

Executive Summary

The Vermont Department of Disabilities, Aging and Independent Living [DAIL] requests a **three-year \$800,000 grant** to develop a system of ADRCs to provide seamless access to long-term care information, referral and assistance [I/R/A] for older Vermonters, younger adults with physical and developmental disabilities or traumatic brain injury by improving and expanding the I/R/A functions performed by the Area Agencies on Aging (AAAs). DAIL is the lead agency for long-term care services for the target populations and is part of the Agency of Human Services, Vermont's single state Medicaid agency. This proposal builds on DAIL's history of strong partnerships with other state agencies and non-profits. Consumer and key stakeholder input will inform every part of the project. Key partners include AAAs, the Vermont Center for Independent Living [VCIL], the Office of Vermont Health Access, the Department for Children and Families and Vermont 2-1-1.

Year 1 Goals: (1) improve the I/R/A system for older Vermonters (2) plan two pilot ADRCs serving additional populations (3) design a streamlined eligibility process for Medicaid and Medicaid Long Term Care (4) design a seamless link between the ADRCs and Medicaid eligibility determinations. **Year 1 Objectives:** (1) ensure all AAAs have REFER software (2) develop a plan to market I/R/A to private-pay consumers, (3) identify mechanisms to expand ADRC services to younger people with disabilities and (4) develop pilot ADRC business plans. **Year 2 Goals:** (1) add younger adults with physical disabilities and the TBI population, (2) increase use of ADRC services to the private-pay market, and (3) implement a streamlined Medicaid eligibility process with seamless links to the ADRCs. **Year 3 Goals:** add the developmental disabilities' population. **Project outcomes** will include (1) informed choice of LTC options for elders and younger adults with disabilities (2) streamlined access to LTC eligibility for elders and younger adults with disabilities, (2) easier access to home- and community-based services and (3) a sustainable ADRC model that can be expanded statewide.

I. Introduction

Vermont is a small rural state with a population of 608,827,¹ modest income levels, geographic challenges and a growing older population. It has been categorized as “an aging state.” The state is nationally recognized as a leader in shifting the balance of long-term care for elders and people with disabilities from nursing facilities and other institutional settings to community-based support. The State’s only institutional setting for the mentally retarded was closed in 1993. Several factors position Vermont to take full advantage of an Aging and Disabilities Resource Center (ADRC) grant. These include:

- the reorganization of Vermont’s Agency of Human Services (AHS);
- a recent statewide assessment of Vermont’s Information/Referral/Assistance (I/R/A) systems;
- receipt of the nation’s first 1115 Medicaid waiver to create more equal access to home and community-based and institutional long-term care;
- a statewide I/R/A system for elders;
- initiatives to foster consumer choice and direction of long-term care supports; and
- a strong history of collaborative cross age/cross disability initiatives among consumers, state agencies, public and private non-profit service providers.

Funding from this joint initiative from AoA and CMS will provide the resources to develop ADRCs – critical access points to long-term care and supports – by improving the I/R/A system for elders, expanding this system to younger adults with disabilities (physical, developmental and traumatic brain injury) and streamlining access to long-term care services for elders and younger adults with disabilities.

¹ U.S. Census 2000

II. Background and Problem Statement

Background

Agency of Human Services

The Vermont Agency of Human Services (AHS) has recently undergone a major reorganization to be more consumer-responsive and to make better use of its resources. As part of that reorganization, the Department of Aging and Disabilities was melded with the Division of Developmental Services, creating a new Department of Disabilities, Aging and Independent Living (DAIL). DAIL now has oversight of all programs that serve older Vermonters and persons with disabilities, with the exception of services for persons with mental illness. These include the Division of Licensing and Protection (the state licensing, survey, certification and adult protective services division), the Division of Disability and Aging Services (1115 Long-Term Care Waiver – *Choices for Care*, developmental disabilities, aging services, children’s personal care, High Tech services and the Traumatic Brain Injury Program), the Division of Vocational Rehabilitation (DVR), the Division for the Blind and Visually Impaired, an Autism Specialist and a Deaf and Hard of Hearing Services Coordinator.

