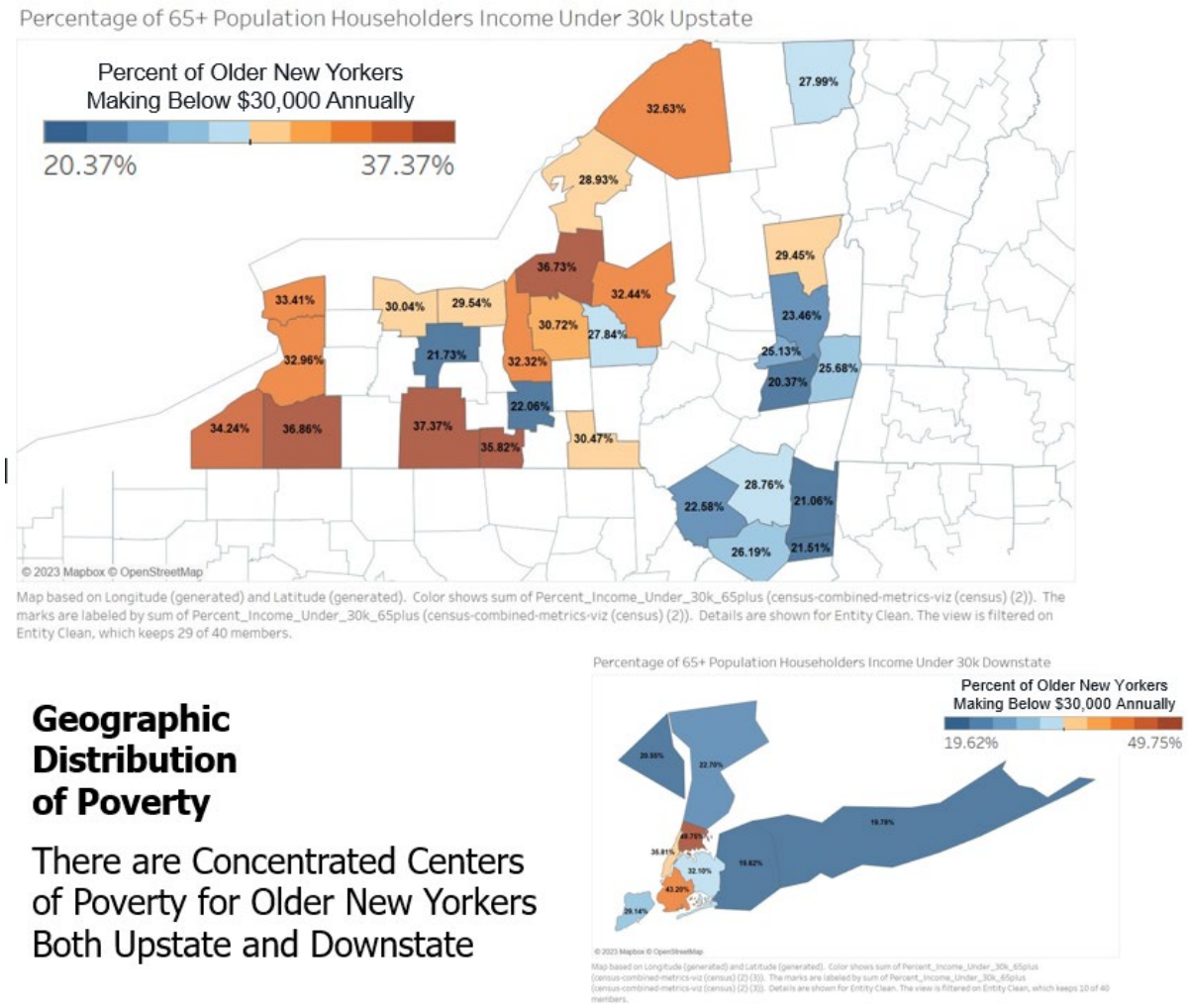


Figure 4: Concentration of poverty in both upstate and downstate counties of New York. This figure was generated from American Community Survey data, which is collected by the United States Census Bureau. Blank counties indicate no data was available.

Organizing Pillar:

Access to Services in and Engagement with Historically Disadvantaged Communities

Challenge: *Many historically disadvantaged communities, and particularly Black and Brown communities, have diminished access to needed services.*

Who is affected: Older and disabled New Yorkers of color, low-income older adults, LGBTQ+ older adults, non-English speaking older adults, older adults with disabilities, older adults from non-Western cultures, underserved and overlooked populations including immigrants and asylum seekers; families of older adults in affected communities; care workers in affected communities with limited or no local employment options.

Goals: Increased availability and accessibility of services in historically disadvantaged communities; direct engagement with such communities in all policymaking.

Keys to resolution: Funding; financing; zoning; staffing; transportation; overcoming historical inequities; community engagement.

Potential solutions: Facilitate growth of needed services in communities affected by historic and contemporary racism, ageism, ableism, xenophobia, homophobia and sexism:

- Require social determinant of health initiatives within value-based payment contracts to encourage investment in historically disadvantaged under-served communities
- Establish licensing and fast-track zoning for housing and care facilities located in, and primarily providing services to underserved communities
- Create a state-sponsored lender for starting or growing healthcare, including behavioral health, businesses in underserved communities
- Develop geocoded maps to identify deserts that may exist for health care (including behavioral health and home health) food and nutrition, pharmacy, or similar services in under-served communities
- Develop and implement training for the caring community on the cultural characteristics of historically marginalized or disadvantaged communities to improve competency in outreach and services for these individuals and families
- Require goals for county and community-based organizations that receive state/federal funding to ensure a percentage of the workforce represents the neighborhoods they serve, similar to the state's contractual MWBE priority

- Encourage standard policies on language access across providers and local offices to increase the access and inclusion of persons for whom English is a second language
- Require county governments and their Community-Based Organization (CBO) partners to contract with a language service provider
- Look to replicate the Bedford Stuyvesant Restoration Corporation model in targeted communities (https://www.restorationplaza.org/)

Figure 5 shows racial and ethnic disparities in access to healthcare and represents a core focus area for the MPA

Figure 5:

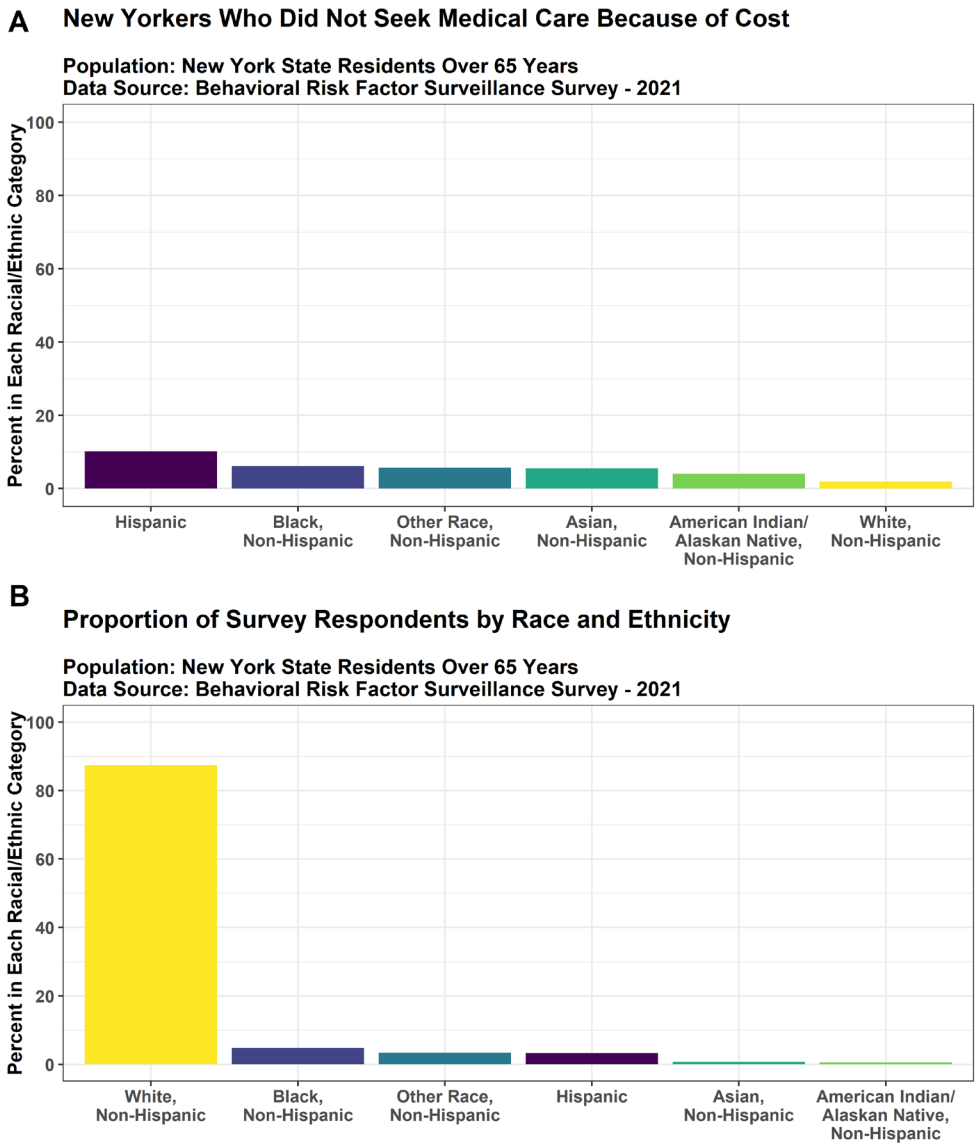


Figure 5:
Figure 5A demonstrates that approximately 10% of Behavioral Risk Factor Surveillance Survey (BRFSS) respondents who indicated they could not pay for medical expenses because it was too expensive identified as both Hispanic and over 65 years of age. Alternatively, approximately 2% of respondents who indicated they could not pay for medical expenses because it was too expensive identified as White, Non-Hispanic and over 65 years of age.

Figure 5B shows the proportion of survey respondents over 65 by racial and ethnic group.

This figure was created using data from the 2021 Behavioral Risk Factor Surveillance Survey.

Organizing Pillar:

Modernization and Financial Sustainability of Healthcare, Residential Facilities, and Community-Based Aging Network Service Providers

Challenge: *Healthcare facilities, agencies and aging services at risk of closure, unable to modernize services and facilities, and reliant on continued public support*

Who is affected: Patients and residents of financially distressed facilities; communities relying on financially distressed facilities, agencies and aging services; employees of financially distressed facilities and agencies.

Goals: Matching service capacity with local need to maximize efficiency while retaining adequate system capacity; preserve quality facilities capable of serving the acute and unique care needs of older adults unable to age in place, especially those with behavioral, mental health or substance use disorders.

Keys to resolution: Enhanced community service obligations for all health service providers; improved monitoring and technical assistance for health care providers; capital assistance for advanced technology; value-based payments; regulatory relief.

Potential solutions: Provide support for transitioning facilities, agencies and aging services to sustainable operations, and establish more regular and formal mechanisms for state support where needed:

- Reduce regulatory barriers to a lower level of care and allow facilities to transition to alternative uses (e.g., from nursing home to assisted living or other lower-support housing options)
- Invest in resources to ensure timely surveillance, with appropriate penalties for deterring poor quality outcomes, and engagement with Long Term Care Ombudsman and Resident Councils to ensure quality of life
- Promote the sharing of best practices by trade associations and financially advantaged health care providers to develop administrative, clinical, and ancillary assistance and training to health care providers in neighboring service areas
- Review/streamline adult care facility and skilled nursing facility need methodologies and Certificate of Need processes

- Allow flexibility in bed licensing to maximize efficiency while retaining adequate system capacity
- Perform a statewide study on the current quality, accessibility and affordability of skilled nursing and adult care facilities to determine best practices to support sustainable quality-driven operations

Organizing Pillar:
Social Engagement of Older Adults

Challenge: *Maintaining opportunities for meaningful social and civic engagement across the lifespan to address isolation and loneliness and help older adults to thrive.*

Who is affected: Older New Yorkers, their families, communities, and support systems burdened by preventable crises; older adults who are stigmatized and are particularly vulnerable to social isolation.

Goals: Institutional and community support systems providing support and giving purpose to older New Yorkers' lives.

Keys to resolution: Highlighting the dimensions and character of the problem; educating caregivers and providers as to symptoms and consequences; providing accessible transportation; designing communities for all ages; access to social adult day care and other Office for the Aging programs that reduce isolation and loneliness.

Potential solutions: Solicit the involvement of researchers, planners and community organizations to develop targeted effective support systems:

- Work with community organizations to develop engagement opportunities and to enhance existing opportunities to reach populations not currently engaged
- Utilize existing technology that connects people virtually, such as GetSetUp, ElliQ, enliveo (Virtual Senior Centers) and Blooming Health
- Look to models like Dorot's friendly visiting program
- Support the development of mental health and substance use clinic satellites in senior centers and other community facilities statewide
- Increase evidence-based programs which promote healthy habits
- Encourage relevant state and local agencies to use loneliness scales to measure social isolation
- Develop a voluntary reporting system for service/care providers to identify individuals at risk, with follow-up to local departments of social services or community organizations
- Community assets and resources (including libraries, museums, cultural institutions, parks and rec, sporting events, religious institutions, public spaces) design their physical plants, programming, and information dissemination to include older adults
- Further integrate age-friendly design into local and regional planning

- Build new roles for older adults that are impactful and beneficial to communities and all generations, and the health and wellbeing of older adults

Figure 6 shows the percentage of 65 and older population living alone in NYS compared to the United States

Figure 6:

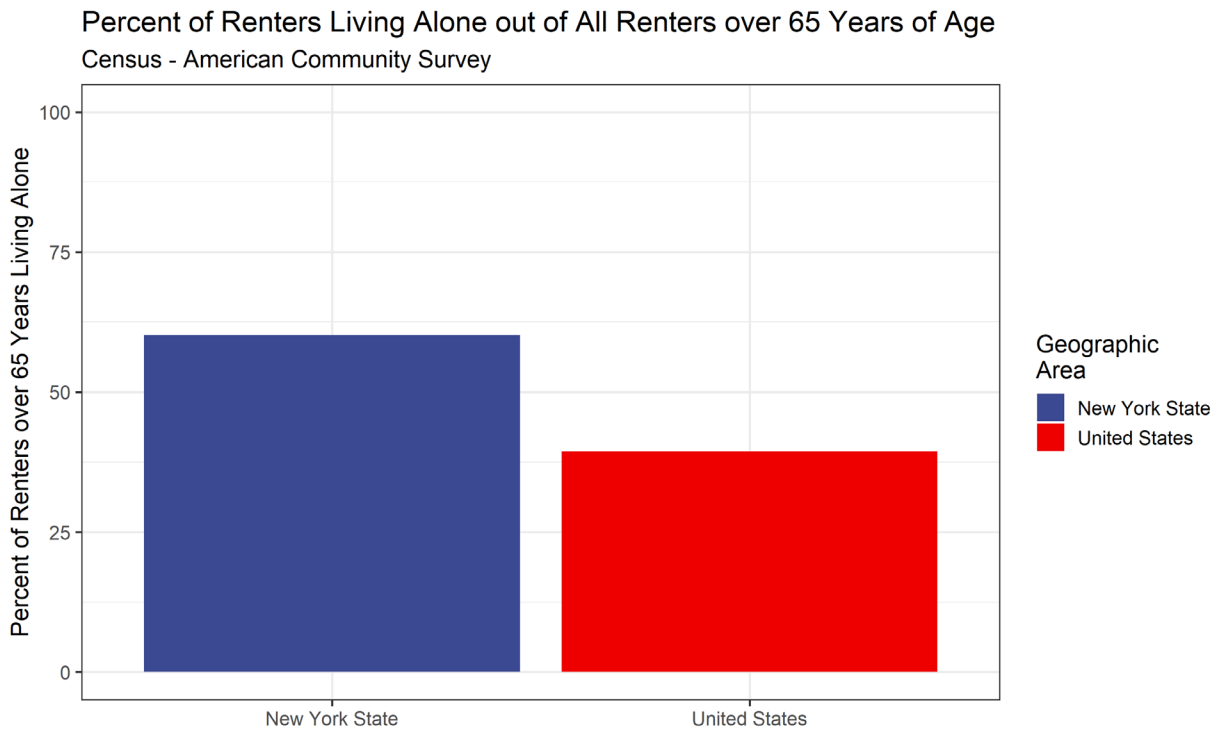


Figure 6: Of the older adults in New York State who are renters, 60% live alone, versus 39% nationally. This figure was generated from American Community Survey data, which is collected by the United States Census Bureau.

Organizing Pillar:

Promoting Health and Access to Services and Supports in Rural Communities

Challenge: *Lack of access to services in rural communities.*

Who is affected: Older individuals and others with disabilities in rural New York; families of older adults in affected communities; care workers in affected communities; service providers who must absorb added costs.

Goals: Promote development of geographically flexible rural-area service providers; create robust public and private transportation systems; encourage accessible city and town planning and design for all areas of the state.

Keys to resolution: Broadband distribution; fuel and transportation infrastructure cost; consolidations and alliances to achieve scale; incentives for rural area workforce.

Potential solutions: Facilitate easier access to digital resources, enhance transportation networks, and target support and regulatory relief for rural service providers:

- Grant zoning and licensing relief for the development of assisted living and other supported residential models, as well as transportation and home and community-based services, to facilitate better options for people to remain in their communities with better access to services
- Invest in and support assessments for and subsidies of home adaptations
- Require rural cost analyses for health and social services to be reflected in rate determinations for all state-regulated plans (in addition to any regulatory requirements under the State Administrative Procedure Act; see SAPA § 202-bb)
- Work with utilities for regulatory relief to encourage the expansion of rural broadband access, and include savings to the health system when evaluating the costs of the expansion
- Minimize telehealth restrictions where safe and appropriate for patients in rural areas
- Incentivize rural-based Community Health Centers to develop additional and specific geriatric competencies

Figure 7 shows the percentage of adults 65 and over who do not seek medical attention due to cost of treatment

Figure 7:

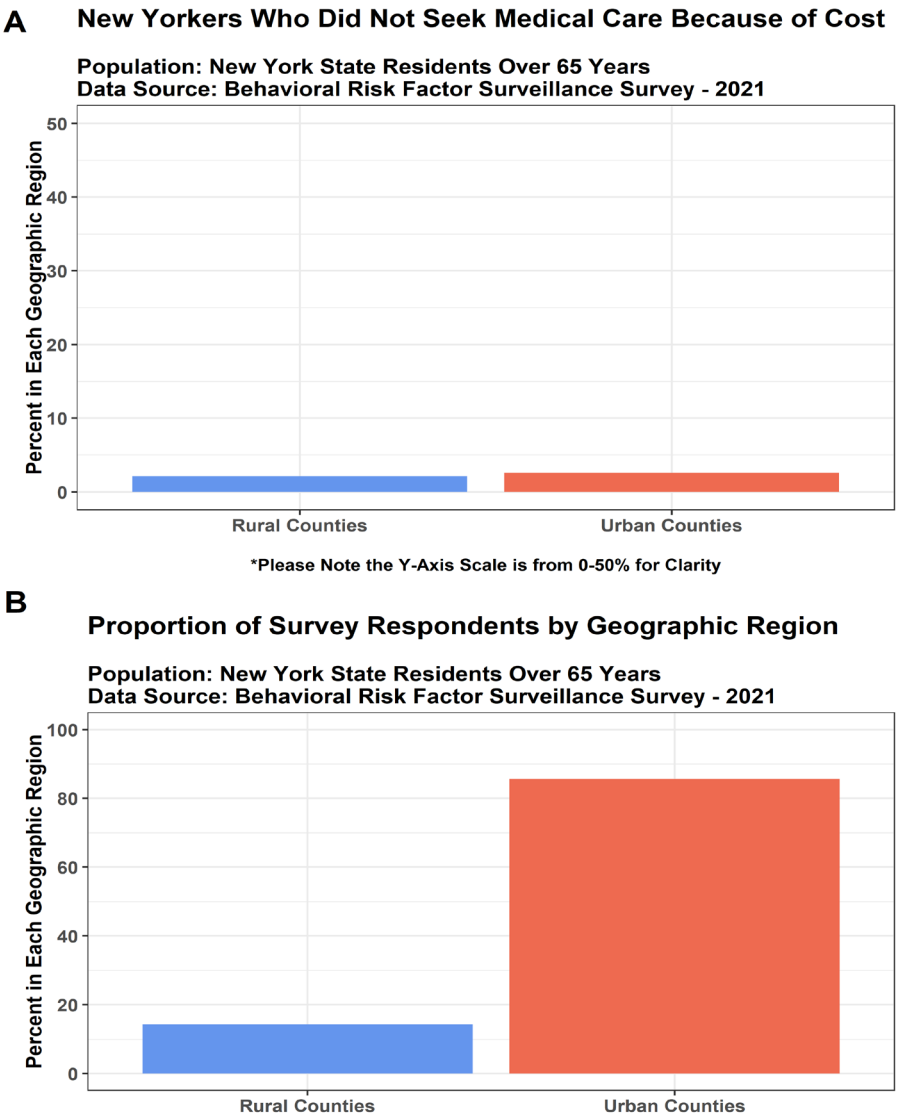


Figure 7:
Some New Yorkers still do not pay for medical services because such services are too expensive.

Figure 7A on the top shows that in Rural Areas, approximately 2% of Behavioral Risk Factor Surveillance Survey (BRFSS) respondents (44 out of 2086 individuals in Rural Areas) indicated they could not pay for medical services due to cost (left blue bar). In Urban Areas, approximately 3% of BRFSS respondents (322 out of 12448 individuals in Urban Areas) also indicated they could not pay for medical services due to cost (left red bar).

Figure 7B on the bottom shows the proportion of survey respondents over 65 by geographic region.
This figure was created using data from the 2021 Behavioral Risk Factor Surveillance Survey.

Organizing Pillar:
Combating Elder Abuse, Ageism, and Ableism

Challenge: *Financial, exploitation; physical, sexual, and emotional abuse; and neglect of older adults, in part due to inadequate identification of and support for people at risk.*

Who is affected: Older New Yorkers; families of the victims; law enforcement; financial institutions.

Goals: Care management and preventive services for all; staffed abuse hotline and development of early risk identification tools; robust supported decision-making; multiple points of access for help, including specific assistance when a family member caretaker commits the abuse.

Keys to resolution: Public awareness; education; robust reporting mechanisms and early identification; in-home and health facility monitoring.

Potential solutions: Identify and empower accountable private sector agents and government programs, educate caregivers, and expand awareness:

- Support not-for-profit guardianship and supported decision-making programs
- Educate care managers working in Health Homes, Managed Care Organizations (MCOs), and county offices for the aging, as appropriate for their roles
- Connect law enforcement with financial institutions to collaborate on recognizing monitoring, and reporting fraud and financial abuse to law enforcement and other appropriate parties
- Encourage the development of supportive programs and adult protective services as alternatives to involving law enforcement
- Coordinate service/care provider education for recognizing symptoms of abuse
- Develop a targeted awareness campaign for victims to self-identify and report abuse, in coordination with the Office of Children and Family Services' statewide public adult abuse awareness campaign
- Communication campaigns on existing and new/emerging scams that target older adults
- Expand bill payer programs to prevent or mitigate financial exploitation

Figure 8 shows incidents per 1000 Older New Yorkers who experienced elder abuse in 2011

Figure 8:

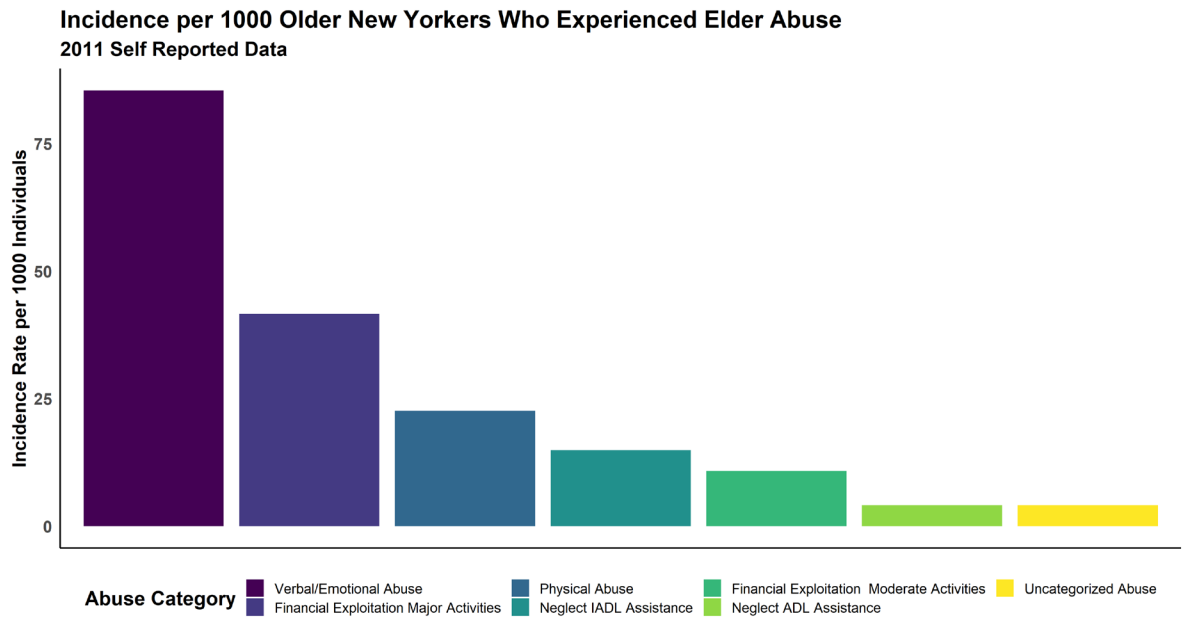


Figure 8: Approximately 85 out of 1000 older New Yorkers who self-reported abuse indicated they experienced verbal/emotional abuse, representing the most frequently reported abuse. This figure was created using data from the May 2011 Final Report Under the Radar: New York State Elder Abuse Prevalence Study.

Organizing Pillar:
Technology Access and Development

Challenge: *Slow technological development or technological inaccessibility which could address challenges related to caring for or empowering the aging and their families; the need to expand existing assistive technologies; cybersecurity threats to privacy.*

Who is affected: Service recipients without options for assistance and care; payor systems; workers unable to observe and report changes in condition; older adults without access to services requiring internet access; individuals who are socially isolated; family members geographically distant from older adults.

Goals: Scaling technological solutions; resolve access and isolation; supporting technology development and organizations facilitating technology use; leveraging technology to facilitate the direct caregiver's role in care management; promoting tech accelerators capable of designing and developing applications for the aging population; creating opportunities for technological interoperability between community-based organizations and health care providers; utilizing data to inform prevention measures and healthy aging.

Keys to resolution: Funding for technology development; technology industry attention; state supported technical assistance for rural households.

Potential solutions: Support technological development and facilitate scaling up products and services:

- Endow an "AgeTech" incubator modeled after state-sponsored and international models for high-tech incubators, which centers on older adults as creators, designers, testers, and users
- Implement an operating system that enables older adults to receive support within the aging environment of their choice through assisted technologies, including technologies to allow caregivers, providers, and family to connect and engage with the system to assist the older adult with care decisions and caregiving responsibilities
- Promote and support use of remote patient monitoring, including use of smart home devices, motion sensors, and personal vital sign monitors, as a supplement to in-home care
- Develop tuition assistance or reimbursement programs for STEM workers interested in development and applications assisting with Activities of Daily Living (ADLs) or supporting aging in place
- Enhance meaningful access to technology through training and technical assistance for older adults on how to use common devices such as tablets and smart phones

- Establish grant funding for purchasing Wi-Fi and equipment for low-income individuals and subsidizing broadband access for those in need
- Prioritize areas of the state for broadband access expansion that have a high percentage of older adult residents
- Use technology to create coordinated tools for older adults and those with disabilities, such as a portal for streamlined benefits application and management which links related programs and agencies
- Create smart-device apps to identify assistance and resources such as accessible transportation options, food assistance, or assistance with chores

Figure 9:

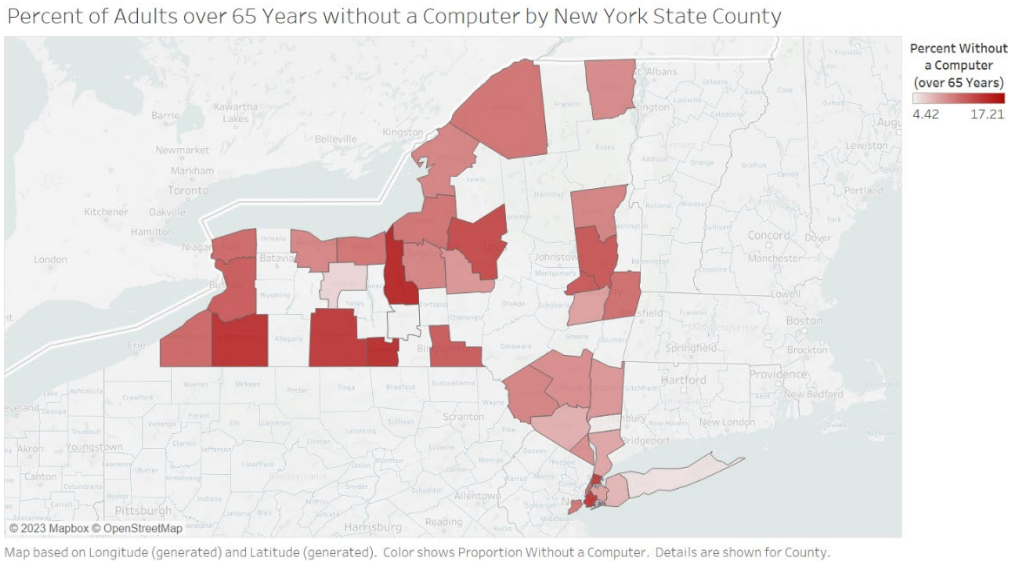


Figure 9: County map demonstrating percent of individuals over 65 years by New York County who do not own a computer (a computer is defined here as a laptop, desktop, tablet, smartphone, etc.). Darker red indicates a higher percent without a computer, lighter red indicates a lower percent without a computer. In total, 339,335 older New Yorkers (10.77% of total) indicated that they do not own a computer, compared to 2,811,861 older New Yorkers (89.23% of total) who indicated that they do own a computer. This figure was generated from data collected by the United States Census Bureau. Blank counties indicate no data was available.[7]

[7] As an additional data example: In 2019, more than 2.3 million people in New York did not have access to either a desktop, laptop, or tablet computer. Both immigrants and U.S.-born citizens face poor access to digital tools, with 15.6 percent of immigrants in New York lacking access to a computer or tablet compared with 11.2 percent of U.S.-born individuals. *See* Examining Gaps in Digital Inclusion in New York, American Immigration Council, December 2022, https://www.americanimmigrationcouncil.org/sites/default/files/examining_gaps_in_digital_inclusion_in_new_york.pdf

Figure 10:

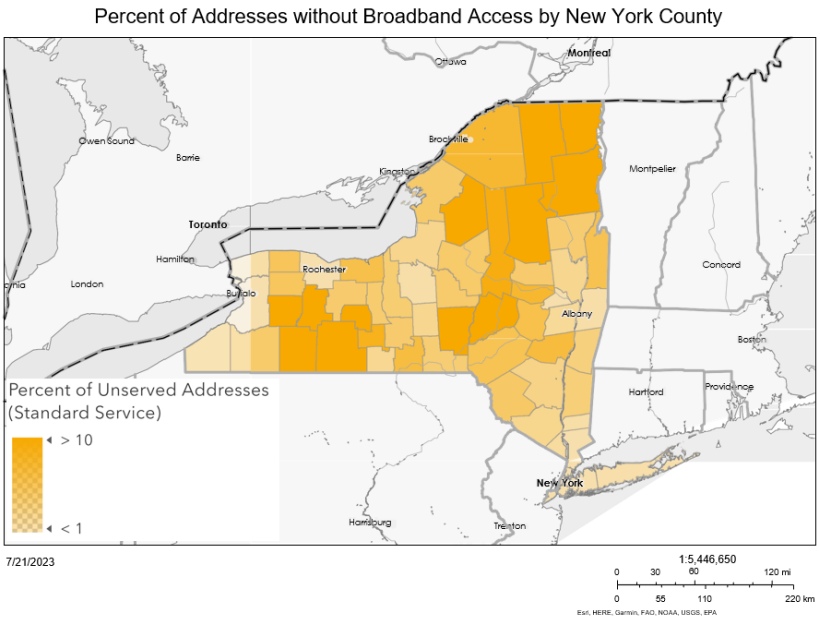


Figure 10: Map of New York State addresses unserved by broadband internet access. Darker orange indicates counties with a higher percent of addresses without broadband coverage relative to counties with a lower percent of addresses without broadband (lighter orange). From the New York State Department of Public Service dashboard.

Organizing Pillar:
Prevention, Wellness Promotion and Access

Challenge: *Preventable acute medical interventions; individuals and informal caregivers must navigate a complex care and supports system; obstacles to supporting healthy aging across the lifespan.*

Who is affected: Primary and secondary prevention measures will particularly benefit the majority of older adults who are in good health or living with mild chronic conditions; secondary and tertiary prevention measures will particularly benefit people with disabilities, people at risk for dementia disorders, people with chronic conditions, people living with substance use disorders, people living with mental illness, people with behavioral health conditions, and people who are medically high-risk; people who are not aware of available benefits; people who delay preventive care; people who may be injured without preventive intervention; caretakers for older adults who must navigate care and support systems.

Goals: Comprehensive planning and education around prevention practices and resources, including broad adoption of best practices and public use; promotion of healthy options and wellness initiatives that will advance health and wellness across the life course through both public health and population health initiatives; expand innovative models for preventing ill health, reducing ability limitations, and promoting long life spans.

Keys to resolution: Consolidating knowledge of best practices; communication efforts and education; simplifying and consolidating information about benefits; benefit programs that provide resources for prevention practices; integration of prevention principles and incorporation of an aging lens into existing programs funded by state and local health departments; engaging the public health system and allied sectors.

Potential solutions: Identify and align resources and programs around best practices, and develop communication materials and strategies to ensure awareness and ease compliance:

- Engage with practitioners to identify best practices and create dynamic, consolidated inventory of critical prevention behaviors and interventions
- Require that all prevention solutions utilize and incorporate the “4Ms” age-friendly framework (what matters, medication, mind and mobility)
- Identify opportunities in benefit programs to drive resources and create incentives for prevention behaviors and interventions

- Develop public-private partnerships to facilitate healthy choices and promote access to preventive services
- Engage the Extreme Heat Workgroup, the Climate Action Council and Climate Justice Working Group, and the Most Integrated Setting Coordinating Council in the integration of prevention principles
- Expand community-based services that are preventive in nature, and which target nutrition, transportation, and civic engagement, while combatting social isolation
- Identify the essential elements for prevention and health promotion across the life course, for all New Yorkers to live healthier lives and have the opportunity to grow old with health

PRELIMINARY REPORT APPENDIX A: Subcommittees, Workgroups, and Workgroup Focus Areas

Housing, Community Development and Transportation

- Housing
    - Zoning
    - Financing
    - Taxation: Carrots and Sticks
    - Affordability
- Community Planning
    - Public spaces
    - Services
    - Smart growth
    - Accessibility
- Transportation
    - Public Transportation
    - Infrastructure
    - Paratransit
    - Private services

Formal Caregivers

- Recruitment and Training
    - Fair pay
    - Workforce investment: training, career ladders and technology
    - Adequacy of existing training programs
    - Rural transportation
    - Stackable Credentials
    - Specialized training
- Retention, Compensation and Benefits
    - Compensation
    - Case assignment
    - Mentoring
    - Childcare
    - Regionality
- Scope of Practice and Job Structure
    - Scope of practice flexibilities
    - Creating opportunities for full-time employment of home care aides

    - Career paths
    - Specialized training
    - Database of available positions
    - Case assignment

Informal Caregivers

- Kinship Caregiving
    - Focused on supports for older adults filling the caregiving role
    - Legal issues
    - Safety net supports
    - Housing challenges
- Caregiver Supports
    - Focused on services that assist caregivers with their responsibilities and their mental health
    - DEI issues
    - Mental health supports
    - Complexity of support systems
    - Social Security issues
- Communications
    - Targeting informal caregivers to help them self-identify and to publicize available resources
- Finances
    - Engaged with the challenges of caregiving to the caregivers and to employers
    - Evaluate market sizing
    - Look at regulatory/tax/funding supports for employers of informal caregivers

Economic Security

- Retirement
    - This workgroup will focus on financial preparation for retirement and long term care needs
    - Savings programs
    - Long term care insurance
    - Education and communication
- Benefit Programs
    - This workgroup will focus on existing and potential benefit programs to support the ability of older New Yorkers to secure the basic needs of daily life, as well as communications and education to ensure that older New

Yorkers are aware of the benefits available to them, and are able to navigate those benefit programs
    - Identifying and closing existing gaps between programs
    - Streamlining programs where navigation is excessively challenging
- Workforce Protections and Training
    - This workgroup will focus on programs and protections to facilitate ongoing engagement in the workforce for older New Yorkers.
    - Legal protections against ageism
    - Workforce training
    - Education about training and ageism protection resources
    - Engagement with employers to develop formal programs for employing older New Yorkers

Long Term Services and Supports

- End of Life Care
    - Hospice, palliative care, and regulatory considerations
    - Specific charge to address for-profit hospice
- Levels of Care
    - Regulatory reforms to facilitate aging in place and ensuring the most integrated setting to meet need
- Person-Centered Navigation and Access
    - Equitable access to care settings
    - Prioritizing person-centered care that is inclusive, integrated and accessible, with an emphasis on dignity and autonomy
- Payor Structures
    - Incentives for quality and preventive care
- Care transitions
    - Ensuring access to better transitions within care settings
- Program of All Inclusive Care for the Elderly (PACE)
    - Addressing barriers to PACE enrollment
    - Addressing barriers to PACE licensure
- Equitable Facility Transformation
    - Modernizing facilities to fit changing needs of older adults

Home and Community-Based Services

- In-Home Services

    - Focused on strategies, services and supports to help people age in place in their homes, especially as activities of daily living become limited.
- In-Community Services
    - Focused on services and supports, including those offered by local Area Agencies on Aging (AAAs), that build community, break-down isolation and help older people thrive within their community via improved access or congregate settings.
- Critical Partnerships and Systems Building
    - Focused on how services can be better integrated within other "systems" and will probably be coordinated across the other Subcommittee workgroups that are discussing integration between Medicaid and HCBS.

Safety and Security

- Financial exploitation, scams
    - Prevention
    - Detection
    - Intervention
- Abuse (physical, sexual, neglect, psychological)
    - Awareness/communication
    - Identifying ways to gather data
- Guardianship/Alternatives to guardianship
    - Role of not-for-profits
    - Awareness
    - Legal structures and mechanisms
- Technology Development; and Access
    - Training
    - Social isolation
    - Design

Health and Wellness

- Promote and sustain physical and mental health, wellbeing and quality of life, including primary and secondary prevention and self-management of chronic disease
- Access to Medicare and Medicaid annual wellness and prevention benefits & communication to improve utilization
- Mental health and substance use disorders
- Cognitive health, Alzheimer’s disease and other dementias
- Nutrition and food insecurity

PRELIMINARY REPORT APPENDIX B: MPA Subcommittee Membership

Subcommittee 1: Long-term Services and Supports

Subcommittee Lead and Co-lead

- Pastor George Nicholas (Lincoln Memorial United Methodist Church)
- Scott LaRue (ArchCare)

State Agency Council Representatives

- Karen Choens (Office of Mental Health)
- Karen Walker (Department of Health)
- Kimberly Hill (Office of the Chief Disability Officer)
- Lisl Maloney (Office of Children and Family Services)
- Shelly Aubertine-Fiebich (Office of Children and Family Services)
- Viviana DeCohen (Department of Veterans' Services)

Stakeholder Advisory Committee Representatives

- Dan Savitt (VNS Health)
- Pat Wang (Healthfirst)
- Dr. Thomas Caprio (University of Rochester Medical Center)
- Wade Norwood (Common Ground Health)

Other Interested Parties

- Adria Powell (Cooperative Home Care Associates)
- Al Cardillo (NYS Home Care Association)
- Alicia Pointer (Orange County)

- Amy Haskins (Wayne County)
- Andrea Deepe (Warren Washington Association for Mental Health Inc.)
- Andrew Cruikshank (Fort Hudson Health System)
- Ann Monroe (American Association of Retired Persons, AARP - New York)
- Ashley Waite (Lewis County)
- Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
- Carlos Martinez (Consumer Directed Personal Assistance Association of NYS)
- Cristopher Comfort (Calvary Hospital)
- Dan Hiem (LeadingAge New York)
- Darius Kirstein (LeadingAge New York)
- Dave Jordan (Office for the Aging)
- Debi Buzanowski (Saint Peter's Health Partners)
- Dora Fisher (Healthcare Association of New York State)
- Doug Hovey (Independent Living, Inc.)
- Dr. Kevin Costello (Albany Medical Center)
- Eric Linzer (New York Health Plan Association)
- Ginger Lynch Landy (Argentum)
- Heidi Schempp (Elderwood at North Creek)
- Ilana Berger (Hand in Hand)
- Jade Gong (Jade Gong & Associates)
- James Rosenman (Andrus on Hudson)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed A. Levine (CaringKind)
- Jeffrey Farber (New Jewish Home)
- Jill Graziano (Rochester Regional Health)
- Jim Kane (Empire State Association of Assisted Living)

- Joe Corwin (Greater New York Hospital Association)
- Karen Lipson (LeadingAge New York)
- Karen Thornton (Empire State Association of Assisted Living)
- Kendra Scalia (NY Caring Majority/Hand-in-Hand)
- Laura Ehrich (NYS Association of Health Care Providers)
- Linda Spokane (Hudson Headwaters)
- Lindsay Heckler (Center for Elder Law and Justice)
- Lisa Alteri (Capital Health Consulting)
- Lisa Betrus (Bassett Health Network)
- Lisa Newcomb (Empire State Association of Assisted Living)
- Lise-Anne Deoul (Sullivan County)
- Luke Tobler (NYS PACE Alliance)
- Lynn Young (Department of Health)
- Marcella Goheen (Essential Care Visitor)
- Mary Gracey-White (Greater New York Health Care Facility Association)
- Michael Gelman (Care Connect Mobile)
- Michael King (Jewish Senior Life)
- Michael Rosenblut (Parker Jewish Institute)
- Michele O'Connor (Argentum)
- Nancy Speller (St. Mary’s Healthcare System for Children)
- Rachel Tart (Elderwood at North Creek)
- Rebecca Preve (AgingNY)
- Rhenda Campbell (Fort Hudson Home Care)
- Roxanne G. Tena-Nelson (Greater New York Hospital Association)
- Ruben Medina (RC Solutions Inc.)
- Shaun Ruskin (CenterLight Health System)

- Sarah Ravenhall (NYS Association of County Health Officials)
- Stephanie Button (PACE CNY)
- Stuart Almer (Gurwin Jewish)
- Susan Hollander (Office of Children and Family Services)
- Tammy DeLorme (Washington County)
- Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
- Walter Kaltenbach (Always Home Care)
- Yuchi Young (University at Albany School of Public Health)

Subcommittee 2: Home and Community-Based Services

Subcommittee Lead and Co-lead

- Kathryn Haslanger (Jewish Association Serving the Aging)
- Allison Nickerson (LiveOn NY)

State Agency Council Representatives

- Christopher Smith (Office of Mental Health)
- Jackie Maclutsky (Office of Children and Family Services)
- Julie Hovey (Office of Children and Family Services /New York State Commission for the Blind)
- Kim Hill (Office of the Chief Disability Officer)
- Lorraine Cortes-Vazquez (NYC Aging)
- Nicole Haggerty (Office of Mental Health)
- Shirley Paul (Faith Based Initiatives, Governor's Office)

Stakeholder Advisory Committee Representatives

- Ann Marie Cook (Lifespan of Greater Rochester)
- Emma DeVito (Village Care)
- James O'Neal (American Association of Retired Persons, AARP - New York)
- Nora OBrien-Suric (Health Foundation for Western and Central New York)
- Stuart Kaplan (Selfhelp Community Services)
- Timothy Seymour (Herkimer County Department of Social Services)

Other Interested Parties

- Alexandra Roth-Kahn (United Jewish Appeal-Federation of New York)
- Anderson Torres (RAIN Total Care)
- Ann Cunningham (Rochester Oasis)
- Ann Marie Selfridge (New York State Adult Day Services Association)
- Bill Ferris (American Association of Retired Persons, AARP - New York)
- Bob Blancato (Elder Justice Coalition)
- Bobbie Sackman (Caring Majority)
- Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
- Carol Deyoe, (NYS Association of Health Care Providers)
- Catherine James (NYS Coalition of Alzheimer's Association Central NY Chapter)
- Cheryl A. Kraus (Hospice and Palliative Care Association of NYS)
- Cynthia L. Cary Woods (Upstate Oasis)
- Daniella Labate Covelli (New York Association of Psychiatric Rehabilitation Services)
- Denise Figueroa (Independent Living Center of the Hudson Valley)
- Erica Tomlinson (Hamilton County)
- Erika Flint (Health Workforce Collaborative)
- Ginger Hall (Jefferson County)
- Ginger Lynch Landy (Argentum)

- Jennifer Michella (Upstate Oasis)
- Joanne Taylor (Senior Helpers Westchester)
- Karen McGraw (Neighbors of Northern Columbia County)
- Kathleen Strack (Franklin County)
- Lauren Wetterhahn (Inclusive Alliance IPA Inc.)
- Lindsay Miller (New York Association on Independent Living)
- Loretta Zolkowski (Human Services Leadership Council)
- Lois Celeste (Saratoga Senior Center)
- Lou Pierro (Pierro, Connor & Strauss)
- Lyndi Scott-Loines (Allegany County)
- Meg Everett (LeadingAge New York)
- Michele O'Connor (Argentum)
- MJ Okma (SAGE - Advocacy & Services for LGBTQ+ Elders)
- Nancy Harvey (Service Program for Older People)
- Nancy Speller (St. Mary’s Healthcare System for Children)
- Nicholas Stella (Jzanus Home Care)
- Nikki Kmicinski (Western New York Integrated Care Collaborative)
- Pascale Leone (Supportive Housing Network of New York)
- Phil Di Sorbo (Saratoga Senior Center)
- Randy Klein (Vesta)
- Rebecca Preve (AgingNY)
- Renee Christian (Home Care Advocate)
- Robbie Felton (Intus Care)
- Ruben Medina (RC Solutions Inc.)
- Sarah Ravenhall (NYS Association of County Health Officials)
- Sue Ruzenski (Helen Keller Services)