DVR administers a Medicaid Infrastructure Grant and has strong links to the Vermont Department of Labor and the Work Force Investment Boards. DVR also works closely with the Department for Children and Families and the Department of Education to assist students with disabilities who are transitioning out of high school. DVR has 13.5 FTE benefits counselors who provide information to people with disabilities about the public benefits they receive, the effects that employment would have on those benefits, and any additional programs or work incentives that might be available to support return-to-work efforts.

AHS is the State Medicaid Agency. Medicaid functions are split between the Office of Vermont Health Access (covered services, payments and clinical) and the Department of Children and Families, Economic Services Division (eligibility determination).

As part of the reorganization efforts, AHS plans to create a “Navigator” function within each of the district offices with the goal of providing better customer service. Navigators will provide information,

assistance and referral to customers who seek assistance from AHS and will receive training that incorporates the Alliance of Information & Referral System (AIRS – an international professional society for groups involved in community information and referral) standards. AHS seeks to develop linkages among AHS staff, 2-1-1 and community providers and advocates.

Providers of Long-Term Supports and I/R/A

Long-term supports are currently provided by five Area Agencies on Aging (AAAs), 12 Medicare-certified Home Health Agencies, 17 state-certified Adult Day Centers, 110 Residential Care Homes, 43 nursing facilities, five Traumatic Brain Injury Providers and 18 service providers for persons with developmental disabilities.

Vermont has developed a fairly mature I/R/A system for older Vermonters and their families and caregivers through the five AAAs. This service, known as the Senior HelpLine has been in operation for approximately 30 years. The Senior HelpLine is marketed to the general public. It provides a seamless “quick link” for callers to their local AAA office through one toll-free number statewide number. In FY 2004, 13.5 I&A staff (10 FTEs) received and handled approximately 30,000 calls.

The AAAs provide I&A, benefits counseling, advocacy, options education and case management for Vermonters age 60 and over. They also house the Vermont State Health Information and Assistance Program (SHIP), the National Family Caregiver Support Program, the Senior Companion Program, case management, Dementia Respite Programs, nutrition programs and successful aging initiatives.

Three I&A Specialists are AIRS-certified and two more plan to become certified in the next 12 months. Three out of the five AAAs use REFER as their I & A software. The other two AAAs would like to use the software, but do not have the resources to do so.

The Vermont Center for Independent Living (VCIL) -- Vermont's only CIL-- provides advocacy, peer counseling and I&R for persons with disabilities. Two FTEs (one staffs the statewide *I-Line*, and two other half-time positions are located in Bennington County (far southern part of the State) and Chittenden County (the most populous county). According to their most recent statistics, VCIL handled 1,677 calls for I&R. Peer Counselors also provide information and referral. Because of resource

limitations, VCIL struggles to provide a statewide presence and to provide a robust I&R system and would welcome additional resources. VCIL uses a different I&R database than is used by the AAAs, which will add another challenge to creating an integrated ADRC. The Benefits Planning, Assistance, and Outreach project at VCIL has 3 counselors and is funded by the Social Security Administration. These counselors also provide assistance to persons with disabilities about public benefit programs and work incentives.

Vermont's I/R/A system has 2 new additions. Vermont 2-1-1 system was launched in February 2005 and has developed a well-functioning system for linking consumers to the AAAs and making referrals to other organizations. Under a Traumatic Brain Injury State Implementation Grant, the Vermont Brain Injury Association is developing independent I/ R/ A for this population and staff are seeking AIRS certification. This organization also uses a different database than the one used by the AAAs.

Long-term Care Initiatives and Consumer Choice

The Vermont long-term care and support system will undergo a transformation. with our 1115 Long-Term Care (LTC) Waiver, *Choices for Care*. This research and demonstration waiver will allow the State to expand the Medicaid LTC entitlement to individuals who are seeking home and community based services (HCBS). Since, on average, HCBS cost less than institutional care, dollars saved on institutional care will be used to serve more people.