- Susan Hollander (Office of Children and Family Services)
- Susan Stamler (United Neighborhood Houses NY)
- Tammy Ryan (Director of Ancillary Services, Prestige Healthcare Group)
- Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
- Vicky Hiffa (NYS Developmental Disabilities Planning Council)
- Walter Kaltenbach (Always Home Care)
- William Hamer (Harlem Advocates for Seniors)
- Yuchi Young (University at Albany School of Public Health)

Subcommittee 3: Informal Caregivers

Subcommittee Lead and Co-lead

- James O'Neal (American Association of Retired Persons, AARP - New York)
- Linda James (Lifespan of Greater Rochester)

State Agency Council Representatives

- Christopher Smith (Office of Mental Health)
- Kathryn Simpson (Office of Mental Health)
- Lorraine Cortes-Vazquez (NYC Aging)
- Shelly Aubertine-Fiebich (Office of Children and Family Services)

Stakeholder Advisory Committee Representatives

- Doris Green (NYS Caregiving and Respite Coalition)
- Sara Czaja (Center on Aging and Behavioral Research, Weill Cornell Medicine)
- Stuart Kaplan (Selfhelp Community Services)

Other Interested Parties

- Aaron Carlson (Hearts and Hands: Faith in Action, Inc.)
- Alexandra Drane (Archangels)
- Ann Marie Selfridge (NYS Adult Day Services Association)
- Bill Gustafson (Alzheimer Association)
- Colette Phipps (Westchester County Dept. of Senior Programs and Services)
- David McNally (American Association of Retired Persons, AARP - New York)
- Debra Tackett (Clinton County)
- Elana Kieffer (The New York Academy of Medicine)
- Emily Hinsey (Grantmakers in Aging)
- Gerard Wallace (NYS Kinship Navigator)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed Levine (CaringKind)
- Kenneth M. Genewick (Health Foundation of Western and Central New York)
- Lindsay Heckler (Center for Law and Justice)
- Liz Loewy (Eversafe)
- Marcella Goheen (Essential Care Visitor)
- Meg Boyce (NYS Coalition of Alzheimer's Association - Hudson Valley Chapter)
- Rae Glaser (NYS Kinship Navigator)
- Rebecca Preve (AgingNY)
- Rimas Jasin (Presbyterian Senior Services)
- Zach Becker (Empire State Development - Central New York)

Subcommittee 4: Formal Caregiving

Subcommittee Lead and Co-lead

- Helen Schaub (1199/SEIU)
- Dan Savitt (VNS Health)

State Agency Council Representatives

- Barbara Guinn (Office for Temporary and Disability Assistance)
- Lorraine Cortes-Vazquez (NYC Aging)
- Lucy Newman (Office of Mental Health
- Shelly Aubertine-Fiebich (Office of Children and Family Services)
- Tom Brooks (Office of Children and Family Services)

Stakeholder Advisory Committee Representatives

- Doris Green (NYS Caregiving and Respite Coalition)
- Pastor George Nicholas (Lincoln Memorial United Methodist Church)
- Stuart Kaplan (Selfhelp Community Services)

Other Interested Parties

- Adria Powell (Cooperative Home Care Associates)
- Al Cardillo (Home Care Association)
- Alexandra Drane (Archangels)
- Alyssa Herman (New Jewish Home)
- Amanda Waite (Fort Hudson Health System)
- Andrea Thomas (Home Care at Sunnyside Community Services)
- Ann Marie Selfridge (New York State Adult Day Services Association)
- Ann Mary Ferrie (VNS Health)
- Anthony Lareau (Office of Children and Family Services)
- Bobbie Sackman (Caring Majority)

- Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
- Carlos Z. Martinez (Consumer Directed Personal Assistance Association of NYS)
- Colleen Rose (Rochester Regional Health)
- Courtney Burke (Rockefeller Institute)
- David McNally (American Association of Retired Persons, AARP - New York)
- Diane Darbyshire (LeadingAge New York)
- Emily Hinsey (Grantmakers in Aging)
- Erica Salamida (NYS Coalition of Alzheimer's Association Chapters)
- Ginger Lynch Landy (Argentum)
- Ilana Berger (Hand in Hand)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed Levine (CaringKind)
- Jodi M. Sturgeon (Paraprofessional Healthcare Institute)
- John Reilly (Northwell Health)
- Kathy Febraio (NYS Association of Health Care Providers)
- Len Statham (New York Association of Psychiatric Rehabilitation Services)
- Linda Mertz (University at Albany School of Social Welfare)
- Lisa Alteri (Capital Health Consulting)
- Liz Loewy (Eversafe)
- Lori Frank (The New York Academy of Medicine)
- Marcella Goheen (Essential Care Visitor)
- Michele O'Connor (Argentum)
- Monique Hodges (Baltic Street AEH)
- Nancy Miller (New York Vision Rehabilitation Association)
- Rebecca LeBaron (Heritage Ministries)
- Rebecca Preve (AgingNY)

- Renee Christian (Home Care Advocate)
- Robert Gibson (Department of Family Services)
- Walter Kaltenbach (Always Home Care)

Subcommittee 5: Health and Wellness

Subcommittee Lead and Co-lead

- Dr. Linda Fried (Columbia University Mailman School of Public Health)
- Dr. Jo Ivey Boufford (NYU School of Global Public Health)

State Agency Council Representatives

- Alexis Arnett (Office of Children and Family Services)
- Audrey Erazo-Trivino (Office of Mental Health)
- Camille Hoheb (Department of Health)
- Christopher Maylahn (Department of Health/Office of Public Health
- John Hartigan (Department of Health/AIDS Institute)
- Katie Seaward (Office of Addiction Services and Supports)
- Lorraine Cortes-Vazquez (NYC Aging)
- Patricia Zuber Wilson (Office of Addiction Services and Supports)
- Rachel Baker (Office for People with Developmental Disabilities)
- Martha Sullivan (Office of Mental Health)
- Maureen Spence (Department of Health/Office of Public Health)

Stakeholder Advisory Committee Representatives

- Allison Nickerson (LiveOn NY)
- Kathryn Haslanger (Jewish Association Serving the Aging)
- Linda James (Lifespan of Greater Rochester)

- Lora Lee La France (St. Regis Mohawk Office for the Aging)
- Nora OBrien-Suric (Health Foundation for Western and Central New York)
- Pastor George Nicholas (Lincoln Memorial United Methodist Church)
- Timothy Seymour (Herkimer County Department of Social Services)

Other Interested Parties

- Adesuwa Watson (Suffolk County)
- Andres Vives (Hunger Solutions)
- Ann Cunningham (Rochester Oasis)
- Beth Finkel (American Association of Retired Persons, AARP - New York)
- Beth Shapiro (Citymeals on Wheels)
- Carlos Martinez (Bridges)
- Claire Proffitt (Schenectady County)
- Corinne Carey (Compassion & Choices New York)
- Cynthia L. Cary Woods (Upstate Oasis)
- Damali Wynter (NYS Department of Agriculture and Markets)
- Daniel Chen (Jamaica Hospital/Flushing Hospital)
- David Hoffman (University at Albany School of Public Health)
- Debbie Pantin (Outreach)
- Diane Devlin (Wayne County)
- Elizabeth Galle (Columbia County)
- Elizabeth Whalen (Albany County)
- Elizabeth Watson (Schuyler County)
- Fred Riccardi (Medicare Rights Center)

- Glenn Liebman (Mental Health Association in New York State)
- Hailee Gilmore (Department of Health/Office of Health Equity and Human Rights)
- Harvey Rosenthal (New York Association of Psychiatric Rehabilitation Services)
- Heather Warner (Delaware County)
- Heidi Bond (Otsego County)
- Ira Frankel (Jamaica Hospital/Flushing Hospital)
- Dr. Irina Gelman (Nassau County)
- Jackie Berman (NYC Aging)
- Jennifer Michella (Upstate Oasis)
- Jo-Ann Yoo (Asian American Federation)
- John Coppola (New York Association of Alcoholism and Substance Abuse Providers, Inc.)
- Jolene Munger (St. Lawrence County)
- Dr. Joshua Chodosh (New York University)
- Dr. Judith A. Salerno (New York Academy of Medicine)
- Karen DeBell (Office of Mental Health/Division of Adult Services)
- Kelly Ann Anderson (Department of Health)
- Krista Hesdorfer (Hunger Solutions New York)
- Lacey Trimble (Orange County Department of Mental Health)
- Laura Churchill (Greene County)
- Lisa Alteri (Capital Health Consulting)
- Lisa Graf (Wayne County Department of Social Services)
- Livia Santiago-Rosado (Dutchess County)
- Lori Frank (The New York Academy of Medicine)
- Luke Sikinyi (NY Association of Psychiatric and Rehabilitation Services Inc.)
- Marcella Goheen (Essential Care Visitor)
- Dr. Maria T. Carney (Hofstra University/Northwell Health)

- Mark Meridy (Generations - DOROT)
- Maryfran Wachunas (Rensselaer County)
- Maureen Henry (Columbia University Medical Center)
- Michelle Barber (New York State Academy of Nutrition and Dietetics)
- MJ Okma (SAGE - Advocacy & Services for LGBTQ+ Elders)
- Nancy Hahn (Suffolk County)
- Nancy Harvey (Service Program for Older People)
- Nancy Miller (New York Vision Rehabilitation Association)
- Norman Reiss (Greenwich House)
- Peter Buzzetti (Chemung County)
- Rebecca Preve (AgingNY)
- Richard Ball (NYS Department of Agriculture and Markets)
- Samara Daly (DalyGonzalez)
- Dr. Sherlita Amler (Westchester County)
- Susan Medina (Tioga County)
- Dr. Thalia Porteny (Columbia School of Public Health)
- Tina McDougall (Washington County)
- Tobi Abramson (Geriatric Mental Health/NYC Aging)
- Vicky Hiffa (NYS Developmental Disabilities Planning Council)

Subcommittee 6: Housing, Community Development and Transportation

Subcommittee Lead and Co-lead

- Stuart Kaplan (Selfhelp Community Services)
- Imran Cronk (Ride Health)

State Agency Council Representatives

- Brett Hebner (Homes and Community Renewal)
- Christopher Maylahn (Department of Health/Office of Public Health)
- Janet Ho (Department of Transportation)
- Julie Duncan (Office of Mental Health)
- Julie Kelleher (Office of Children and Family Services)
- Mary Ellen Brown (Office of Mental Health)
- Noah Rayman (Empire State Development)
- Paul Beyer (Department of State)
- Shelly Aubertine-Fiebich (Office of Children and Family Services)

Stakeholder Advisory Committee Representatives

- Allison Nickerson (LiveOn NY)
- Jessica Bacher (Pace University)
- Kathryn Haslanger (Jewish Association Serving the Aging)
- Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)
- Wade Norwood (Common Ground Health)

Other Interested Parties

- Andrea Montgomery (St. Lawrence County)
- Ann McHugh (The Jewish Board of Family and Children's Services)
- Annalyse Komoroske Denio (LeadingAge New York)
- Barry Kaufmann (NYS Alliance for Retired Americans)
- Brittany Perez (Local Initiatives Support Corporation)
- Cara Longworth (Empire State Development - Long Island)
- Courtenay Loiselle (Homes and Community Renewal)
- Darby Nagpaul (Sullivan County Department of Health)

- David Hoglund (Perkins Eastman)
- Doug Hovey (Independent Living, Inc.)
- Elana Kieffer (The New York Academy of Medicine)
- Eric Alexander (Vision Long Island)
- Esther Greenhouse (Silver to Gold Strategic Planning)
- Ginger Lynch Landy (Argentum)
- Holly Rhode-Teague (Suffolk County)
- Jackie Maclutsky (Office of Children and Family Services)
- Jennifer Rodriguez (Livingston County)
- Jessica Bacher (Pace University)
- Jessica Mathew (Metropolitan Transportation Authority)
- Jill Peckenpaugh (United States Committee for Refugees and Committees Albany)
- Jo-Ann Yoo (Asian American Federation)
- Leo Asen (American Association of Retired Persons (American Association of Retired Persons, AARP - New York)
- Linda Hoffman (New York Foundation for Senior Citizens)
- Lindsay Miller (New York Association on Independent Living)
- Maclain Berhaupt (Department of Health)
- Mandy Walsh (Delaware County)
- Marc Jahr (Forsyth Street Advisors)
- Mark Castiglione (Capital District Regional Planning Commission)
- Mark Fuller (DePaul)
- Mark Streb (NYS Neighborhood Preservation Coalition)
- Michael Seereiter (Alliance for Inclusion and Innovation)
- Michele O'Connor (Argentum)
- Nancy Williams-Frank (Broome County)
- Nate Storring (Project for Public Spaces)

- Patricia Hernandez (The Corporation for Supportive Housing)
- Randy Klein (Vesta Health Care)
- Rebecca Heller (The Bridge)
- Robyn Haberman (American Association of Retired Persons (American Association of Retired Persons, AARP - New York)
- Ron Roel (American Association of Retired Persons (American Association of Retired Persons, AARP - New York)
- Sarah Ravenhall (NYS Association of County Health Officials)
- Sasha Yerkovich (Canopy of Neighbors)
- Sebrina Barret (Association for Community Living)
- Steve Piasecki (Supportive Housing Network of New York)
- Vicki Been (New York University School of Law)
- William Hamer (Harlem Advocates for Seniors)
- William P. McDonald (American Association of Retired Persons, AARP - New York)
- Karen Nicolson (Center for Elder Law & Justice)

Subcommittee 7: Economic Security

Subcommittee Lead and Co-lead

- Pat Wang (Healthfirst)
- Stephen Berger (Odyssey Partners)

State Agency Council Representatives

- Amir Bassiri (Department of Health)
- Andy Sink (Office of Mental Health)
- Allison Gold (Department of Financial Services)
- Audrey Erazo-Trivino (Office of Mental Health)
- Barbara Guinn (Office for Temporary and Disability Assistance)

- Benjamin Pomerance (Department of Veterans' Services)
- Elizabeth Furth (Department of Labor)
- Jillian Kirby Bronner (Division of the Budget)
- Katie Seaward (Office of Addiction Services and Supports)

Stakeholder Advisory Committee Representatives

- Dennis Rivera (Former Chairman of the Medicaid Redesign Team)
- Dr. Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)

Other Interested Parties

- Allison Cook (Better Aging and Policy Consulting)
- Anita Mattison (Allegany County)
- Barry Kaufmann (NYS Alliance for Retired Americans)
- Colette Phipps (Westchester County Department of Senior Programs and Services)
- Courtney Burke (Rockefeller Institute)
- Denise Shukoff (Lifespan Rochester)
- Diana Caba (Hispanic Federation)
- Dr. Oxiris Barbot (United Hospital Fund)
- Karen Nicholson (Elder Justice NY)
- Erin Killian (Elder Justice NY)
- Fred Riccardi (Medicare Rights Center)
- Ginger Lynch Landy (Argentum)
- Heidi Pasos (Empire State Development - Capital District)
- June Hanrahan (Oneida County)
- Kristen McManus (American Association of Retired Persons, AARP - New York)
- Liz Loewy (Eversafe)

- Maria Alvarez (NY Statewide Senior Action Council)
- Mark Castiglione (Capital District Regional Planning Commission)
- Melinda Mack (New York Association of Training and Employment Professionals)
- Michele O'Connor (Argentum)
- Nancy Dingee (Schoharie County)
- Richard Gottfried (Former NYS Assembly Health Chair)
- Valerie Bogart (NY Legal Assistance Group)

Subcommittee 8: Safety, Security and Technology

Subcommittee Lead and Co-lead

- Raj Mehra (Sage)
- Dr. Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)

State Agency Council Representatives

- Elizabeth Alowitz (Office of Mental Health)
- Elizabeth Cronin (Office of Victims Services)
- Katie Egglefield (Office of Victims Services)
- James Clancy (Office of Emergency Management)
- Heidi Hayes (Department of Health)

Stakeholder Advisory Committee Representatives

- Ann Marie Cook (Lifespan of Greater Rochester)
- Karen Nicolson (Center for Elder Law & Justice)
- Sara Czaja (Center on Aging and Behavioral Research, Weill Cornell Medicine)

Other Interested Parties

- Anthony Lareau (Office of Children and Family Services)
- Azaleea Carlea (Project Guardianship)
- Bob Blancato (Elder Justice Coalition)
- Corey Haertel (Center for Elder Law & Justice)
- Deborah Riitano (Albany County)
- Denise Shukoff (Lifespan Rochester)
- Elvira Fardella-Roveto (St. Mary's Healthcare System for Children)
- Erin Mitchell (American Association of Retired Persons, AARP - New York)
- Ethan Heimowitz (Emerest Connect)
- Jenee Alleman-Goodman (Helen Keller National Center)
- Joan Levenson, Esq. (NYS Unified Court System)
- Lise Hamlin (Hearing Loss Association of America)
- Lisl Maloney (Office of Children and Family Services)
- Liz Loewy (Eversafe)
- Marie Cannon (Erie County)
- Mark Castiglione (Capital District Regional Planning Commission)
- Mary Moller (Albany Guardian Society)
- Nancy Miller (Visions)
- Ruthanne Becker (The Mental Health Association of Westchester Inc.)
- Sabrina Jaar Marzouka (Dutchess County)
- Sarah Duval (Elder Justice NY)
- Sheng Guo (Office of Court Administration)
- Stephanie Lederman (American Federation for Aging Research)
- Steven Dahlberg (Center for Elder Law and Justice)
- Steve Lovi (Empire State Association of the Deaf)

PRELIMINARY REPORT APPENDIX

C: MPA State Agency Council

Membership

New York State Department of Health (NYSDOH), Chair

New York State Office for the Aging (NYSOFA), Vice-Chair

Department of Financial Services (DFS)

Department of Labor (DOL)

Department of State (DOS)

Department of Transportation (DOT)

Division of Budget (DOB)

Division of Veterans' Services (DVS)

Empire State Development (ESD)

Faith Based Initiatives – Governor's Office

Governor's Chief Disability Officer

Homes and Community Renewal (HCR)

New York City Department of Aging (NYC Aging)

Office for New Americans (ONA)

Office for People with Developmental Disabilities (OPWDD)

Office for Temporary and Disability Assistance (OTDA)

Office of Addiction Services and Supports (OASAS)

Office of Children and Family Services (OCFS)

Office of Emergency Management (DHSES)

Office of Mental Health (OMH)

Office of Real Property Tax Services (ORPTS)

Office of Victims Services (OVS)

PRELIMINARY REPORT APPENDIX D:

Subcommittee and Workgroup Meetings to Date and Projected through August 2023

Subcommittee/ Workgroup	Meeting Dates											
Economic Security	5/4/23	6/16/23	7/14/23	8/11/23								
Retirement/Long Term Planning & Preparation	6/29/23	7/6/23	7/27/23	8/10/23	8/24/23							
Workplace Engagement	8/3/23	8/17/23	8/31/23									
Benefit and Resource Utilization	6/29/23	7/6/23	7/20/23	8/3/23	8/17/23	8/31/23						
Formal Caregivers	4/25/23	5/18/23	6/8/23	7/13/23	8/10/23							
Recruitment and Training	6/6/23	6/8/23	6/13/23	6/20/23	7/11/23	7/25/23	8/8/23	8/16/23	8/22/23			
Retention, inclusive of Compensation and Benefits and Supports	6/8/23	6/16/23	6/21/23	7/5/23	7/19/23	8/2/23	8/30/23					
Scope of Practice and Structure of Work	6/8/23	6/14/23	6/28/23	7/12/23	8/23/23							
Health and Wellness	5/10/23	6/7/23	7/5/23	8/9/23								
Behavioral health and substance use disorders	6/7/23	6/27/23	7/11/23	7/14/23	7/18/23	7/25/23	8/1/23	8/8/23	8/15/23	8/22/23	8/29/23	
Cognitive Health, Alzheimer's Disease, and other dementias	6/7/23	6/23/23	6/30/23	7/7/23	7/14/23	7/21/23	7/28/23	8/4/23	8/11/23	8/18/23	8/25/23	
Medicare and Medicaid annual wellness and prevention benefits	6/7/23	6/29/23	7/6/23	7/13/23	7/27/23	8/3/23	8/10/23	8/17/23	8/24/23			
Nutrition and Food Insecurity	6/7/23	6/27/23	7/3/23	7/24/23	8/7/23	8/21/23						
Promote and sustain physical and mental health, wellbeing and quality of life including primary	6/7/23	6/23/23	6/30/23	7/7/23	7/14/23	7/21/23	7/28/23	8/4/23	8/11/23	8/18/23	8/25/23	

and secondary prevention and self-management of chronic disease												
Home and Community-Based Services	4/19/23	5/24/23	6/28/23	6/28/23	7/26/23	8/23/23						
Critical Partnerships	5/24/23	6/12/23	6/26/23	6/26/23	7/10/23	7/17/23	7/24/23	7/31/23	8/7/23	8/14/23	8/21/23	8/28/23
In-Community Services	5/24/23	5/30/23	6/6/23	6/13/23	7/11/23	7/18/23	7/25/23	8/1/23	8/15/23	8/22/23	8/29/23	
In-Home Services	5/24/23	6/5/23	6/12/23	6/20/23	7/3/23	7/17/23	7/31/23	8/14/23	8/28/23a			
Housing, Community Development and Transportation	5/2/23	6/14/23	7/12/23	8/9/23								
Housing	6/14/23	6/22/23	6/29/23	7/6/23	7/20/23	8/3/23	8/17/23	8/31/23				
Community Design	6/14/23	6/23/23	6/30/23	7/7/23	7/14/23	7/28/23	8/11/23	8/25/23				
Transportation	6/14/23	6/21/23	7/10/23	7/24/23	8/7/23	8/21/23						
Informal Caregivers	4/26/23	5/19/23	6/9/23	7/14/23	8/11/23							
Caregiver supports	5/26/23	6/2/23	6/9/23	6/16/23	7/7/23	7/14/23	7/28/23	8/11/23	8/25/23			
Kinship caregivers	6/1/23	6/8/23	6/29/23	7/6/23	7/12/23	7/19/23	8/2/23	8/16/23	8/23/23	8/30/23		
Communication Strategies	5/24/23	5/31/23	6/14/23	7/5/23	8/2/23	8/16/23	8/23/23	8/30/23				
Finances	6/13/23	6/20/23	6/27/23	7/5/23	7/18/23	7/25/23	8/1/23	8/4/23	8/8/23	8/15/23	8/22/23	8/29/23
Long-term Services and Supports	5/11/23	6/21/23	7/19/23	8/16/23								
Care Transitions	6/21/23	6/28/23	7/5/23	7/19/23	8/2/23	8/16/23	8/30/23					
End of Life Care	6/27/23	7/11/23	7/18/23	7/28/23	8/1/23	8/8/23	8/15/23	8/22/23	8/29/23			
Equitable Facility Transformation	6/23/23	6/30/23	7/7/23	7/14/23	7/21/23	7/28/23	8/4/23	8/11/23	8/18/23	8/25/23		
Levels of Care	6/27/23	7/11/23	7/18/23	7/25/23	8/1/23	8/8/23	8/15/23	8/22/23	8/29/23			
PACE	6/22/23	7/6/23	7/13/23	7/27/23	8/10/23	8/24/23						
Payor Structure	6/29/23	7/7/23	7/11/23	7/14/23	7/21/23	8/2/23	8/4/23	8/11/23	8/18/23	8/25/23		
System Navigation	8/3/23	8/8/23	8/17/23	8/31/23								

Safety, Security and Technology	5/1/23	6/14/23	7/12/23	8/9/23								
Financial Exploitation, Scams	6/8/23	6/15/23	6/22/23	6/29/23	7/13/23	7/27/23	8/10/23	8/24/23				
Technology	6/1/23	6/8/23	6/15/23	6/22/23	7/6/23	7/20/23	8/3/23	8/17/23	8/31/23			
Abuse (Physical, Sexual, Psychological)	6/13/23	6/20/23	7/18/23	8/1/23	8/15/23	8/29/23						
Guardianship	5/31/23	6/14/23	6/21/23	6/28/23	8/2/23	8/16/23	8/30/23					

DATA DISCLAIMER

Consistent with the goals of this Preliminary Report on the MPA, which represents a snapshot in time of the State's progress on this initiative, all data and graphic visuals are provided for informational purposes only to enhance the reader's experience and visual understanding of the overarching issues discussed.

Appendix J: Interim Report

NEW YORK STATE
MASTER PLAN FOR AGING
Interim Report

This report (the "Interim Report") fulfills the reporting requirements of section 5.d of Executive Order 23, Establishing the New York State Master Plan for Aging. The Emerging Potential Proposals section outlines the current index of potential proposals considered and put forth by the subcommittees and workgroups to date. These potential proposals will be reviewed by the Stakeholder Advisory Committee and the MPA Council to inform the Final Advisory Report and the Final MPA report, which will also need to balance available resources, implementation requirements, and other key factors in formulating the Final Master Plan for Aging report.

The authors would like to recognize the visionary leadership of Governor Hochul and the staff of the Executive Chamber in enacting EO 23, and the contributions of the dedicated staff of the NYS Department of Health and the Office for the Aging, the NYS Department of State, the Office of the Chief Disability Officer, the NYS Long Term Care Ombudsman, the DOH and NYSOFA Offices of Diversity, Equity and Inclusion, the Office of Public Health, and the NYS Public Health and Health Planning Council's Ad-Hoc Committee to Lead the Prevention Agenda.

This report was developed primarily through the work of the hundreds of stakeholders who participated in the MPA workgroups. For nearly a year, the workgroup members contributed countless hours to developing ideas for addressing the needs of older adults and people with disabilities. Their work, summarized in this report, forms the basis for the ongoing work of the MPA to define the next era of aging and long-term care policy for the state, to ensure older New Yorkers can live fulfilling lives, in good health, with freedom, dignity and independence to age in place for as long as possible.

Executive Summary

This Interim Report is the second progress report on the development of New York State's Master Plan for Aging ("MPA"). The report summarizes the challenges the MPA aims to address, an update on the process and stakeholder involvement thus far, and a list of emerging proposals developed by the eight subcommittees – made up of stakeholders and state agency partners.

Since Executive Order No. 23 was signed by Governor Kathy Hochul on November 4, 2022, the New York State Department of Health ("DOH") and the New York State Office for the Aging ("NYSOFA") have assembled state agency leads, subject matter experts and partners from across the State to develop proposals for policies and programs that will ensure all New Yorkers are able to age with dignity and independence in their community of choice. Many of the emerging proposals build on and recognize the strengths and opportunities that derive from an increasingly aging population.

As of the writing of this report, this undertaking has resulted in:

- Assembling more than **430 total members**, representing experts from the field of aging, medicine, transportation, technology, housing, organized labor, home care, State and local

government, and more. To ensure inclusivity in the MPA's proposals, these representatives include members from historically disadvantaged or underserved groups including BIPOC (Black, Indigenous and People of Color) communities, rural communities, and the disability community, among others; and

- Convening **more than 640 total meetings** since EO 23 was signed. These meetings serve to advance the goals of the MPA and work toward the development of a final set of proposals. Meetings include:
    - 6 State Agency Council meetings with the MPA's 22 State agency and government partners.
    - 6 Stakeholder Advisory Committee meetings.
    - 61 subcommittee meetings, representing the work of 8 subcommittees (discussed herein).
    - More than 550 workgroup meetings, representing the work of 34 distinct workgroups.
    - 6 roundtables and 22 town halls or listening sessions to ensure input from the public and industry leaders is taken into consideration.

The Preliminary Report of the MPA was issued in August 2023 and identified ten pillars as organizing concepts: (1) housing access and community development, (2) informal caregiver and workforce support, (3) affordability of basic necessities, (4) access to services in and engagement with historically disadvantaged communities, (5) modernization and financial sustainability of healthcare, residential facilities, and community-based aging network service providers, (6) social engagement of older adults, (7) promoting health and access to services and supports in rural communities, (8) combating elder abuse, ageism, and ableism, (9) technology access and development, and (10) prevention, wellness promotion and access.

Since then, workgroups have developed proposals touching on these pillars – recognizing the need to break down silos across different subjects. The MPA has also gathered feedback from industry leaders and the public via roundtables, town halls, listening sessions, and a public survey. The next phase of the MPA will move beyond identifying challenges and developing initial policy proposals, to an analysis of policy, operational, and fiscal feasibility as well as a prioritization of final proposals.

The information reflected in this report is a result of the thousands of hours of professional and personal time that was dedicated to this process by the stakeholders, work group members, all of their organizations and the community at large. Their dedication, and generous provision of institutional and historical knowledge, and passion for the field made this work possible. We are appreciative, and DOH and NYSOFA remain committed to working with State and local partners, stakeholders and the public to provide updates on the MPA's progress and incorporate feedback.

Introduction

On November 4, 2022, Governor Kathy Hochul signed Executive Order No. 23 - Establishing the New York State Master Plan for Aging (the "EO"), led by the Department of Health (DOH) and the New York State Office for the Aging (NYSOFA). The EO provides a process for drafting guidance for the MPA and is the first step towards building a comprehensive roadmap of proposals to meet the needs of all New Yorkers as they age.

Building on New York State's status as the first state in the nation to officially receive AARP's age-friendly designation, the MPA aims to help coordinate existing and new state policies and programs for older adults and their families, while also addressing challenges to aging with dignity and independence. Accordingly, the MPA seeks to improve and address: communication, coordination, caregiving, service disparities, wellness, community design, long-term care financing and care models and programs that support healthy longevity and community engagement.

The final MPA report will provide a comprehensive set of proposals for consideration by the Governor to help build upon and improve systems of services and supports for aging and long-term care. Proposals will be organized around short-, medium- and long-term goals, and take into account urgency, impact, fiscal implications - including return on investment, and challenges to implementation, as well as the ability to advance key priorities. Proposals will include legislative, administrative and regulatory proposals at the state and local levels, as well as proposals for public-private partnerships. This ensures a commitment at every level to engage society in rising to meet the challenges and opportunities of ensuring New York's future as an outstanding place to grow up and grow old - a community that rises to the moral obligation of caring for its most vulnerable members.

This Interim Report is the second progress report on the development of New York State's MPA. The report summarizes the work the MPA aims to focus on, an update on the process and stakeholder involvement thus far, and a list of potential proposals developed by the subcommittees – made up of stakeholders and state agency partners. Proposals will continue to be developed by the stakeholder and agency participants in order to shape the State's Master Plan for Aging.

Challenges Underscoring the Need for the MPA

Today, the State has a variety of siloed systems for supporting the needs of aging New Yorkers. In light of projected demographic changes that will increase demands on these systems, the State must develop a statewide, coordinated plan to support aging New Yorkers. The State's projected demographic changes are likely to result in an increased demand for both community-based and skilled long-term care services and supports (LTSS). The effects of these demographic changes are already being felt through capacity issues in aging and long-term care services, declining informal caregiving arrangements and volunteers, and increases in unmet needs for supports and services. The State must take action to meet this increasing demand, including ensuring that those that are suited to age in place can do so safely in home and community settings. Being able

to age in place both respects the desires of many older adults, as well as often having the benefit of being a less costly method of care.

Another significant challenge associated with the projected demographic changes will be the availability of a workforce to support the provision of needed care. In 2010, the number of working age individuals was equal to those over the age of 65, but since then, the number of New Yorkers over the age of 65 has grown while that of working age New Yorkers has declined. The over-age-65 population is growing in every county of the State. According to a report published by AARP in partnership with the Center for Urban Justice, the fastest rates of growth in the over-65 population from 2011 to 2021 have occurred in Monroe County (+64 percent), Saratoga County (+50 percent), Onondaga County (+43 percent), Queens County (+39 percent), Dutchess County (+37 percent), New York County (+36 percent), and Orange County (+36 percent). In fact, the growth of New York's older adult population is outpacing overall population growth in the State's 19 largest counties and most of its largest cities, including Rochester, Syracuse, Yonkers, Albany, and New York City. According to Woods and Poole Economics, Inc., individuals aged 60 and over will make up over 25% of the populations in 50 counties in the State by 2030 and over 30% in a third of counties.

These demographic changes also strain the State's more than 4.1 million "informal"—unpaid—caregivers. These caregivers provide the bulk of services and supports to their loved ones. While caregivers can be any age, older caregivers, such as spouses and adult children, may also be managing their own health conditions or functional limitations. According to AARP, caregivers are in growing need of direct services and supports (respite, support groups, training, Social Adult Day Services, etc.) as well as indirect services and supports (those that take pressure off a caregiver, i.e., shopping assistance, transportation, nutrition support, etc.) to sustain their role. Without the support of these invaluable caregivers, whose services, if valued at current market rates, equal roughly $39 billion, there would be an untenable strain on the rest of New York's health system. Many caregivers also continue to work despite the round-the-clock nature of providing care to a loved one. Health and long-term care systems rely on these caregivers and community-based programming to prevent more costly care paid for through Medicaid. Implementing a service infrastructure that sustains these services and supports is necessary to meet increasing demand due to demographic changes.

The Master Plan for Aging also presents an opportunity to better harness the contributions of an aging population. Currently, New York has the fourth-largest population of older adults in the country. Older adults in New York are an integral part of local economies and the State's healthcare system. New Yorkers aged 50 and over account for the majority of spending on healthcare, durable and non-durable goods, utilities, motor vehicles and parts, financial services, household goods – supporting 5.9 million jobs in the state and generating $72 billion in state and local taxes. This doesn't include the previously mentioned value of caregiving contributions made by informal caregivers in New York, who are disproportionately over the age of 50. Many Older New Yorkers continue to contribute to the workplace, generating $482 billion in wages and salary. NYSOFA's 2023 statewide needs assessment survey, with over 23,000 responses

from people over 60 across the state, found that many older adults plan to continue working into their mid-70's. Moreover, like all New Yorkers, New York's older adults would prefer to continue aging in and working near their homes, and in their home state – 62% of new entrepreneurial ventures are begun by those over the age of 60, and 80% of New York State Retirement System payouts stay in the State.

The Master Plan for Aging must also confront the reality of rapidly growing Medicaid spending on long-term care. Between FY2023 and FY2024, the total Medicaid Global Cap grew by $2.1 billion of state share, a growth rate of 8.0%, while the state share of fee-for-service long term care spending and managed long term care spending grew by $1.7 billion, a growth rate of 14.4%, or more than 75% faster than overall spending growth. In order to ensure Medicaid's spending trajectory remains sustainable, the State must rigorously evaluate the efficacy and efficiency of existing and new long-term care programs and policies. The State must ensure that the right balance of services – including preventative services and services addressing the social determinants of health – are available to support aging New Yorkers, and must equally ensure that the State's limited resources are deployed in support of those New Yorkers most in need.

MPA Process and Progress To-Date

The MPA process has both generated initial ideas and served as a forum for stakeholders to provide input and build consensus around their proposals. Accordingly, the MPA process has engaged a spectrum of NYS agencies, forming the MPA Council, that can be found in **Appendix B**. A Stakeholder Advisory Committee has been formed to advise the MPA Council on ideas and perspectives to be taken into consideration in the development of the Master Plan for Aging. This group includes a range of non-governmental stakeholders includes, but is not limited to, representatives from organized labor, researchers in medical and non-medical fields, leaders of community organizations, and executives of businesses engaged in home care, real estate services, transportation, and technology; a list of these stakeholders can be found in **Appendix C**. The MPA process includes voices from BIPOC (Black, Indigenous and People of Color) communities, rural communities, the disability community, and other historically disadvantaged or under-served groups.

In the initial months of its operations, the MPA governing bodies convened, as directed by the EO, created and populated eight subcommittees intended to do the bulk of the drafting of the proposals that would constitute the MPA, and began a series of initiatives to solicit public engagement in the process. The subcommittees, in turn, established workgroups to focus on specific topics recommended by their members. A list of the subcommittees and their workgroups can be found in **Appendix D** and **Appendix E**. Early on, several topics repeatedly came up during subcommittee and workgroup discussions – these issue areas were turned into a series of pillars to guide the MPA work.

In February 2023, the Stakeholder Advisory Committee reviewed and agreed upon the following set of goals, establishing aspirational achievements for the MPA to accomplish in ten years. The goals are:

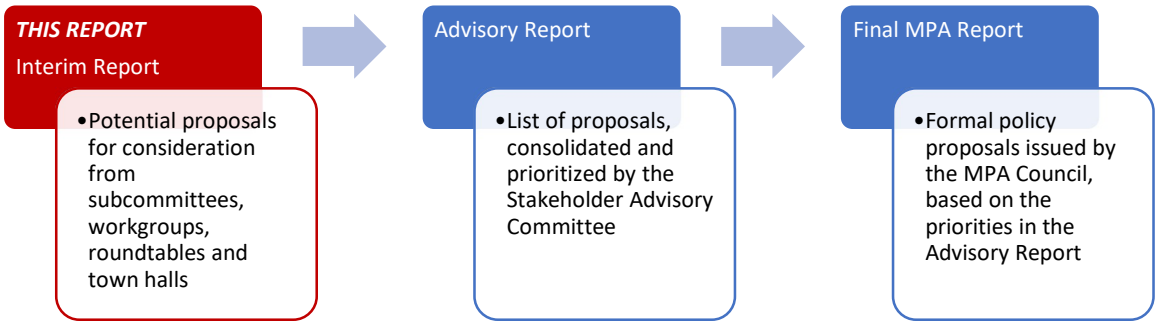
- Significantly transform communities and community design to promote healthy aging across the lifespan;
- Establish programs - residential, medical and social - which engage with the barriers to historically underserved, marginalized and minority communities receiving equal levels of care;
- Incorporate behavioral health as a primary element of geriatric medical care that is integrated with other interventions;
- Be instrumental in developing regulatory reforms and funding structures for senior housing (supportive, affordable, or otherwise integrated into Home and Community Based Services);
- Engage community and religious organizations in combatting social isolation, in partnership with social workers and medical providers;
- Expand the availability of programs, particularly adult day care and primary medical care, in minority communities that are currently underserved relative to state averages;
- Establish career development pipelines and incentives that expand the population of nurses and home health and personal care aides, relative to the growth of the older adult population in the State;
- Provide adequate training, workforce support and community-services for family caregivers;
- Ensure an adequate supply of personal care aides, home health aides and nurses with necessary cultural competencies, or provided an adequate population of interpreters to assist nurses and home care aides;
- Support the development of transportation support services and networks that enable older adults to access needed services regardless where they live;
- Propose and have the Legislature pass a series of laws providing for stronger elder abuse and fraud protections, including investment in elder-specific dedicated ombudsmen, investigators and guardians;
- Establish early detection programs, a screening and a reporting system for Alzheimer's and other dementia disorders that every medical provider in the state is aware of and into which they can properly guide each of their patients; and
- Strengthen programs for educating older adults regarding their insurance options and benefits and providing ongoing advising regarding the functioning of their insurance coverage.

In order to meet these goals, each subcommittee and their respective workgroups met to develop initial ideas. Additionally, ideas were gathered from public input and engagement through hosting town halls and listening sessions across the State, roundtable discussions with industry leaders, and the issuance of a public survey that launched at the 2023 State Fair and closed February 2024, garnering over 10,000 responses. These initial ideas highlight the fragmented nature of current systems of long-term care, aging services, and healthcare delivery, as well as the lack of a coordinated approach between healthcare and aging services and community-based organizations.

This report consolidates and summarizes the ideas gathered from the subcommittees and public, to be considered by the Stakeholder Advisory Committee and MPA Council. The proposal summaries are organized according to the pillars developed in the Preliminary Report and overlapping proposals have been combined. The Stakeholder Advisory Committee will review the full proposals and will sort them into a cohesive set of priorities for the MPA Council. The MPA Council will then assess the operational, policy, and fiscal feasibility of the proposals to develop a final set of proposals to be considered by the Governor for the final issuance of New York's Master Plan for Aging.

Emerging Potential Proposals

The previous phases of the MPA drafting process focused on soliciting ideas and feedback, and produced the foundational material for developing the final MPA. The following section lists potential proposals that have been considered to date, emerging from the MPA subcommittees and their respective workgroups, public feedback (e.g., town halls, listening sessions), and roundtables with industry leaders. In future phases of the MPA drafting process, the Stakeholder Advisory Committee will evaluate the proposals for completeness and will organize them by priority. The MPA Council will assess the proposals for feasibility, and will translate feasible proposals into actionable plans that balance available resources, implementation requirements, and other key factors in formulating the final Master Plan for Aging report to be delivered to the governor.



List of MPA Proposals

I. Informal Caregiver and Workforce Support and Modernization of Community-Based Aging Network Service Providers

Support Community-Based Aging Services

Establish budget parity for aging services by increasing access to resources for community-based services including statewide funding opportunities and capital funding programs, expansion of Medicaid provider licensure to the network of community-based services providers, and innovative financing programs (i.e., social impact bonds) to ensure that all New Yorkers can age in their community of choice.

Peer-to-Peer Legacy of Care Mentorship Program

Institute a demonstration pilot for the peer-to-peer Legacy of Care Mentorship Program within home care service provider agencies statewide, in which seasoned home care staff will mentor newly hired staff over a six-month period, with the aim of boosting retention rates and enhancing job satisfaction. The proposal includes a proposed structure for the program and compensation for the mentors.

Require Alzheimer's Disease and Dementia Care Training

Improve Alzheimer's Disease and dementia care by requiring applicable training for nursing home and assisted living staff. This proposal also includes a series of measures to improve available training in dementia care.

Procurement of Regional Direct Training Centers to Increase Accessibility and Availability of Training

Direct the Department of Health (DOH) to procure Regional Direct Care Training Centers (Centers) throughout NYS to increase access and availability to training. The proposal includes the regulatory framework for operating the training centers.

Establish Regional Caregiver Support Hubs

Have DOH procure Regional Caregiver Support Hubs. Hubs will facilitate support services for individuals training to become direct caregivers and will provide assistance in navigating changes to benefits that result from caregivers achieving full-time employment (i.e. where their employment results in them losing eligibility).

SkillSpring Program to Bolster the Direct Care Workforce

Recommendations to expand the SkillSpring program to prepare care workers to serve older adults and provide health care jobs to young, low-income New Yorkers. The proposal also includes partnerships with the Department of Health Regional Direct Care Training Centers to certify the program's students.

Support Immigration Reform to Expand the Paid Caregiver Workforce

Expand the paid caregiver workforce through immigration reform by amending the Immigration and Nationality Act (INA) to recapture unused permanent employment-based visas to fill health care workforce shortages. Modifications include classifying direct care professions as Schedule A shortage occupations, creating a temporary work visa for low-skill workers, and establishing a legalization program for qualifying foreign-born workers.

Regulatory Reform to Support Direct Care Workforce Recruitment

Establish financial investment in workforce recruitment and provide education about the direction of the new facility model. This proposal includes recommendations to decrease educational barriers, review safety, efficacy and requirements of technicians and assistants, and promote flexible career ladder opportunities.

Establish the Statewide Caregiver Peer Support System

Establish or expand statewide caregiver peer support system(s) based on successful peer support programs to support the needs of caregivers. Successful models to replicate or expand include the Family Essential Care Program (FEP), Pfc. Dwyer Veteran Peer to Peer Program, Alzheimer's Association Peer Support, Living Communities Caregiver Coaching Program, and OPWDDs Family Education Support Groups.

Develop a Caregiving Toolkit

Create a caregiving toolkit that promotes caregiver services and supports to leadership of non-profits, community organizations, and faith-based organizations. This proposal includes collaboration with the Office of Faith and Non-Profit Development Services to disseminate the toolkit, build on the faith-based respite network, engage with the faith-based registry, and expand direct caregiver services delivered by volunteers.

Workforce Development Center for Professional Development in Gerontological and Geriatric Education

Create a pilot program for schools with an active aging program or specialization in place and create a workforce development center for professional development in gerontological education. The program would include the development of relevant, aging-focused curricula, track learning opportunities, and efforts to expand the program into other interested schools.

Strengthen the Direct Care Workforce Through Reforming the Credentialing Infrastructure

Establish a revised training and credentialing infrastructure for direct care workers that allows for portability across long-term care settings. Revise current training curriculum to create a foundational direct care worker training program with the goal of establishing a recognized universal direct care worker credential.

Anti-Discrimination of Caregivers in the Workplace

Produce a model working caregiver education training program to inform working informal caregivers of their rights and resources in the workplace. This proposal also includes a call to prohibit discrimination based on caregiver status.

Education of Informal Caregivers in the Workplace

Improve education of informal caregivers in the workplace by requiring workplace training on caregiving and caregiver rights. This proposal also includes recommendations to produce a model working caregiver education training program.

Establish Caregiver Coordinating Commission

Establish a Governor-appointed Caregiver Coordinating Commission to coordinate statewide planning, development, and implementation of caregiver support services for informal family caregivers. This Commission will incorporate caregiver feedback, analyses of respite programs and best practices, and develop an annual report.

Caregiver Tax Credit and Reimbursement Program

Create a caregiver tax credit to be paid directly to the caregiver and a reimbursement program for caregiving expenses to offset expenses such as home safety modifications, medical equipment, hiring of home health aides, etc.

Establish Administrative Infrastructure to Support Kinship Caregivers

Support kinship caregivers through identifying unmet needs and providing assistance by establishing Interagency Council on Kinship Care and Kinship Legal Network leveraging the existing Kinship Navigator program to collect data and recognize trends as a means to identify success stories, identify unmet needs related to housing, mental health access, financial assistance, childcare and respite care for kinship caregivers, including systemic challenges and solutions, and to document the benefit of the program.

Person-Centered Service Delivery Direct Care Workforce Training

Revise assessment, care planning, and direct care worker training infrastructure to reflect person-centered principles. Adjustments will include convening experts to identify the comprehensive needs of long-term care service recipients, engaging local authorities and resources, and updating assessment tools to consider inclusivity and psychosocial needs.

Funding and Recognizing NYSCRC in State Law

Codify the duties and responsibilities of NYS Caregiving and Respite Coalition (NYSCRC) to establish the program in state Elder Law, focused on advocacy, networking, public education, caregiver training, increasing access to respite, and assisting family caregivers in accessing respite care services.

Expand Workforce Development Initiative

Consider budgetary and regulatory actions that would expand workforce development services and job training for older adults through the Department of Labor's Workforce Development Initiative to better maintain and find employment and/or start encore careers.

Statewide Caregiver Engagement Campaign

Expand the Any Care Counts – NY campaign statewide to include development of engagement kits, training on community access points for education and website for continued engagement of caregiving population.

NYS Working Caregiver Initiative and Pilot

Establish pilot program supporting working caregivers for up to five businesses with findings used to inform a newly established Caregiver Coordinating Commission (see proposal MPA2024R63), legislative actions, and dissemination plans beyond the pilot businesses.

Support for Nursing Educators

Increase the number of nurse educators – school faculty and clinical preceptors – in NYS by expanding scholarship and loan forgiveness programs, consideration of tax incentives for those serving as clinical nurse preceptors and facilitating private-educational partnerships that would offer joint appointments for clinical educators/faculty.

Increase Advertising to Recruit More Caregivers

Consider regulatory and budgetary actions that would enhance current activities under Workforce Investment Organization funding and related programing for the recruitment and retention of healthcare workers.

Assess Appropriate Respite Care and Social Adult Day Services Wages

Through budgetary and regulatory actions, as well as advocacy to the federal government, improve wages received by Respite and Social Adult Services employees.

Incentivize Geriatric Specialties

Develop mechanisms to provide incentives that support those interested in entering the fields of geriatrics and geriatric psychiatry, such as scholarships, loan forgiveness, or additional provider reimbursement add-ons for serving specialized populations. The proposal includes incorporating geriatric-specialty-focused elements into existing loan forgiveness programs.

II. Modernization and Financial Sustainability of Healthcare and Residential Facilities

Nursing Home Capital Assistance

Recommendations to provide a flexible approach to nursing home capital improvements by a combination of updates to existing regulatory requirements and metrics. The proposal also includes an evaluation of industry interest in developing specialty care units, and a statement of principle regarding grant program utilization.

Facilitating Nursing Home Reform Efforts

Create a more home-like environment through the development of the Green House or other small house-type facilities and the renovation of other facilities to facilitate the creation of a home-like environment. The proposal also includes recommendations to update regulatory requirements in order to facilitate complementary transformations to the nursing home industry.

Reactivate and Modify the Voluntary Residential Health Care Facility Rightsizing Demonstration Program

Modify and reactivate the Voluntary Residential Health Care Facility Rightsizing Demonstration Program to incentivize facilities to voluntarily give up unneeded beds and ensure appropriate placement through further expansion of alternate levels of service and save Medicaid funds. Proposed modifications would include loosening regulations around reactivation, providing a financial incentive for decertification, and expanding the program.

Adult Care Facility (ACF) Voucher Demonstration

Create a limited demonstration program modeled on the successful Special Needs Assisted Living Voucher Demonstration Program for persons with dementia aimed at preventing or delaying the need for more costly, higher-level care. The program would provide a sliding-scale subsidy for ACF residents who are at risk of nursing home care due to depleted resources and to individuals not eligible for Medicaid or SSI but in need of Adult Day Health Care services.

Diversifying Long-Term Care (LTC) Facility Services

Diversify long-term care facility services to encourage high quality and person-centered specialized clinical services. This includes expansion of Adult Care Facilities/Assisted Living and Adult Day Health Care access, expansion of access to and improved clinical expertise in psychiatric, mental health, and behavioral health services for long-term services and supports providers, and the revision of regulations that complicate compliance with staffing mandates.

Improve Nursing Home Quality Incentive Pool

Create a robust Nursing Home Quality Incentive Pool through reallocation of funding from the Vital Access Provider pool to offset changes to nursing home quality incentive pool. Recommendations for increased investment in improved nursing home quality include collective stakeholder input, additional metrics for staff, and investments in workforce training.

Interagency Integration of Social and Healthcare Services

Establish an interagency office to develop a plan to fully integrate social and healthcare services for New Yorkers of all ages based on research and available data on positive outcomes. In cross-sector partnerships, state agency members will develop shared goals to assess the effects of ageism and foster sustainable health and social care alignment.

Expanding Flexibility for Long-Term Care Facilities

Reduce regulatory and programmatic barriers through creating a sustainable, person and quality centric Assisted Living Model for the future, developing one uniform licensure category

for assisted living, and increasing financial support for transitioning nursing homes to other care models. Allow Adult Care Facilities to add Assisted Living Program (ALP) beds.

Hospice and Palliative Care Support and Reform

Improve and preserve the quality and availability of hospice and palliative care. Recommendations include reestablishment of the Hospice and Palliative Care Education and Training Council, development of a Regulatory and Certificate of Need Task Force, funding for a stakeholder statewide coalition, offering an interdisciplinary palliative care benefit for qualifying Medicaid recipients regardless of location, and recognizing Physician Assistants as Hospice Attendings.

Continuing Care Retirement Communities Oversight Reform

Encourage the growth of Continuing Care Retirement Communities by consolidating oversight to the Department of Health, updating the priority reservation fee deposit, and reallocate state resources to the DOH to support expanded oversight. This proposal includes alternative opportunities to reduce barriers to growth, all of which align with the recommendations to reduce oversight and improve CRCCs ability to effectively serve their populations.

Adult Day Health Care Family Caregiver Program

Increase and incentivize Adult Day Health Care programs through regulatory reforms that address reimbursement and financing, expanded staffing, innovative partnerships with other service providers including with transportation providers, and encourage pilot programs that integrate adult day services.

Review and update ADL Requirements for Medicaid in-home services

Consider regulatory reforms related to current ADL requirements for in-home services covered by Medicaid and develop a universal eligibility tool to ensure accurate, timely, and quality assessment of eligibility of needed in-home services to ensure coverage regardless of payor source.

Elevate Integrated Care Programs

Create ways to upscale service delivery to the most integrated settings possible by incorporating enrollees who receive services through provider programs without coordination and aging individuals receiving OPWDD services into more comprehensive programs such as PACE without disenrollment or automatic exclusion from their current program, their care can be more holistically coordinated.

Support PACE Expansion and Enrollment

Consider regulatory, budget and programmatic actions to implement that would increase Program of All-inclusive Care for the Elderly (PACE) enrollment by increasing accessibility and awareness of PACE.

Medicaid Rate Reform

Consider reforms to Medicaid reimbursement across long term service and support providers, including facility-and-home-based providers, through examination and adjustments to SSI/SSP, rate methodology, and episodic payment system policies.

Coordination of Homecare and Aging Services at OMH Housing Through 1115 Waiver

Create a demonstration program for individuals being discharged from hospitals participating in the evidence based care transition demonstration. The demonstration would coordinate home care and aging services for individuals with co-occurring LTC and mental health and/or substance use needs who are transitioning back to or newly being transitioned to community-based OMH housing.

Assisted Living Reform

Combine accreditation programs and regulatory reforms to drive higher quality care and improved access to specialized services at assisted living residences. Encourage integration, including digital systems, into larger network of care providers.

III. Prevention, Wellness Promotion and Access

Evaluate Payor Support for Preventive Services and Supports

Consider regulatory and programmatic actions to, on an annual basis, analyze policy decisions that affect the delivery of Medicaid Long Term Services and Supports (LTSS) for Medicaid Managed Care, Managed Long Term Care and Fee for Service (FFS) for consideration of support for LTSS that defer, delay and eliminate the need for Medicaid long-term care with an annual report that recommends methods for greater integration of services and payors across the DOH and SOFA landscape.

Prevention and Geriatrics Continuing Medical Education (CME)

Establish a blue-ribbon commission to develop Continuing Medical Education content on prevention and geriatric medicine to increase provider awareness of contemporary best practices. The proposal additionally provides details on the membership of the commission, the target audience for the content, and content distribution.

Food As Medicine promotion

Build an integrated social care delivery system through resource allocation, regulatory and statutory actions with a focus on health equity to enable aging service providers, the existing AAA network, and local health departments to provide Food As Medicine interventions tailored to each community to be scaled statewide over a decade.

Review and Update of the Patient Review Instrument (PRI)

Review and engage in an update of the PRI Screening Tool in consultation with appropriate partner agencies and stakeholders with the goal of reflecting the current acuity-based Medicaid reimbursement system and an evolving health information technology landscape, increase efficiencies and better integrate into the State HIT and exchange framework the aging and LTC services providers.

Promotion of the Annual Wellness Visit

Undertake programmatic and educational efforts, and consideration of innovative partnerships between community-based and health service providers to provide better awareness and utilization of Annual Wellness Visits with primary care providers to create or update a personalized prevention plan.

Public Education and Awareness

Establish public awareness campaigns regarding best practices for addressing the following health issues or needs: Falls, Diabetes, Hypertension, The importance of physical activity, Nutrition benefits (including SNAP, the Elderly Simplified Application Process, and the Restaurant Meals Program), Malnutrition Prevention and Awareness, Advance care planning (particularly end-of-life), Caregiver education, Brain health, Adult Abuse and Scams, and Generalized prevention.

Ecosystem Demonstration Pilot

Establishes a partnership among NYSOFA, DOH and the Department of State to create local teams to facilitate better coordination across health systems, local health departments, primary and specialty providers, and Area Agencies on Aging. Includes a recommendation that initial demonstrations be located in counties that have at least one health system certified as an Age-Friendly Health System.

Support Services for Older New Americans

Support older new Americans by funding trusted community benefit organizations in the Older New Americans network. Target organizations would provide case management support, referrals, and information and translation services in a way that overcomes existing linguistic and cultural barriers.

Firearm Retirement Plan

Provide education and active engagement of older adults to facilitate better firearm safety. Include mental health and suicide prevention in a program of engagement for firearm owners.

Support Older Adults Aging in Place in OMH Licensed and Permanent Housing

Proposes a formal collaboration among DOH, the Homecare Association of NYS, OMH Housing Providers and Advocacy groups to address challenges for accessing needed services in OMH housing.

Community Immunization Program

Support increasing vaccination rates. The proposal includes a combination of partnerships and studying the most effective ways to encourage vaccination.

Prevention Curriculum

Develop a Prevention curriculum for elementary, middle and high schools. Additionally facilitates social interactions via volunteer programs, and provides exposure and encouragement for caregiving careers.

More Effective Care Integration Through Plans

Introduce a care mandate that incorporates mental, behavioral and physical health for managed care plans. The proposal includes a plan to work with CMS for the needed program changes.

IV. Housing Access and Community Development

Addressing Housing Supply

The proposal includes reforms that encourage new construction or adaptive reuse of existing buildings, pilots accessory dwelling units (ADUs), recommends zoning ordinance revisions, and suggests housing models for senior and "missing middle" housing.

Eviction Prevention

Ensure people can stay in their homes and avoid eviction. Recommendations include reviewing budgetary opportunities to provide a state-funded housing voucher or a state funded plan for housing assistance for New York's lowest-income seniors, modeled after the Senior Citizen Rent Increase Exemption and providing legal assistance to all older adults, individuals with disabilities, and their caregivers facing eviction or foreclosure.

Supporting Community Housing Models

Support different housing models that provide a range of services. This proposal includes recommendations to create a 5-year Resident Assistant demonstration project, expand the N/NORC program and senior housing with services model, expand housing models that benefit people with mental health and substance use disorders and reduce social isolation, and allow for operators of Family Type Homes for Adult to apply for special licenses to perform specific duties.

62+ Housing Exemption for Kinship Caregivers

Work with the Division of Human Rights to amend waivers for 62 plus senior housing developments. The current rules disproportionately impact minorities populations.

Strengthen Home Modification Programs

Review, consolidate and direct policy and budgetary actions to implement improvements to current programs that maintain or modify homes to be accessible for older adults and people with disabilities.

Incorporate Age-Friendly Principles Into Community Design

Establish an interagency group responsible for the coordination of community design and housing solutions. Incorporate or encourage age-friendly principles into community design through incorporation into state procurement and spending policies, planning for enhanced and expanded pedestrian infrastructure in and around communities with an aging population as well as public engagement of older New Yorkers to remain living in, or relocate to, communities with a higher population density and concentration of jobs, social/medical services, recreational opportunities, and public transit options.

Funding Infrastructure Upgrades and Investing in Municipalities

Establish a fund for grants to municipalities to make infrastructure upgrades and capital investments. The proposal includes requirements to encourage local support for capital projects.

V. Affordability of Basic Necessities

Establish a Lifetime Financial Planning Program

Create a Lifetime Financial Planning Program which would be responsible for assisting New Yorkers in planning their finances throughout their lifetime, including budgeting, financial literacy, planning for life's milestones (including retirement), dealing with debt and referrals to career counseling.

Establishing the Office of Benefits Coordination

Establish a Benefits Coordination Office to streamline existing benefits programs across the New York State government. The office would document existing benefits and provider resources, develop a single portal website for benefit identification, and operate a universal benefits application for streamlined application processes.

Benefits Program Expansion

Increase and expand a variety of existing benefit programs. The proposal recommends updates to regulatory and programmatic requirements and metrics to increase the number of enrollees and improve the access and availability of critical health programs.

Increase Utilization of the Elderly Pharmaceutical Insurance Coverage Program (EPIC)

Increase utilization of EPIC program by addressing stubborn barriers to enrollment, access and retention through program oversight and transparency, simplify program administration, address stigma, improve a lack of adequate outreach and education, as well as culturally and linguistically competent education and outreach to support application assistance.

LTSS Finance Reform

Consider a new financing regime to pay for LTSS in the State, focusing on a long-term care social insurance model. This new program would supplement the existing Medicaid, EISEP, and private long-term care insurance markets after conducting an actuarial study on LTSS financing model feasibility, which would consider the types of benefits, who should qualify, how it should be funded and other variables and concurrent study of LTSS benefit design which includes cash-only, services-only, and an option between the two and covers all LTSS services, including examination of anticipated costs for funding of public education and workforce investments.

Improving Use of Medicare Savings Program

Undertake regulatory, budgetary, outreach and education and programmatic actions that aim to increase, streamline, and simplify enrollment into the Medicare Savings Program.

VI. Access to Services in and Engagement with Historically Underserved and Rural Communities

Support Electronic Health Records Adoption

Budgetary considerations for long-term care providers who were not eligible for federal Meaningful Use funding for electronic health record adoption, and policy and regulatory actions to increase efficiency, support workforce and partner with systems across the continuum to ensure seamless care transitions and support technology acquisition and implementation.

Loan Forgiveness for Nurses in Medically Underserved Areas

Expand eligibility for Nurses Across New York by including specific considerations for serving older adults or within the LTSS field, consideration of eligibility for other titles, and development of a solicitation of interest related to interest in serving the LTSS population.

Encourage Transportation Network Integration and Growth

Improve scale, efficiency, and capacity of transportation networks by exploring the expansion of micro transit services to regions with a high percentage of older New Yorkers, expanding the supply of volunteer drivers, encouraging the coordination of rural transit providers into a regional entity that can coordinate services, and establishing local transportation and considerations into existing funding programs and expanded funding opportunities.

VII. Social Engagement of Older Adults

Supporting Social Connection with the US Surgeon General's Recommendations

Support social connection through the implementation of the U.S. Surgeon General's ten recommendations for government. Those recommendations generally propose regulations,

government leadership positions and roles, and collaborative governance across federal, state and local functions, to prioritize social connection, which would be connected by newly standardized metrics.

Reduction in Social Isolation Through Peer Model Programming Engagement and Expansion

Conduct public education campaign on peer-to-peer models and connections available, benefits thereof, and enrollment support combined with establishment of a wellness screening website that includes a social connections component to provide information on the value of social connections, strategies to strengthen healthy social connections such as accessing outreach volunteers, peer services, and other resources. State agencies explore current programs utilizing peer-to-peer models and how to expand access and utilization and consideration of creation of state-level position to implement actions and to target older adults not currently accessing aging services.

Social Isolation and Loneliness in State Policy

Require a social connections component embedded across all state policies and programs, including: the design and implementation of a standardized data set and monitoring system for evaluations of social connection interventions statewide; the building of age-friendly social infrastructure within the community that values the assets of older adults and enables opportunities for paid work and volunteering; a focus on the built environment to provide spaces and opportunities to access social engagement; a focus on the community-based programming designed to create social connection, meaning, and purpose; and the creation of a one-stop-shopping opportunity for people to obtain a listing of the wide range of opportunities to be engaged with.

Co-Location of Childcare Services

Co-locate childcare services in facility-based long-term care settings. Establish programs to encourage interaction between children and appropriately screened and supervised residents.

VIII. Combatting Elder Abuse, Ageism and Ableism

Inclusive Disaster Response and Preparedness

Enhance and promote New York State's disaster preparedness and response education opportunities. This proposal includes recommendations to promote the Citizens Preparedness Corp trainings and strategies for identifying and developing best practices for assisting older adults and those with access and functional needs during disasters and emergencies.

Improve Guardianship

Establish and fund a statewide Article 81 guardianship program to oversee Article 81 guardianship services, including a committee within the NYS Unified Court System, and pursue

a holistic approach to expanding the awareness and availability of guardianship alternatives by focusing on education, planning, and providing supports tailored to each individual's specific need.

Elder Abuse and Elder Justice Forum

Create a permanent, state government sponsored forum focused on elder abuse and elder justice for a diverse partnership of representatives to share ideas from both academia and the field, provide feedback, and encourage evidence-based and culturally responsive strategies to prevent and intervene in cases of financial exploitation and elder abuse and regularly provide review and feedback on potential updates to operations, programs and regulations related to elder abuse and justice.

Challenging Ageism, Ableism and Abuse

Encourages implementing the recommendations contained in the final report of the 2021 New York State Elder Abuse Summit Seeking Solutions: Elder Abuse - Creating a Clear Vision of Where We Go From Here and examining opportunities for collaboration among agencies on training and programs addressing ageism, as well as establishing an Elder Justice Coordinating consisting of state agency representatives working in the realm of elder justice.

IX. Technology Access and Development

Involving the User in the Design and Development of Technology

Develop policies that encourage the technology sector to involve end-users in the design and development of such technology products, trainings, and support services, including incentives for companies that include end-user in design and development, establishing formalized standards for procurements, involvement of end-users in policy development, and implementation of end-user feedback.

Statewide Uniform Care Platform

Develop, launch, and maintain a statewide, uniform HIPAA compliant care platform aiming to empower users to proactively help clients receive the care and services, allowing for benefits and services enrollment based on data analysis, trends, and recommendations generated by the platform. The platform would replace the current use of individual assessment tools and data sheets by various programs and allow users to seamlessly coordinate services and benefits across multiple agencies and programs.

Improve Cognitive Health Data Accessibility

Establish a central repository of HIPAA-compliant cognitive health data to inform policymaking and resource prioritization in support of optimizing value, equity, inclusion and effectiveness of cognitive health promotion and care in NYS. The proposal includes an evaluation of existing data sets and of use cases for the repository.

Integrate Data and Case Management Across Care Settings

Leverage the Statewide Health Information Network for New York (SHINNY) in a series of three pilots to integrate information from medical, behavioral, and mixed payer client data systems to connect to Qualified Entities such as HIXNY or Healthix to facilitate use of electronic information from local provider systems. The pilots would prioritize data sharing to facilitate better transitions across care settings.

Meaningful Access to Technology

Increase efforts to ensure meaningful access to technology for all populations, including access to the hardware, software, and other equipment necessary to meet needs; an internet connection with sufficient bandwidth; and the training, support, and skills necessary to use them delivered in an engaging and culturally component way.

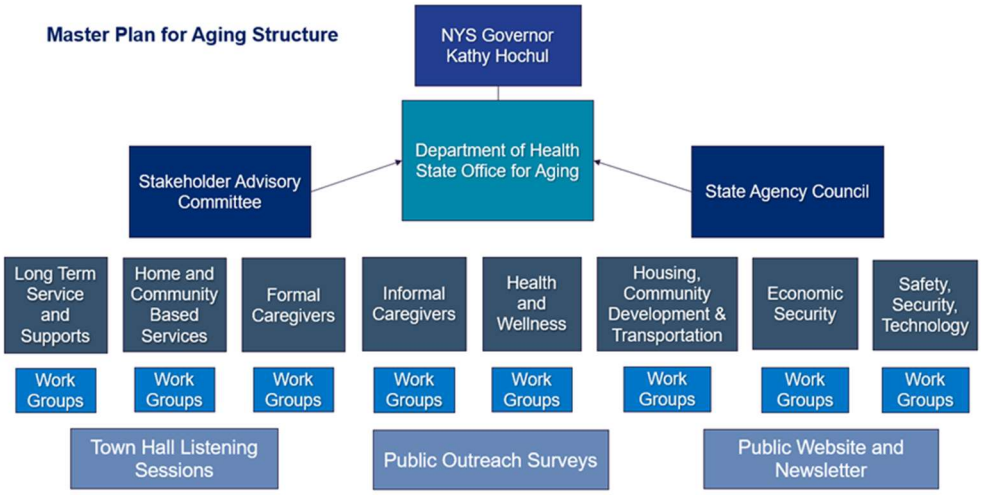
AgeTech and Assistive Technology Incubator

Establish a State-sponsored technology incubator focused on "AgeTech" and assistive technology. The incubator would be a public-private partnership leveraging State opportunities to encourage development of needed technologies.

INTERIM REPORT

APPENDIX A: MPA

Structure



INTERIM REPORT APPENDIX B:

MPA State Agency Council Membership

New York State Department of Health (NYSDOH), Chair

New York State Office for the Aging (NYSOFA), Vice-Chair Department of State (DOS)

Department of Financial Services (DFS)

Department of Labor (DOL)

Department of Transportation (DOT)

Division of Budget (DOB)

Division of Veterans' Services (DVS)

Empire State Development (ESD)

Faith Based Initiatives – Governor's Office

Governor's Chief Disability Officer

Homes and Community Renewal (HCR)

New York City Department of Aging (NYC Aging)

Office for New Americans (ONA)

Office for People with Developmental Disabilities (OPWDD)

Office for Temporary and Disability Assistance (OTDA)

Office of Addiction Services and Supports (OASAS)

Office of Children and Family Services (OCFS)

Office of Emergency Management (DHSES)

Office of Mental Health (OMH)

INTERIM REPORT APPENDIX C

Stakeholder Advisory Committee Membership

Jessica Bacher, Pace Land Use Law Center

Stephen Berger, Odyssey Partners

Dr. Jo Ivey Boufford, Robert F. Wagner Graduate School of Public Service, NYU Dr. Thomas Caprio, Finger Lakes Geriatric Education Center

Ann Marie Cook, LifeSpan of Greater Rochester

Sara Czaja, PhD, New York-Presbyterian Hospital, Weill Cornell Medicine Emma DeVito, VillageCare

Ruth Finkelstein, PhD, Brookdale Center for Healthy Aging

Dr. Linda Fried, Columbia University, Mailman School of Public Health

Doris Green, New York State Caregiving & Respite Coalition

Kathryn Haslanger, Jewish Association Serving the Aging

Linda James, Former Kinship Caregiver

Stuart C. Kaplan, Selfhelp Community Services

Scott LaRue, ArchCare

Stephanie Lederman, American Federation for Aging Research

Lora Lee La France, St. Regis Mohawk Office for the Aging

Raj Mehra, Sage

George Nicholas, African American Health Equity Task Force

Allison Nickerson, LiveOn NY

Karen Nicolson, Center for Elder Law and Justice

Wade Norwood, Common Ground Health

Nora O'Brien-Suric, Health Foundation for Western and Central New York James O'Neal, AARP New York

Dennis Rivera, Former Chairman of Medicaid Re-Design Team

Dan Savitt, VNS Health

Helen Schaub, 1199/SEIU

Timothy Seymour, Herkimer County Dept. of Social Services

Courtney Burke, Sachs Policy Group

INTERIM REPORT APPENDIX D

Subcommittees, Workgroups, and Workgroup Focus Areas

Housing, Community Development and Transportation

- Housing
  - Zoning
  - Financing
  - Taxation: Carrots and Sticks
  - Affordability
- Community Planning
  - Public spaces
  - Services
  - Smart growth
  - Accessibility
- Transportation
  - Public Transportation
  - Infrastructure
  - Paratransit
  - Private services

Formal Caregivers

- Recruitment and Training
  - Fair pay
  - Workforce investment: training, career ladders and technology
  - Adequacy of existing training programs
  - Rural transportation
  - Stackable Credentials
  - Specialized training
- Retention, Compensation and Benefits
  - Compensation
  - Case assignment
  - Mentoring
  - Childcare
  - Regionality
- Scope of Practice and Job Structure
  - Scope of practice flexibilities
  - Creating opportunities for full-time employment of home care aides
  - Career paths
  - Specialized training

    - Database of available positions
    - Case assignment

Informal Caregivers

- Kinship Caregiving
    - Focused on supports for older adults filling the caregiving role
    - Legal issues
    - Safety net supports
    - Housing challenges
- Caregiver Supports
    - Focused on services that assist caregivers with their responsibilities and their mental health
    - DEI issues
    - Mental health supports
    - Complexity of support systems
    - Social Security issues
- Communications
    - Targeting informal caregivers to help them self-identify and to publicize available resources
- Finances
    - Engaged with the challenges of caregiving to the caregivers and to employers
    - Evaluate market sizing
    - Look at regulatory/tax/funding supports for employers of informal caregivers

Economic Security

- Retirement
    - This workgroup will focus on financial preparation for retirement and long term care needs
    - Savings programs
    - Long term care insurance
    - Education and communication
- Benefit Programs
    - This workgroup will focus on existing and potential benefit programs to support the ability of older New Yorkers to secure the basic needs of daily life, as well as communications and education to ensure that older New Yorkers are aware of the benefits available to them, and are able to navigate those benefit programs
    - Identifying and closing existing gaps between programs
    - Streamlining programs where navigation is excessively challenging
- Workforce Protections and Training
    - This workgroup will focus on programs and protections to facilitate ongoing engagement in the workforce for older New Yorkers.
    - Legal protections against ageism

    - Workforce training
    - Education about training and ageism protection resources
    - Engagement with employers to develop formal programs for employing older New Yorkers

Long Term Services and Supports

- End of Life Care
    - Hospice, palliative care, and regulatory considerations
    - Specific charge to address for-profit hospice
- Levels of Care
    - Regulatory reforms to facilitate aging in place and ensuring the most integrated setting to meet need
- Person-Centered Navigation and Access
    - Equitable access to care settings
    - Prioritizing person-centered care that is inclusive, integrated and accessible, with an emphasis on dignity and autonomy
- Payor Structures
    - Incentives for quality and preventive care
- Care transitions
    - Ensuring access to better transitions within care settings
- Program of All Inclusive Care for the Elderly (PACE)
    - Addressing barriers to PACE enrollment
    - Addressing barriers to PACE licensure
- Equitable Facility Transformation
    - Modernizing facilities to fit changing needs of older adults

Home and Community-Based Services

- In-Home Services
    - Focused on strategies, services and supports to help people age in place in their homes, especially as activities of daily living become limited.
- In-Community Services
    - Focused on services and supports, including those offered by local Area Agencies on Aging (AAAs), that build community, break-down isolation and help older people thrive within their community via improved access or congregate settings.
- Critical Partnerships and Systems Building
    - Focused on how services can be better integrated within other "systems" and will probably be coordinated across the other Subcommittee workgroups that are discussing integration between Medicaid and HCBS.

Safety and Security

- Financial exploitation, scams
    - Prevention
    - Detection
    - Intervention
- Abuse (physical, sexual, neglect, psychological)
    - Awareness/communication
    - Identifying ways to gather data
- Guardianship/Alternatives to guardianship
    - Role of not-for-profits
    - Awareness
    - Legal structures and mechanisms
- Technology Development; and Access
    - Training
    - Social isolation
    - Design

Health and Wellness

- Promote and sustain physical and mental health, wellbeing and quality of life, including primary and secondary prevention and self-management of chronic disease
- Access to Medicare and Medicaid annual wellness and prevention benefits & communication to improve utilization
- Behavioral health and substance use disorders
- Cognitive health, Alzheimer's disease and other dementias
- Nutrition and food insecurity

INTERIM REPORT APPENDIX E

Subcommittee and Workgroup Rosters

Subcommittee 1: Long-Term Care Supports and Services (LTSS)

Subcommittee Lead and Co-lead

- Scott LaRue (ArchCare)
- Pastor George Nicholas (Lincoln Memorial UMC)
- Wade Norwood (Common Ground Health)

State Agency Council Representatives

- Shelly Aubertine-Fiebich (OCFS)
- Kimberly Hill (Office of the Chief Disability Officer)
- Karen Choens (OMH)
- Karen Walker (DOH)
- Katie Seaward (OASAS)
- Lisl Maloney (OCFS)

Stakeholder Advisory Committee Representatives

- Dr. Thomas Caprio (Geriatric Assessment Clinic at Monroe Community)
- Dan Savitt (VNS Health)
- Kathryn Haslanger (JASA)
- Stuart Kaplan (Selfhelp Community Services, Inc.)

Other Interested Parties

- Adria Powell (Cooperative Home Care Associates)
- Al Cardillo (NYS Home Care Association)
- Alene Hokenstad (1199SEIU)
- Alicia Pointer (Orange County)
- Amy Haskins (Wayne County)
- Andrea Deepe (Warren Washington Association for Mental Health Inc.)
- Andrew Cruikshank (Fort Hudson Health System)
- Ann Monroe (AARP New York)
- Ann Marie Cook (Lifespan Rochester)
- Ann Marie Selfridge (NYSADSA)
- Annette Horvath (Able Body)
- Ashley Waite(Lewis County)
- Brad Markowitz (Hospice of New York)
- Bryan O'Malley (Consumer Directed Personal Assistance Association of New York State)
- Carlos Martinez (Consumer Directed Personal Assistance Association of New York State)
- Carrie Roseamelia (DOH)

- Cheryl Kraus (HPCANYS)
- Christina Foster (HANYS)
- Cindy Lovetro (St. Ann's Community)
- Corinne Carey (Compassion & Choices New York)
- Cristopher Comfort (Calvary Hosp)
- Crystal Collette (NYSOFA)
- Dan Hiem (LeadingAge NY)
- Dan Lowenstein (VNS Health)
- Darius Kirstein (Leading Age New York)
- Dave Jordan (Office for Aging)
- Debi Buzanowski (Saint Peter's Health Partners)
- Diane Gotebiowski (Ever Homecare)
- Doug Hovey (Independent Living, Inc.)
- Dr. Carolyn McLaughlin (Albany Common Council President)
- Dr. Christopher Kerr (Hospice and Palliative Care Buffalo)
- Dr. Isabella Park (Northwell Health)
- Dr. Kevin Costello (Albany Med)
- Dr. Tara Liberman (Northwell Health)
- Eric Linzer (New York Health Plan Association)
- Eva Cohen (Hospice and Palliative Care Association of NYS (HPCANYS))
- Ginger Lynch Landy (Argentum)
- Heidi Schempp (Elderwood at North Creek)
- Ian Magerkurth (Welbe Health PACE)
- Ilana Berger (Hand in Hand)
- Jade Gong (Jade Gong & Associates)
- James Rosneman (Andrus on Hudson)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed A. Levine (CaringKind)
- Jeffrey Farber (New Jewish Home)
- Jill Graziano (Rochester Regional Health)
- Jim Kane (Empire State Association of Assisted Living)
- Joe Corwin (GYNHA)
- Joe Pecora (Home Healthcare Workers of America (HHWA))
- Kevin Christiano (Ashton Place Senior Living)
- Kara Travis (Mountain Valley Hospice)
- Karen Lipson (LeadingAge NY)
- Kendall Drexler (Chenango County Hospice and Palliative Care)
- Kendra Scalia (NY Carning Majority, Hand-in-Hand
- Karen Thornton (Empire State Association of Assisted Living)
- Kristin DeVries (NYSHFA|NYSCAL)
- Laura Ehrich (NYS Association of Health Care Providers - HCP)
- Laura Niland (policy arm of national hospice and palliative care organization)
- Linda K.P. Mertz (UAlbany School of Social Welfare and IAP)
- Linda Spokane (Hudson Headwaters)

- Lindsay Heckler (Center for Elder Law and Justice)
- Lisa Alteri (Capital Health Consulting)
- Lisa Betrus (Bassett Health Network)
- Lisa Newcomb (Empire State Association of Assisted Living)
- Lise-Anne Deoul (Sullivan County)
- Lucy Newman (OMH)
- Luke Tobler (NYS PACE alliance)
- Lynn Young (DOH)
- Marcella Goheen (Essential Care Visitor)
- Marie Rosenthal (Archcare at Terence Cardinal Cooke)
- Mary Gracey-White (Greater New York Health Care Facility Association)
- Mary McLaughlin (Adirondack Health Institute)
- Maxine Smalling (OMH)
- Meg Everett (Leading Age)
- Michael Gelman (Care Connect Mobile)
- Michael King (Jewish Senior Life)
- Michael Rosenblut (Parker Jewish Institute)
- Michele O'Connor (Argentum)
- Michelle Arnot (Gray Panthers NYC)
- Misty Boldt (NASW)
- Nancy Miller (Visions VCB)
- Nancy Speller (St Mary's Healthcare System for Children)
- Nikki Kmicinski (WNY Integrated Care Collaborative)
- Rachel Tart (Elderwood at North Creek)
- Rebecca LeBaron (Heritage Ministries)
- Rebecca Preve (AgingNY)
- Rhenda Campbell (Fort Hudson Home Care)
- Ricky Fortune (SUNY Albany)
- Roxanne G. Tena-Nelson (Greater New York Hospital Association)
- Ruben Medina (RC Solutions Inc.)
- Russell Lusak (Selfhelp Community Services Inc.)
- Shaun Ruskin (CenterLight Health System)
- Sally Dreslin (Step Two Policy Project)
- Sarah Ravenhall (NYS Association of County Health Officials- NYSACHO)
- Stephanie Button (PACE CNY)
- Stephen Hanse (NYSHFA|NYSCAL)
- Stuart Almer (Gurwin Jewish)
- Susan Hollander (OCFS)
- Suzanne Sullivan (SED)
- Tammy DeLorme (Washington County)
- Tara Liberman (Northwell Health and Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Health)
- Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
- Walter Kaltenbach (Always Home Care)

- Yuchi Young (University at Albany School of Public Health)

LTSS Workgroups

- Care Transitions & Navigation
    - Karen Choens (Office of Mental Health) **Chair**
    - Kim Hill (Office of the Chief Disability Officer)
    - Amy Haskins (Wayne County Department for the Aging)
    - Andrea Deepe (Warren Washington Association for Mental Health Inc.)
    - Christina Foster (HANYS)
    - Dan Savitt (VNS Health)
    - Ilana Berger (Hand in Hand)
    - Eva Cohen (Hospice and Palliative Care Association of NYS (HPCANYS))
    - Karen Thornton (Empire State Association of Assisted Living)
    - Marcella Goheen (Essential Care Visitor)
    - Mary McLaughlin (Adirondack Health Institute)
    - Bryan O'Malley (Consumer Directed Personal Assistance of New York State)
    - Rebecca Preve (AgingNY)
    - Rhenda Campbell (Fort Hudson Home Care)
    - Dr. Kevin Costello (Albany Medical Center)
    - Jeanne Chirico (Hospice and Palliative Care Association)
    - Dr. Thomas Caprio (Geriatric Assessment Clinic at Monroe Community)
    - Laura Ehrich (New York State Association of Health Care Providers)
    - Roxanne G. Tena-Nelson (Greater New York Hospital Association) **Chair**
    - Ruben Medina (RCSolutions, Inc)
    - Russell Lusak (Selfhelp Community Services Inc.)
- End of Life Care
    - Dr. Christopher Kerr (Hospice and Palliative Care Buffalo)
    - Dr. Kevin Costello (Geriatrics, Albany Medical Center)
    - Dr. Thomas Caprio (Geriatric Assessment Clinic at Monroe Community)
    - Jeanne Chirico (Hospice and Palliative Care Association) **Chair**
    - Cristopher Comfort (Calvary Hosp)
    - Dan Savitt (VNS Health)
    - Kara Travis (Mountain Valley Hospice)
    - Kendall Drexler (Chenango County Hospice and Palliative Care)
    - Laura Niland (National Hospice and Palliative Care Organization)
    - Mary Gracey-White (Greater New York Health Care Facility Assoc.)
- Equitable Facility Transformation
    - James Rosenman (Andrus on Hudson)
    - Lindsay Heckler (Center for Law and Justice)
    - Debi Buzanowski (St. Peter's Health Partners)
    - Michael King (Jewish Senior Life)
    - Stuart Almer (Gurwin Jewish) **Chair**
- Levels of Care
    - Lisl Maloney (Office of Children and Family Services)
    - Andrew Cruikshank (Fort Hudson Health System)

    - Ashley Waite (Lewis County Public Health Department)
    - Bryan O'Malley (Consumer Directed Personal Assistance of New York State)
    - Debi Buzanowski (Polaris Health)
    - Karen Lipson (LeadingAge NY) **Chair**
    - Kim Hill (Office of the Chief Disability Officer)
    - Amy Haskins (Wayne County Office for the Aging)
    - Andrea Deepe (Warren Washington Association for Mental Health Inc.)
    - Ginger Lynch Landy (Argentum)
    - Lisa Newcomb (Empire State Association of Assisted Living)
    - Roxanne G. Tena-Nelson (Greater New York Hospital Association)
    - Laura Ehrich (New York State Association of Health Care Providers)
    - Lise-Anne Deoul (Sullivan County Office for the Aging)
    - Nancy Speller (St Mary's Healthcare System for Children)
    - Tara Liberman (Northwell Health and Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Health)
    - Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
- Licensed Professionals
    - Carrie Roseamelia (Department of Health)
    - Crystal Collette (New York State Office for the Aging)
    - Lucy Newman (Office of Mental Health)
    - Lynn Young (Department of Health)
    - Maxine Smalling (Office of Mental Health)
    - Susan Hollander (Office of Children and Family Services)
    - Suzanne Sullivan (State Education Department)
    - Al Cardillo (Home Care Association)
    - Alene Hokenstad (1199SEIU)
    - Ann Marie Selfridge (New York State Adult Day Services Association)
    - Annette Horvath (Able Body)
    - Cindy Lovetro (St. Ann's Community)
    - Cristopher Comfort (Calvary Hospital)
    - Dan Lowenstein (VNS Health)
    - Diane Gotebiowski (Ever Homecare)
    - Dr. Tara Liberman (Northwell Health)
    - Karen Choens (Office of Mental Health)
    - Bryan O'Malley (Consumer Directed Personal Assistance of New York State)
    - Jeanne Chirico (Hospice and Palliative Care Association)
    - Kara Travis (Mountain Valley Hospice)
    - Kendall Drexler (Chenango County Hospice and Palliative Care)
    - Rhenda Campbell (Fort Hudson Home Care)
    - Joe Pecora (Home Healthcare Workers of America) **Chair**
    - Kathryn Haslanger (Center for Elder Law and Justice)
    - Linda Mertz (State University of New York, University at Albany)
    - Marie Rosenthal (Archcare at Terence Cardinal Cooke)
    - Michael Gelman (Care Connect Mobile)
    - Michele O'Connor (Argentum)
    - Misty Boldt (National Association of Social Workers)

    - Nancy Miller (Visions VCB)
    - Nikki Kmicinski (Western New York Integrated Care Collaborative)
    - Rebecca LeBaron (Heritage Ministries)
    - Ricky Fortune (State University of New York, University at Albany)
    - Sally Dreslin (Step Two Policy Project)
    - Stuart Kaplan (Selfhelp Community Services, Inc.)
- Program of All Inclusive Care for the Elderly (PACE)
    - Ian Magerkurth (Welbe Health PACE)
    - Jade Gong (Jade Gong & Associates)
    - Jill Graziano (Rochester Regional Health)
    - Linda Spokane (Hudson Headwaters)
    - Luke Tobler (New York State PACE Alliance) **Chair**
    - Scott LaRue (ArchCare)
    - Shaun Ruskin (CenterLight Health System)
    - Stephanie Button (PACE Central New York) **Chair**
- Payor Structures
    - Ann Monroe (AARP New York)
    - Dan Hiem (LeadingAge NY)
    - Darius Kirstein (Leading Age New York) **Chair**
    - Eric Linzer (New York Health Plan Association)
    - Ginger Lynch Landy (Argentum)
    - Jim Kane (Empire State Association of Assisted Living)
    - Joe Corwin (Greater New York Hospital Association)
    - Kristin DeVries (New York State Health Facilities Association| New York State Center for Assisted Living)
    - Lisa Betrus (Bassett Health Network)
    - Lisa Newcomb (Empire State Association of Assisted Living)
    - Meg Everett (Leading Age)
    - Michael Rosenblut (Parker Jewish Institute)
    - Stephen Hanse (New York State Health Facilities Association| New York State Center for Assisted Living)
    - Ilana Berger (Hand in Hand)
    - Tara Liberman (Northwell Health and Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Health)
    - Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
    - Bryan O'Malley (Consumer Directed Personal Assistance Association of New York State)

Subcommittee 2: Home and Community Based Services (HCBS)

Subcommittee Lead and Co-lead

- Kathryn Haslanger (JASA)
- Allison Nickerson (LiveOn)

State Agency Council Representatives

- Katie Seaward (OASAS)
- Kim Hill (Office of the Chief Disability Officer)
- Shirley Paul (Faith Based Initiatives, Governor's Office)
- Christopher Smith (OMH)
- Julie Hovey (OCFS/NYSCB)
- Nicole Haggerty (OMH)

Stakeholder Advisory Committee Representatives

- James O'Neal (AARP)
- Ann Marie Cook (Lifespan at Greater Rochester)
- Stuart Kaplan (Selfhelp Community Services, Inc.)
- Emma DeVito (Village Care)
- Nora OBrien-Suric (AARP)
- Timothy Seymour (Herkimer County Dept. of Social Services)

Other Interested Parties

- Alexandra Roth-Kahn (UJA-Federation of New York)
- Anderson Torres (RAIN Total Care)
- Ann Cunningham (Rochester Oasis)
- Ann Marie Selfridge (New York State Adult Day Services Association)
- Annette Horvath (Able Body Homecare Agency of NY, Inc.)
- Bill Ferris (AARP New York)
- Bob Blancato (Elder Justice Coalition)
- Bobbie Sackman (Caring Majority)
- Britt Burner (Burner Prudenti Law, P.C.)
- Bryan O'Malley (Consumer Directed Personal Assistance Association of New York State)
- Carol Deyoe, (NYS Association of Health Care Providers)
- Catherine James (NYS Coalition of Alzheimer's Association Central NY Chapter)
- Cheryl A. Kraus (Hospice and Palliative Care Association of NYS)
- Cynthia L. Cary Woods (Upstate Oasis)
- Daniella Labate Covelli (New York Association of Psychiatric Rehabilitation Services (NYAPRS))
- Denise Figueroa (Independent Living Center of the Hudson Valley)
- Dr. Carolyn McLaughlin (Albany Common Council President)
- Erica Tomlinson (Hamilton County)
- Ericka Reyes (Optimum Choice Services Inc.)
- Erika Flint (Health Workforce Collaborative)
- Francis Colon (The Jewish Board)
- Ginger Hall (Jefferson County)
- Ginger Lynch Landy (Argentum)
- Jackie Maclutsky (OCFS)

- Jennifer Michella (Upstate Oasis)
- Jennifer Schranz (Alzheimer's Association)
- Joanne Taylor (Senior Helpers Westchester)
- Jocelyn Groden (NYC Aging)
- Joe Pecora (Home Healthcare Workers of America (HHWA))
- Karen McGraw (Neighbors of Northern Columbia County)
- Kathleen Strack (Franklin County)
- Katie Seaward (OASAS)
- Lauren Wetterhahn (Inclusive Alliance IPA Inc)
- Lindsay Miller (New York Association on Independent Living)
- Loretta Zolkowski (Human Services Leadership Council)
- Lorraine Cortes-Vazquez (NYC Aging)
- Lois Celeste (Saratoga Senior Center)
- Lou Pierro (Pierro, Connor & Strauss)
- Lyndi Scott-Loines (Allegany County)
- Meg Everett (LeadingAge NY)
- Meghan Schobert (Parkview Health Services)
- Michele O'Connor (Argentum)
- Misty Boldt (NASW)
- MJ Okma (SAGE - Advocacy & Services for LGBTQ+ Elders)
- Nancy Harvey (Service Program for Older People)
- Nancy Speller (St Mary’s Healthcare System for Children)
- Nicholas Stella (Jzanus Home Care)
- Nikki Kmicinski (Western New York Integrated Care Collaborative)
- Pascale Leone (Supportive Housing Network of New York (SHNNY))
- Phil Di Sorbo (Saratoga Senior Center)
- Randy Klein (Vesta)
- Rebecca Heller (The Bridge)
- Rebecca Preve (AgingNY)
- Renee Christian (Home Care Advocate)
- Robbie Felton (Intus Care)
- Ruben Medina (RC Solutions Inc.)
- Sarah Ravenhall (NYS Association of County Health Officials- NYSACHO)
- Shelley Madore (Office of Chief Disability Officer)
- Sue Ruzenski (Helen Keller Services)
- Susan Hollander (OCFS)
- Susan Stamler (United Neighborhood Houses NY)
- Tammy Ryan (Community Home Healthcare)
- Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
- Vicky Hiffa (NYS Developmental Disabilities Planning Council)
- Walter Kaltenbach (Always Home Care)
- Yuchi Young (University at Albany School of Public Health)
- Steven Hornsby (The Jewish Board)

HCBS Workgroups

- Critical Partnerships & Systems Building
    - Carol Deyoe, (NYS Association of Health Care Providers)
    - Nora OBrien-Suric (Health Foundation for Western & Central New York)
    - Ann Marie Cook (LifeSpan of Greater Rochester)
    - Catherine James (NYS Coalition of Alzheimer's Association Chapters)
    - Denise Figueroa (Independent Living Center of the Hudson Valley)
    - Emma DeVito (Village Care)
    - Jean Chirico (Hospice & Palliative Care Association of New York State)
    - Lauren Wetterhahn (Inclusive Alliance IPA Inc)
    - Loretta Zolkowski (Human Services Leadership Council)
    - Phil Di Sorbo (Saratoga Senior Center)
    - Rebecca Heller (The Bridge)
    - Steven Hornsby (The Jewish Board)
    - Stuart Kaplan (Selfhelp Community Services)
    - Vicky Hiffa (Developmental Disabilities Planning Council)
    - Yvonne Ward (Glatt Health)
    - Christopher Smith (Office of Mental Health)
    - Kim Hill (Office of the Chief Disability Officer)
    - Cynthia L. Cary Woods (Syracuse Oasis)
    - Nancy Speller (St Mary's Healthcare System for Children)
    - Pascale Leone (Supportive Housing Network of New York (SHNNY) **Chair**
    - Tammy Ryan (Community Home Healthcare)
    - Timothy Seymour (Herkimer County Dept. of Social Services)
    - Karen Walker (Department of Health)
    - Anderson Torres (RAIN Total Care)
    - Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
    - Cheryl A. Kraus (Hospice and Palliative Care Association of NYS)
    - Nicholas Stella (Jzanus Home Care)
    - Rebecca Preve (AgingNY)
    - Robbie Felton (Intus)
    - Traci Allen (The Alliance of TBI & NHTD Waiver Providers)

- In-Community Services
    - Kim Hill (Office of the Chief Disability Officer)
    - Ann Cunningham (Rochester Oasis)
    - Bob Blancato (Elder Justice Coalition)
    - Cynthia L. Cary Woods (Syracuse Oasis)
    - Michele O'Connor (Argentum)
    - Misty Boldt (National Association of Social Workers)
    - Nancy Harvey (Service Program for Older People)
    - Julie Hovey (Office of Children & Family Services /NYS Commission for the Blind)
    - Ann Marie Cook (LifeSpan of Greater Rochester) **Chair**
    - Ann Marie Selfridge (New York State Adult Day Services Association)
    - Bill Ferris (AARP New York)

- Bobbie Sackman (Caring Majority)
- Catherine James (NYS Coalition of Alzheimer's Association Chapters)
- Denise Figueroa (Independent Living Center of the Hudson Valley)
- Emma DeVito (Village Care)
- Lauren Wetterhahn (Inclusive Alliance IPA Inc)
- Karen Walker (Department of Health)
- Lindsay Miller (New York Association on Independent Living)
- Lyndi Scott-Loines (Allegany County)
- Meg Everett (LendingAgeNY)
- Stuart Kaplan (Selfhelp Community Services)
- Tammy Ryan (Community Home Healthcare)

- In-Home Services
  - Julie Hovey (Office of Children & Family Services /NYS Commission for the Blind)
  - Karen Walker (Department of Health)
  - Nicole Haggerty (Office of Mental Health)
  - Anderson Torres (RAIN Total Care)
  - Ann Marie Selfridge (New York State Adult Day Services Association)
  - Bill Ferris (AARP New York)
  - Bobbie Sackman (Caring Majority)
  - Britt Burner (Burner Prudenti Law, P.C.)
  - Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
  - Carol Deyoe, (NYS Association of Health Care Providers) **Chair**
  - Cheryl A. Kraus (Hospice and Palliative Care Association of NYS)
  - Daniella Labate Covelli (New York Association of Psychiatric Rehabilitation Services (NYAPRS))
  - Francis Colon
  - Joanne Taylor (Senior Helpers Westchester)
  - Lindsay Miller (New York Association on Independent Living)
  - Lyndi Scott-Loines (Allegany County)
  - Meg Everett (LendingAgeNY)
  - Meghan Schobert (Parkview Health Services)
  - Nancy Speller (St Mary's Healthcare System for Children)
  - Nicholas Stella (Jzanus Home Care)
  - Pascale Leone (Supportive Housing Network of New York)
  - Rebecca Preve (AgingNY)
  - Robbie Felton (Intus)
  - Tammy Ryan (Community Home Healthcare)
  - Timothy Seymour (Herkimer County Dept. of Social Services)
  - Traci Allen (The Alliance of TBI & NHTD Waiver Providers)
  - Walter Kaltenbach (Always Home Care)
  - Yuchi Young (University at Albany School of Public Health)

Subcommittee 3: Informal Caregivers

Subcommittee Lead and Co-Lead

- James O'Neal (AARP)
- Linda James (Lifespan of Greater Rochester)

State Agency Council Representatives

- Christopher Smith (OMH)
- Kathryn Simpson (OMH)
- Julie Kelleher (OCFS)

Stakeholder Advisory Committee Representatives

- Stuart Kaplan (Selfhelp Community Services)
- Doris Green (New York State Caregiving & Respite Coalition)

Other Interested Parties

- Aaron Carlson (Hearts and Hands: Faith in Action, Inc.)
- Alexandra Drane (ARCHANGELS)
- Ann Marie Selfridge (NYS Adult Day Services Association)
- Bill Gustafson (Alzheimer Association)
- Carolina Hoyos (NYC Aging)
- Colette Phipps (Westchester County Dept. of Senior Programs and Services)
- David McNally (AARP New York)
- Debra Tackett (Clinton County)
- Drew Velting (Gray Panthers NYC)
- Elana Kieffer (The New York Academy of Medicine)
- Emily Hinsey (Grantmakers in Aging)
- Ira Copperman (Transplant Recipients International Organization)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed Levine (CaringKind)
- JulieAnn Calareso (Gleason, Dunn, Walsh & O'Shea)
- Katie Mahar (DOH)
- Kenneth M. Genewick (Health Foundation of Western and Central NY)
- Kim LaBarge (DOH)
- Lindsay Heckler (Center for Law and Justice)
- Liz Loewy (Eversafe)
- Lorraine Cortes-Vazquez (NYC Aging)
- Marcella Goheen (Essential Care Visitor)
- Meg Boyce (NYS Coalition of Alzheimer's Association- Hudson Valley Chapter)
- Michelle Stefanik (DOH)
- Rae Glaser (NYS Kinship Navigator)
- Rebecca Preve (AgingNY)

- Sarah Stephens Winnay (ARCHANGELS)
- Shelly Aubertine-Fiebich (OCFS)
- Rimas Jasin (Presbyterian Senior Services)
- Zach Becker (ESD Central)

Informal Caregivers Workgroups

- Caregiver Supports
    - Katie Mahar (Department of Health)
    - Kim LaBarge (Department of Health)
    - Michelle Stefanik (Department Of Health)
    - Julie Kelleher (Office of Children and Family Services)
    - Alexandra Drane (ARCHANGELS)
    - Ann Marie Selfridge (New York State Adult Day Services Association)
    - Doris Green (New York State Caregiving & Respite Coalition)
    - Drew Velting (Gray Panthers NYC)
    - Elana Kieffer (The New York Academy of Medicine)
    - James O'Neal (AARP New York)
    - Jed Levine (CaringKind)
    - JulieAnn Calareso (Gleason, Dunn, Walsh & O'Shea)
    - Rebecca Preve (Association on Aging in New York) **Chair**
    - Ken Genewick (Health Foundation of Western and Central NY)
    - Linda James (Lifespan of Greater Rochester)
    - Liz Loewy (Eversafe)
    - Marcella Goheen (Essential Care Visitor)
    - Meg Boyce (NYS Coalition of Alzheimer's Association Chapters)
    - Rimas Jasin (Presbyterian Senior Services)

- Communication Strategies
    - Kathryn Simpson (Office of Mental Health)
    - Colette Phipps (Westchester Dept. Senior Programs and Services)
    - Emily Hinsey (Grantmakers in Aging)
    - Ira Copperman (Transplant Support Organization)
    - Jeanne Chirico (Hospice and Palliative Care Association)
    - Karen DeBell (Office of Mental Health)
    - JulieAnn Calareso (Gleason, Dunn, Walsh & O'Shea)
    - James O'Neal (AARP New York)
    - Ken Genewick (Health Foundation of Western and Central NY)
    - Linda James (Lifespan of Greater Rochester)
    - Marcella Goheen (Essential Care Visitor)
    - Rimas Jasin (Presbyterian Senior Services)
    - Doris Green (New York State Caregiving & Respite Coalition) **Chair**

- Finances
    - Alexandra Drane (ARCHANGELS) **Chair**
    - Michael Roy (Department of Health)

    - Bill Gustafson (NYS Coalition of Alzheimer's Association Chapters)
    - David McNally (AARP New York)
    - Rebecca Preve (AgingNY)
    - Sarah Stephens Winnay (ARCHANGELS) **Chair**
    - Stuart Kaplan (Selfhelp Community Services)
    - Michelle Stefanik (Department Of Health)
    - Ann Marie Selfridge (New York State Adult Day Services Association)
    - Doris Green (New York State Caregiving & Respite Coalition)
    - Liz Loewy (Eversafe)

- Kinship Caregivers
    - Karen DeBell (Office of Mental Health)
    - Shelly Aubertine-Fiebich (Office of Children and Family Services)
    - Carol McCarthy (Office of Children and Family Services)
    - Randi Kowalski (Office of Children and Family Services)
    - Debra Tackett (Clinton County Health Department)
    - Drew Velting (Gray Panthers NYC)
    - Jessica Marie Canale (Cornell Cooperative Extension, Dutchess County)
    - Laura Weaver (Catholic Charities Family and Community Services)
    - James O'Neal (AARP New York)
    - Linda James (Lifespan of Greater Rochester)
    - Rae Glaser (NYS Kinship Navigator) **Chair**
    - Doris Green (New York State Caregiving & Respite Coalition) **Chair**

Subcommittee 4: Formal Caregivers

Subcommittee Lead and Co-lead

- Helen Schaub (1199/SEIU)
- Dennis Short (1199/SEIU)
- Dan Savitt (VNS Health)

State Agency Council Representatives

- Tom Brooks (OCFS)
- Barbara Guinn (OTDA)
- Lucy Newman (OMH)
- Rachel Baker (OPWDD)

Stakeholder Advisory Committee Representatives

- Pastor George Nicholas (Lincoln Memorial UMC)
- Doris Green (New York State Caregiving & Respite Coalition)
- Stuart Kaplan (Selfhelp Community Services)

Other Interested Parties

- Adria Powell (Cooperative Home Care Associates)
- Al Cardillo (Home Care Association)
- Alexandra Drane (Archangels)
- Alyssa Herman (New Jewish Home)
- Amanda Waite (Fort Hudson Health System)
- Andrea Thomas (Home Care at Sunnyside Community Services)
- Ann Marie Selfridge (New York State Adult Day Services Association)
- Ann Mary Ferrie (VNS)
- Anthony Lareau (OCFS)
- Bobbie Sackman (Caring Majority)
- Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS)
- Carlos Z. Martinez (Consumer Directed Personal Assistance Association of NYS)
- Carolina Hoyos (NYC Aging)
- Colleen Rose (Rochester Regional Health)
- Courtney Burke (Rockefeller Institute)
- David McNally (AARP New York)
- Dana Politis (Department of Labor (DOL)
- Diane Darbyshire (LeadingAge New York)
- Emily Hinsey (Grantmakers in Aging)
- Erica Salamida (NYS Coalition of Alzheimer's Association Chapters)
- Ginger Lynch Landy (Argentum)
- Ilana Berger (Hand in Hand)
- Jeanne Chirico (Hospice and Palliative Care Association of NYS)
- Jed Levine (CaringKind)
- Jodi M. Sturgeon (Paraprofessional Healthcare Institute)
- Joe Pecora (Home Healthcare Workers of America (HHWA))
- John Reilly (Northwell Health)
- Julie Kelleher (OCFS)
- Kathy Febraio, (President and CEO, NYS Association of Health Care Providers
- Kevin Howell (The Anchor Group)
- Len Statham (New York Association of Psychiatric Rehabilitation Services (NYAPRS))
- Lisa Alteri (Capital Health Consulting)
- Liz Loewy (Eversafe)
- Lori Frank (The New York Academy of Medicine)
- Laurie Thomson (Department of Labor (DOL)
- Marcella Goheen (Essential Care Visitor)
- Michele O'Connor (Argentum)
- Monique Hodges (Baltic Street AEH)
- Nancy Miller (New York Vision Rehabilitation Association)
- Rebecca LeBaron (Heritage Ministries)
- Rebecca Preve (AgingNY)
- Renee Christian (Home Care Advocate)

- Richard Marchese (Woods, Oviatt, Gilman LLP)
- Robert Gibson (Department of Family Services)
- Walter Kaltenbach (Always Home Care)

Formal Caregivers Workgroups

- Recruitment and Training
    - Carol Rodat (Department of Health)
    - Dana Politis (Department of Labor)
    - Elizabeth Furth (Department of Labor)
    - Laurie Thomson (Department Of Labor)
    - Lucy Newman (Office of Mental Health)
    - Tom Brooks (Office of Children and Family Services)
    - Alyssa Herman (New Jewish Home)
    - Bill Gustafson (NYS Coalition of Alzheimer's Association Chapters)
    - Courtney Burke (Rockefeller Institue)
    - David McNally (AARP New York)
    - Doris Green (NYS Caregiving and Respite Coalition)
    - Ginger Lynch Landy (Argentum)
    - Liz Loewy (Eversafe)
    - Rebecca LeBaron (Heritage Ministries)
    - Stuart Kaplan (Selfhelp Community Services)
    - Kathy Febraio (NYS Association of Health Care Providers) **Chair**
    - Diane Darbyshire (Leading Age)

- Retention, Compensation and Benefits
    - Robert Gibson (Department of Family Services)
    - Al Cardillo (Home Care Association)
    - Alexandra Drane (Archangels)
    - Andrea Thomas (Home Care at Sunnyside Services)
    - Ann Mary Ferrie (VNS Health)
    - Bobbie Sackman (Caring Majority)
    - Bryan O'Malley (Consumer Directed Personal Assistance Association of NYS - CDPAANYS)
    - Colleen Rose (Rochester Regional Health)
    - Diane Darbyshire (Leading Age)
    - Ilana Berger (Hand in Hand)
    - Jed Levine (Caring Kind)
    - Kathy Febraio (NYS Association of Health Care Providers)
    - Lisa Alteri (Capital Health Consulting)
    - Lori Frank (NY Academy of Medicine)
    - Lorraine Cortes-Vazquez (NYC Aging)
    - Rebecca Preve (Aging NY)
    - Renee Christian (Home Care Advocate)
    - Diane Darbyshire (Leading Age) **Chair**
    - Carol Rodat (Department of Health)

- Scope of Practice
    - Julie Kelleher (OCFS)
    - Amanda Waite (Fort Hudson Health System)
    - Erica Salamida (NYS Coalition of Alzheimer's Association Chapters)
    - (Pastor) George Nicholas (Lincoln Memorial United Methodist Church)
    - Nancy Miller (NY Vision Rehabilitation Association)
    - Richard Marchese (Woods and Oviatt)
    - Jodi Sturgeon (PHI) **Chair**
    - Carol Rodat (Department of Health)
    - Stuart Kaplan (Selfhelp Community Services)

Subcommittee 5: Health and Wellness

Subcommittee Lead and Co-lead

- Dr. Linda Fried (Columbia University Mailman School of Public Health)
- Dr. Jo Ivey Boufford (NYU School of Global Public Health)

State Agency Council Representatives

- Patricia Zuber Wilson (OASAS)
- Maureen Spence (DOH/OPH)
- Alexis Arnett (OCFS)
- John Hartigan (DOH/AI)
- Katie Seaward (OASAS)
- Audrey Erazo-Trivino (OMH)

Stakeholder Advisory Committee Representatives

- Linda James (Lifespan of Greater Rochester)
- Kathryn Haslanger (Jewish Association Serving the Aging (JASA))
- Nora OBrien-Suric (Health Foundation for Western and Central New York)
- Timothy Seymour (Herkimer County Dept. of Social Services)
- Lora Lee La France (St. Regis Mohawk Office for the Aging)
- Pastor George Nicholas (Lincoln Memorial UMC)
- Allison Nickerson (LiveOn NY)

Other Interested Parties

- Adesuwa Watson (Suffolk County)
- Al Cardillo (HCA)
- Andres Vives (Hunger Solutions)
- Ann Cunningham (Rochester Oasis)

- April Feld (Stony Book Medicine)
- Beth Finkel (AARP New York)
- Beth Shapiro (Citymeals on Wheels)
- Bethany Munn (Jefferson County)
- Bill Gustafson (NYS Coalition of Alz. Association Chapters)
- Brittany Gambini (Stony Book Medicine)
- Camille Hoheb (DOH)
- Carlos Martinez (Bridges)
- Carol Basford (St. Lawrence County Public Health Dept.)
- Dr. Carolyn McLaughlin (Albany Common Council President)
- Chris Maylahn (DOH/OPH)
- Claire Proffitt (Schenectady County)
- Cynthia L. Cary Woods (Upstate Oasis)
- Damali Wynter (NYS Dept. Agriculture and Markets) designee
- Dan Egan (Feeding NYS)
- Daniel Chen (Jamaica Hospital/Flushing Hospital)
- David Hoffman (University at Albany School of Public Health)
- Debbie Pantin (Outreach)
- Diane Devlin (Wayne County)
- Drew Velting (Gray Panthers NYC)
- Elizabeth Galle (Columbia County)
- Elizabeth Walen (Albany County)
- Elizabeth Watson (Schuyler County)
- Emerson Ea (NYU)
- Emily Franzosa (Bronx VA)
- Fern Finkle (Elder Law and Special Needs Section, New York State Bar Association)
- Francine Lombardi (DOH)
- Fred Riccardi (Medicare Rights Center)
- Glenn Liebman (Mental Health Association in New York State)
- Hailee Gilmore (DOH/OHEHR)
- Harvey Rosenthal (New York Association of Psychiatric Rehabilitation Services)
- Heather Warner (Delaware County)
- Heidi Bond (Otsego County)
- Ilyssa Meyer (ZocDoc)
- Ingrid Werge (OASAS)
- Ira Frankel (Jamaica Hospital/Flushing Hospital)
- Dr. Irina Gelman (Nassau Co)
- Jackie Berman (NYC DFTA/NYC Aging)
- Jason Stowell (Jewish Community Center of Greater Buffalo)
- Jeanette Estima (Citymeals on Wheels)
- Jennifer Michella (Upstate Oasis)
- Jeremy Powers (Adirondacks ACO)
- Jo-Ann Yoo (Asian American Federation)
- Joe Pecora (Home Healthcare Workers of America (HHWA))

- John Coppola (New York Association of Alcoholism and Substance Abuse Providers, Inc.)
- Jolene Munger (St. Lawrence County)
- Dr. John Reilly
- Dr. Joshua Chodosh (New York University)
- Dr. Judith A. Salerno (New York Academy of Medicine)
- Dr. Robert Wahler (University at Buffalo, State University of New York)
- Karen DeBell (Division of Adult Services OMH)
- Kari Johnson (50 Forward Mohawk Valley)
- Kelly Ann Anderson (DOH)
- Krista Hesdorfer (Hunger Solutions New York)
- Kristi Lyn Ladowski (Stony Book Medicine)
- Lacey Trimble (DMH Orange County)
- Laura Churchill (Greene County)
- Lisa Alteri (Capital Health Consulting)
- Lisa Camp (Saratoga Regional YMCA)
- Lisa Graf (Wayne County Dept. of Social Services)
- Livia Santiago-Rosado (Dutchess County)
- Lori Frank (The New York Academy of Medicine)
- Lorraine Cortes-Vazquez (NYC Aging)
- Luke Sikinyi (NY Association of Psychiatric and Rehabilitation Services Inc.)
- Lynn Young (DOH)
- Marcella Goheen (Essential Care Visitor)
- Dr. Maria T. Carney (Hofstra University/Northwell Health)
- Maria Mahar (Onondaga County)
- Mark Meridy (Generations- DOROT)
- Martha Petteys (Alliance of NYS YMCAs)
- Dr. Martha Sullivan (Citywide Behavioral Health Coalition for Black Elders Inc.)
- Martin Cahill (VP Westchester Council of the Blind)
- Mary Moller (Albany Guardian Society)
- Meghan Shineman (NYC Aging)
- Maryfran Wachunas (Rensselaer County)
- Maureen Henry (Columbia University Medical Center)
- Michelle Barber (New York State Academy of Nutrition and Dietetics)
- MJ Okma (SAGE - Advocacy & Services for LGBTQ+ Elders)
- Nancy Dingee (Schoharie County)
- Nancy Hahn (Suffolk County)
- Nancy Harvey (Service Program for Older People)
- Nancy Miller (New York Vision Rehabilitation Association)
- Natasha Pernicka (The Food Pantries for the Captial District)
- Norman Reiss
- Patricia Yang (NYC Health and Hospitals)
- Patty Simonson (Jewish Community Center of Greater Buffalo)
- Peter Buzzetti (Chemung County)

- Rebecca Preve (AgingNY)
- Renee Fillette (Dutchess Outreach)
- Richard Ball (NYS Dept. of Agriculture and Markets)
- Samara Daly (DalyGonzalez)
- Sarah Cohen (Stony Book Medicine)
- Sarah Ravenhall (New York State Association of County Health Officials (NYSACHO))
- Sarah Sanchala (NYC Aging)
- Sebrina Barret (ACL)
- Dr. Sherlita Amler(Westchester County)
- Susan Lee (Stony Book Medicine)
- Susan Medina (Tioga County)
- Suzanne Fields (Stony Book Medicine)
- Dr. Thalia Porteny (Columbia School of Public Health)
- Tammy Ryan (Community Healthcare)
- Tina McDougall (Washington County)
- Tobi Abramson (Geriatric Mental Health NYC DFTA/NYC Aging)
- Tracy Sinnott (DOH)
- Vicky Hiffa (NYS Developmental Disabilities Planning Council)

Health and Wellness Workgroups

- Nutrition and Food Insecurity
    - Alexis Arnett (Office of Children and Family Services)
    - Damali Wynter (New York State Agriculture and Markets)
    - Hailee Gilmore (Department of Health/Office of Health Equity and Human Rights)
    - Adesuwa Watson (Suffolk County Department of Health Services)
    - Andres Vives (Hunger Solutions)
    - Bethany Munn (Jefferson County Office for the Aging)
    - Claire Proffitt (Schenectady County Public Health Department) **Chair**
    - Dan Egan (Feeding New York State)
    - Diane Devlin (Wayne County Public Health Department)
    - Dr. Irina Gelman (Nassau County Health Department)
    - Elizabeth Watson (Schuyler County Public Health Department)
    - Jeanette Estima (Citymeals on Wheels)
    - Krista Hesdorfer (Hunger Solutions New York)
    - Linda James (Lifespan of Greater Rochester)
    - Lora Lee La France (St. Regis Mohawk Office for the Aging)
    - Maria Mahar (Onondaga County Department of Mental Health) **Chair**
    - Michelle Barber (New York State Academy of Nutrition and Dietetics)
    - MJ Okma (SAGE USA)
    - Natasha Pernicka (The Food Pantries for the Captial District)
    - Peter Buzzetti (Chemung County Public Health Department)
    - Rebecca Preve (AgingNY)
    - Kelly Ann Anderson (Department of Health)

- Promote & Sustain Physical and Mental Health, Wellbeing and Quality of Life
    - Audrey Erazo-Trivino (Office of Mental Health)
    - Brittany Gambini (Stony Brook Medicine)
    - Camille Hoheb (Department of Health)
    - Francine Lombardi (Department of Health)
    - John Hartigan (Department of Health)
    - Maureen Spence (Department of Health/Office of Public Health)
    - Allison Nickerson (LiveOn)
    - Ann Cunningham (Rochester Oasis)
    - Carlos Martinez (Consumer Directed Personal Assistance of New York State)
    - Cynthia L. Cary Woods (Syracuse Oasis)
    - Dr. Linda Fried (Columbia University) **Chair**
    - Dr. Robert Wahler (State University of New York, University at Buffalo)
    - Drew Velting (Gray Panthers NYC)
    - Dr. Sherlita Amler (Westchester County Health Department)
    - Fern Finkle (Elder Law and Special Needs Section, New York State Bar Association)
    - Heather Warner (Delaware County Public Health Department)
    - Jackie Berman (New York City Department for the Aging)
    - Jeremy Powers (Adirondacks ACO)
    - Jo-Ann Yoo (Asian American Federation)
    - Jolene Munger (St. Lawrence County Public Health Department)
    - Kari Johnson (50 Forward Mohawk Valley)
    - Kelly Ann Anderson (Department of Health) **Chair**
    - Kristi Lyn Ladowski (Stony Book Medicine)
    - Laura Churchill (Greene County Public Health Department)
    - Lisa Alteri (Capital Health Consulting)
    - Lisa Camp (Saratoga Regional YMCA)
    - Livia Santiago-Rosado (Dutchess County Health Department)
    - Lorraine Cortes-Vazquez (New York City Department for the Aging)
    - Mark Meridy (DOROT)
    - Martha Petteys (Alliance of New York State YMCAs)
    - Martha Sullivan (Citywide Behavioral Health Coalition for Black Elders Inc.)
    - Maryfran Wachunas (Rensselaer County Public Health Department)
    - Maureen Henry (Columbia University Medical Center)
    - Nancy Miller (New York Vision Rehabilitation Association)
    - Norman Reiss
    - Pastor George Nicholas (Lincoln Memorial UMC)
    - Patricia Yang (New York City Health and Hospitals)
    - Samara Daly (DalyGonzalez)
    - Sarah Cohen (Stoney Brook Medicine)
    - Susan Medina (Tioga County Public Health Department)
    - Timothy Seymour (Herkimer County Department of Social Services)
    - Tina McDougall (Washington County Public Health Department)

- Dr. John Reilly (Northwell Health)
- Meghan Shineman (New York City Department for the Aging)
- MJ Okma (SAGE)

- Access to Medicare & Medicaid Benefits
  - Al Cardillo (Home Care Association)
  - April Field (Stony Brook Medicine)
  - Beth Finkel (AARP New York) **Chair**
  - Beth Shapiro (Citymeals on Wheels)
  - Elizabeth Galle (Columbia County Public Health Department)
  - Emerson Ea (New York University)
  - Emily Franzosa (Bronx VA)
  - Fred Riccardi (Medicare Rights Center)
  - Ilyssa Meyer (ZocDoc)
  - Ira Frankel (Jamaica Hospital/Flushing Hospital)
  - Kathryn Haslanger (Jewish Association Serving the Aging)
  - Lisa Graf (Wayne County Department of Social Services)
  - Mary Moller (Albany Guardian Society)
  - Nancy Dingee (Schoharie County Office for the Aging)
  - Nora OBrien-Suric (Health Foundations of Western and Central New York) **Chair**
  - Dr. Maria Carney (Hofstra University/Northwell Health)
  - Jeremy Powers (Adirondacks ACO)
  - Meghan Shineman (New York City Department for the Aging)
  - Susan Lee (Stony Brook Medicine)
  - Suzanne Fields (Stony Brook Medicine)

- Cognitive Health
  - Lynn Young (Department of Health)
  - Tracy Sinnott (Department of Health)
  - Bill Gustafson (New York State Coalition of Alz. Association Chapters)
  - Daniel Chen (Jamaica Hospital/Flushing Hospital)
  - David Hoffman (State University of New York, University at Albany)
  - Dr. Josh Chodosh (New York University)
  - Dr. Judith Salerno (New York Academy of Medicine)
  - Dr. Maria Carney (Hofstra University/Northwell Health) **Chair**
  - Dr. Thalia Porteny (Columbia University)
  - Glenn Liebman (Mental Health Association of New York State)
  - Jennifer Michella (Syracuse Oasis)
  - Lori Frank (The New York Academy of Medicine) **Chair**
  - Marcella Goheen (Essential Care Visitor)
  - Vicky Hiffa (New York State Developmental Disabilities Planning Council)
  - Lora Lee La France (St. Regis Mohawk Office for the Aging)
  - Nancy Hahn (Suffolk County Public Health Department)
  - Tina McDougall (Washington County Public Health Department)

- Mental Health & Substance Use Disorders
    - Drew Velting (Gray Panthers NYC)
    - Ingrid Werge (Office of Alcohol and Substance Abuse Services)
    - Karen DeBell (Division of Adult Services Office of Mental Health)
    - Katie Seaward (Office of Alcohol and Substance Abuse Services)
    - Patricia Zuber Wilson (Office of Alcohol and Substance Abuse Services)
    - Debbie Pantin (Outreach)
    - Dr. John Reilly (Northwell Health)
    - Heidi Bond (Otsego County Public Health Department)
    - John Coppola (New York Associates Alcoholism) **Chair**
    - Lacey Trimble (Orange County Department of Mental Health) **Chair**
    - Luke Sikinyi (New York Association of Psychiatric and Rehabilitation Services Inc.)
    - Meghan Shineman (New York City Department of Aging)
    - Nancy Hahn (Suffolk County Public Health Department)
    - Nancy Harvey (Service Program for Older People)
    - Sebrina Barret (Administration for Community Living)
    - Tobi Abramson (New York City Department for the Aging, Geriatric Mental Health)
    - Alexis Arnett (Office of Children and Family Services)
    - Adesuwa Watson (Suffolk County Department of Health Services)

Subcommittee 6: Housing, Community Development and Transportation

Subcommittee Lead and Co-lead

- Stuart Kaplan (Selfhelp Community Services)
- Imran Cronk (Ride Health)

State Agency Council Representatives

- Brett Hebner (HCR)
- Janet Ho (DOT)
- Noah Rayman (ESD)
- Paul Beyer (DOS)
- Julie Kelleher (OCFS)
- Mary Ellen Brown (OMH)
- Julie Duncan (OMH)
- Shelly Aubertine-Fiebich (OCFS)
- Ross Farrell (DOT)

Stakeholder Advisory Committee Representatives

- Kathryn Haslanger (JASA)
- Wade Norwood (Common Ground Health)

- Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)
- Allison Nickerson (LiveOn)
- Jessica Bacher (Pace University)

Other Interested Parties

- Aaron Carlson (Hearts and Hands)
- Andrea Harris (Fern Transportation)
- Andrea Montgomery (St. Lawrence County)
- Ann McHugh (The Jewish Board of Family and Children's Services (JBFCS))
- Annalyse Komoroske Denio (LeadingAge)
- Barry Kaufmann (NYS Alliance for Retired Americans)
- Belinda Hoad (NYS Mobility Managers Association)
- Bob Zerrillo (NYS Public Transit Association)
- Bridget McBrien (The Jewish Board)
- Cara Longworth (ESD-Long Island)
- Carrie Ward (Capital Region Transportation Council)
- Chris Maylahn (DOH/OPH)
- Chris Pangilinan (NYC Transit)
- Courtenay Loiselle (HCR)
- Darby Nagpaul (Sullivan Co DOH)
- David Hoglund (Perkins Eastman)
- Doris Carbonell-Medina (LISC)
- Doug Hovey (Independent Living, Inc.)
- Elana Kieffer (The New York Academy of Medicine)
- Eric Alexander (Vision Long Island)
- Erika Sherwood (Hearts and Hands)
- Ginger Lynch Landy (Argentum)
- Hannah Weiss (Corporation for Supportive Housing)
- Holly Rhode-Teague (Suffolk County)
- Jackie Maclutsky (OCFS)
- Jennifer Rodriguez (Livingston County)
- Jessica Bacher
- Jessica Mathew (MTA)
- Jill Peckenpaugh (US Committee for Refugees and Committees Albany)
- Jo-Ann Yoo (Asian American Federation)
- Jordana L. Maisel (University at Buffalo, State University of New York)
- Kathleen Farrell Strack (Franklin County)
- Laura Haynes (DOT)
- Linda Hoffman (New York Foundation for Senior Citizens)
- Linda Redlisky (Rafferty & Redlisky, LLP)
- Lindsay Miller (New York Association on Independent Living)
- Maclain Berhaupt (DOH)
- Margo Downey (Niagara Frontier Transportation Authority)

- Marc Jahr (Forsyth Street Advisors)
- Mark Castiglione (Capital District Regional Planning Commission)
- Mark Fuller (DePaul)
- Mark Streb (NYS Neighborhood Preservation Coalition)
- Martin Cahill (VP Westchester Council of the Blind)
- Michael Seereiter (Alliance for Inclusion and Innovation)
- Michele O'Connor (Argentum)
- Nancy Williams-Frank (Broome County)
- Nate Storring (Project for Public Spaces)
- Patricia Hernandez (The Corporation for Supportive Housing (CSH))
- Randy Klein (Vesta Health Care)
- Robyn Haberman (AARP New York)
- Ron Roel (AARP New York)
- Sarah Ravenhall (NYS Association of County Health Officials- NYSACHO)
- Sasha Yerkovich (Canopy of Neighbors)
- Sebrina Barret (ACL)
- Steve Piasecki (Supportive Housing Network of New York (SHNNY))
- Vicki Been (New York University School of Law)
- William P. McDonald (AARP)

Housing, Community Design, and Transportation Workgroups

- Community Planning
    - Shelly Aubertine-Fiebich (Office of Children and Family Services)
    - Julie Kelleher (Office of Children and Family Services)
    - Jessica Mathew (Metropolitan Transportation Authority)
    - Mary Ellen Brown (Office of Mental Health)
    - Noah Rayman (Empire State Development)
    - Darby Nagpaul (Sullivan County)
    - Elana Kieffer (New York Academy of Medicine)
    - Holly Rhode-Teague (Suffolk County)
    - Jo-Ann Yoo (Asian American Federation)
    - Linda Hoffman (New York Foundation for Senior Citizens)
    - Lindsay Miller (New York Association on Independent Living)
    - Mandy Walsh (Delaware County)
    - Nate Storring (Project for Public Spaces)
    - Ron Roel (AARP New York)
    - Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)
    - Sasha Yerkovich (Canopy of Neighbors)
    - Paul Beyer (Department of State) Chair
    - Julie Duncan (Office of Mental Health)
    - Annalyse Komoroske Denio (LeadingAge)
    - Ann McHugh (The Jewish Board of Family and Children’s Services (JBFCS)
    - Doug Hovey (Independent Living)
    - Eric Alexander (Vision Long Island)

- Mark Castiglione (Capital District Regional Planning Commission)
- Michael Seereiter (Alliance for Inclusion and Innovation)
- Robyn Haberman (AARP New York)
- Sebrina Barret (Association of Community Living)
- Stuart Kaplan (Selfhelp Community Services) **Chair**

- Housing
  - Maclain Berhaupt (Department of Health)
  - Brett Hebner (Home and Community Renewal)
  - Courtenay Loiselle (Home and Community Renewal)
  - Jackie Maclutsky (Office of Children and Family Services)
  - Julie Duncan (Office of Mental Health)
  - Cara Longworth (Empire State Development- Long Island)
  - Annalyse Komoroske Denio (LeadingAge)
  - Ann McHugh (The Jewish Board of Family and Children's Services (JBFCS)
  - Barry Kaufmann (NYS Alliance for Retired Americans)
  - Bridget McBrien (The Jewish Board of Family and Children's Services (JBFCS)
  - David Hoglund (Perkins Eastman)
  - Doug Hovey (Independent Living)
  - Eric Alexander (Vision Long Island)
  - Hannah Weiss (Corporation for Supportive Housing)
  - Jessica Bacher (Pace University)
  - Kathryn Haslanger (Jewish Association Serving the Aging)
  - Linda Redlisky (Rafferty & Redlisky, LLP)
  - Marc Jahr (Forsyth Street Advisors)
  - Mark Castiglione (Capital District Regional Planning Commission)
  - Mark Streb (NYS Neighborhood Preservation Coalition)
  - Michael Seereiter (Alliance for Inclusion and Innovation)
  - Patricia Hernandez (The Corporation for Supportive Housing)
  - Rebecca Heller (The Bridge NY)
  - Robyn Haberman (AARP New York)
  - Sebrina Barret (Association of Community Living)
  - Steve Piasecki (Supportive Housing Network of New York)
  - Stuart Kaplan (Selfhelp Community Services)
  - Vicki Been(New York University School of Law) **Chair**

- Transportation
  - Janet Ho (Department of Transportation)
  - Ross Farrell (Department of Transportation)
  - Laura Haynes (Department of Transportation)
  - Paul Beyer (Department of State)
  - Chris Pangilinan (Metropolitan Transportation Authority)
  - Aaron Carlson (Hearts and Hands)
  - Andrea Harris (Fern Transportation)
  - Andrea Montgomery (St. Lawrence County)
  - Belinda Hoad (NYS Mobility Managers Association)

- Bob Zerrillo (NYS Public Transit Association)
- Carrie Ward (Capital Region Transportation Council)
- Jordana L. Maisel (University at Buffalo, State University of New York)
- Kathleen Farrell Strack (Franklin County)
- Laura Haynes (Department of Transportation)
- Margo Downey(Niagara Frontier Transportation Authority)
- William P. McDonald (AARP)
- Imran Cronk (Ride Health) Chair
- Eric Alexander (Vision Long Island)
- Jessica Mathew (Metropolitan Transportation Authority)
- Barry Kaufmann (NYS Alliance for Retired Americans)
- Darby Nagpaul (Sullivan County)
- Holly Rhode-Teague (Suffolk County)
- Lindsay Miller (New York Association on Independent Living)
- Doris Carbonell-Medina (LISC)
- Erika Sherwood (Hearts and Hands)

Subcommittee 7: Economic Security

Subcommittee Lead and Co-lead

- Courtney Burke (Rockefeller Institute)
- Stephen Berger (Odyssey Partners)

State Agency Council Representatives

- Allison Gold (DFS)
- Barbara Guinn (OTDA)
- Elizabeth Furth (DOL)
- Jillian Kirby (DOB)
- Benjamin Pomerance (DVS)
- Andy Sink (OMH)
- Katie Seaward (OASAS)
- Audrey Erazo-Trivino (OMH)
- Rachel Ingalsbe (NYS Tax and Finance)

Stakeholder Advisory Committee Representatives

- Dennis Rivera (MRT)
- Dr. Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)
- Karen Nicolson (Center for Elder Law and Justice)

Other Interested Parties

- Allison Cook (Better Aging and Policy Consulting)
- Amanda Lothrop (DOH)
- Anita Mattison (Allegany County)
- Barry Kaufmann (NYS Alliance for Retired Americans)
- Christian Gonzalez-Rivera (Hunter College)
- Colette Phipps (Westchester County Dept. of Senior Programs and Services)
- Denise Shukoff (Lifespan Rochester)
- Diana Caba (Hispanic Federation)
- Dr. Oxiris Barbot (United Hospital Fund)
- Erin Killian (Elder Justice NY)
- Fred Riccardi (Medicare Rights Center)
- Ginger Lynch Landy (Argentum)
- Heidi Pasos (ESD Capital District)
- June Hanrahan (Oneida County)
- Kristen McManus (AARP New York)
- Liz Loewy (Eversafe)
- Maria Alvarez (NY Statewide Senior Action Council)
- Mark Castiglione (Capital District Regional Planning Commission)
- Michele O'Connor (Argentum)
- Nancy Dingee (Schoharie County)
- Richard Gottfried (Former NYS Assembly Health Chair)
- Shannon Tucker (DFS)
- Tara Anne Pleat (Wilenski Pleat Law)
- Valerie Bogart (NY Legal Assistance Group)

Economic Security Workgroups

- Workforce Engagement, Protections and Training
  - Andy Sink (Office of Mental Health)
  - Katie Seaward (Office of Addiction Services and Supports)
  - Elizabeth Furth (Department of Labor)
  - Christian Gonzalez-Rivera (Hunter College)
  - Dr. Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)
  - Erin Killian (Elder Justice NY)
  - Karen Nicolson (Center for Elder Law and Justice) **Chair**

- Retirement
  - Benjamin Pomerance (Department of Victim Services)
  - Shannon Tucker (Department of Financial Services)
  - Allison Cook (Better Aging and Policy Consulting)
  - Colette Phipps (Westchester Dept. Senior Programs and Services)

    - Dr. Oxiris Barbot (United Hospital Fund)
    - Ginger Lynch Landy (Argentum)
    - Kristen McManus (AARP New York)
    - Mark Castiglione (Capital District Regional Planning Commission)
    - Michele O'Connor (Argentum)
    - Nancy Dingee (Schoharie County)
    - Courtney Burke (Rockefeller Institute) **Chair**
    - Tara Anne Pleat (Wilenski Pleat Law)
    - Stephen Berger (Odyssey Partners)

- Benefit Programs
    - Amanda Lothrop (Department of Health)
    - Audrey Erazo-Trivino (Office of Mental Health)
    - Barbara Guinn (Office of Temporary and Disability Assistance)
    - Denise Shukoff (Lifespan Rochester)
    - Fred Riccardi (Medicare Rights Center) Chair
    - Maria Alvarez (NY Statewide Senior Action Council)
    - Richard Gottfried (Former NYS Assembly Health Chair)
    - Valerie Bogart (New York Legal Assistance Group)
    - Dennis Rivera (Medicaid Redesign Team)
    - Allison Cook (Better Aging and Policy Consulting)
    - Rachel Ingalsbe (NYS Tax and Finance)

Subcommittee 8: Safety, Security and Technology

Subcommittee Lead and Co-lead

- Raj Mehra (Sage)
- Ruth Finkelstein (Brookdale Center for Healthy Aging at Hunter College)

State Agency Council Representatives

- Katie Egglefield (OVS)
- James Clancy (DSHES)
- Heidi Hayes (DOH)
- Elizabeth Alowitz (OMH)
- Rachel Baker (OPWDD)

Stakeholder Advisory Committee Representatives

- Ann Marie Cook (Lifespan Rochester)
- Karen Nicolson (Center for Elder Law and Justice)
- Sara Czaja (Center on Aging and Behavioral Research at Weill Cornell Medicine)

Other Interested Parties

- Allison Gold (DFS)

- Allison Laubacher (Brighton PD)
- Annette Esposito (OCFS)
- Arlene Markarian (FCA)
- Anthony Lareau (OCFS)
- Bob Blancato (Elder Justice Coalition)
- Bob Heppenheimer (Guardianship Corp)
- Dr. Carolyn McLaughlin (Albany Common Council President)
- Corey Haertel (Center for Elder Law & Justice)
- Deborah Ball (Deborah S. Ball, Elder Law, Estate Planning, and Estate Administration Law Firm)
- Deborah Riitano (Albany County)
- Denise Shukoff (Lifespan Rochester)
- Elvira Fardella-Roveto (St Mary's Healthcare System for Children)
- Erin Mitchell (AARP New York)
- Ethan Heimowitz (Emerest Connect)
- Jackie Maclutskey (OCFS)
- Jenee Alleman-Goodman (Helen Keller National Center)
- Jesslyn Holbrook (CELJ)
- Joan Levenson (NYS Unified Court System)
- Josh Siliano (CELJ)
- Lindsay Counts (Financial inclusion and Empowerment)
- Julie Kelleher (OCFS)
- Kevin Howell (The Anchor Group)
- Lise Hamlin (Hearing Loss Association of America)
- Lisl Maloney (OCFS)
- Liz Loewy (Eversafe)
- Marie Cannon (Erie County)
- Mark Castiglione (Capital District Regional Planning Commission)
- Marin Gibson (SIFMA State Government Affairs)
- Mary Moller (Albany Guardian Society)
- Nancy Miller (Visions)
- Ronald Long (Aging client services consultant)
- Ruthanne Becker (The Mental Health Association of Westchester Inc.)
- Sabrina Jaar Marzouka (Dutchess County)
- Sarah Duval (Elder Justice NY)
- Sheng Guo (Office of Court Administration)
- Susan Hollander (OCFS)
- Steven Dahlberg (Center for Elderly law and Justice)
- Stephanie Lederman (American Federation for Aging Research)
- Steve Lovi (Empire State Association of the Deaf)
- Tammy Lawlor (Miller & Milone, P.C.)

Safety, Security and Technology Workgroups

- Financial Exploitation and Abuse
    - Allison Gold (Department of Financial Services)
    - Katie Egglefield (Office of Victim Services)
    - Lindsay Counts (DFS-Financial inclusion and Empowerment)
    - Ann Marie Cook (Lifespan at Greater Rochester) Chair
    - Allison Laubacher (Brighton PD)
    - Arlene Markarian (Family & Children Association)
    - Denise Shukoff (Lifespan Rochester)
    - Erin Mitchell (AARP New York)
    - Josh Siliano (Center for Elder Law & Justice)
    - Liz Loewy (Eversafe)
    - Marin Gibson (SIFMA State Government Affairs)
    - Sarah Duval (Elder Justice NY)
    - Steven Dahlberg (Center for Elder law and Justice)
    - Stephanie Lederman (American Federation for Aging Research)
    - Joan Levenson (NYS Unified Court System)
    - Mary Moller (Albany Guardian Society)
    - Anothny Lareau (Office of Children and Family Services)
    - Jackie Maclutsky (Office of Children and Family Services)
    - Annette Esposito (Office of Children and Family Services)
    - Susan Hollander (Office of Children and Family Services)

- Technology Development and Access
    - Rachel Baker (Office for People with Developmental Disabilities)
    - Ethan Heimowitz (Emerest Connect)
    - Karen Nicolson (Center for Elder Law and Justice)
    - Mary Moller (Albany Guardian Society) Chair
    - Nancy Miller (Visions)
    - Sabrina Jaar Marzouka (Dutchess County)
    - Dr. Sara Czaja (Center on Aging and Behavioral Research at Weill Cornell Medicine)
    - Azaleea Carlea (Project Guardianship)
    - Liz Loewy (Eversafe)

- Guardianship / Alternatives to Guardianship
    - Elizabeth Alowitz (Office of Mental Health)
    - Bob Heppenheimer (Guardianship Corp)
    - Jesslyn Holbrook (Center for Elder Law and Justice) Chair
    - Joan Levenson (NYS Unified Court System)
    - Tammy Lawlor (Miller & Milone, P.C.)
    - Arlene Markarian (Family & Children Association)
    - Lisl Maloney (Office of Children and Family Services)
    - Julie Kelleher (Office of Children and Family Services)