The Waiver also allows us to create a new expansion group that does not need to be clinically or financially eligible for Medicaid LTC. This group will test the hypothesis that preventive services can delay or prevent the need for more costly services.

Under the Waiver, individuals seeking long term supports may enter through may different portals, e.g. hospital discharge planners, home health agencies, adult day centers, self-referrals, residential care homes and nursing facilities. Referrals will be made to DAIL regional staff. These 12 RNs, trained in person-centered values, will complete an assessment with the applicant, complete the Level of Care determinations, provide options counseling, and create an initial plan for care and supports. Consumers will then choose a case management agency and the case will be referred to that agency. Consumers will

receive help completing their Medicaid financial applications from a number of sources: AAAs; home health agency social workers; nursing facility social workers; hospital discharge planners/social workers; and family members. Financial eligibility determinations will continue to be done by the Department for Children and Families, Economic Services Division (ESD). Whenever possible, DAIL will co-locate RN staff with the ESD Medicaid Long Term Care Eligibility Specialists.

The goal of maximizing consumer choice and control is woven into every program within DAIL. Waiver participants have a choice of case management agencies (AAA or home health agency) and also have the choice of receiving their personal care support through a home health agency or through consumer- or surrogate-directed options (CD/SD). More than 50% of the personal care provided under the Aged and Disabled waiver is delivered through CD/SD options. Vermont has received a grant from the Robert Wood Johnson Foundation to develop a “Cash and Counseling” program, to expand opportunities for consumer choice and control to meet their long-term support needs. The first Real Choice grant is providing funding to develop a supportive Intermediate Service Organization (ISO) that will help individuals with developmental disabilities manage budgets for their individual service plans.

Problem Statement

Need for Consistent Standards for Provision of I/R/A

Vermont’s first Real Choice System Change grant funded a study of the state of I/R/A for elders and adults with disabilities (physical, developmental and mental health) and provided recommendations to improve the system. The October 2004 report provides recommendations that will serve as a framework and provide standards for I/R/A delivered by our ADRCs. These recommendations include:

- Delivery of I/R/A:
 - o Agencies that provide I/R/A must clearly distinguish I&R services from intake, eligibility determination, or other service provision.
 - o Agencies that provide assistance, in addition to I&R, should be committed to helping consumers navigate the service system and provide advocacy to secure the services they need.

- o Agencies that provide I/R/A services should designate and allocate adequate staff to provide these services and provide training and resources to ensure the provision of quality services.
- o I/R/A providers should be AIRS certified or working toward certification.
- o Agencies should have written protocols and policies regarding acceptable response times, presentation of information on a range of options including services offered by other agencies.
- o Agencies must ensure that I/R/A staff are prepared to provide culturally competent responses.
- o Agencies should be prepared to provide I&R to other service providers.
- High Quality Information:
 - o Agencies should use a centralized resource file that is regularly updated (may include 2-1-1 and/or AHS databases).
 - o Agencies should have written protocols, which outline proactive strategies for developing and updating specialized resource files for particular populations.
 - o A formal mechanism should be in place to gather caller feedback to ensure that resource files are updated, accurate and address consumer needs.
- Advocacy and Collaboration:
 - o Agencies should use AIRS Taxonomy so that information on needs and services is consistent.
 - o Agencies providing I/R/A should have a formal mechanism to track and share information on unmet service needs. I/R/A staff should receive in-service and cross-service training on community resources and services.
 - o Agencies should participate in Vermont AIRS conferences and trainings. Agencies should work closely with Vermont 2-1-1 to develop and maintain resource files.
 - o Agencies should work collaboratively to create strategies for achieving seamless transitions for consumers.
- Outreach and Public Education: Agencies should have an articulated plan for outreach and creating public awareness of its I/R/A services.

Visibility of I/R/A Services

Vermont is using Real Choice grant funds to promote the Senior HelpLine, and the AAAs publicize the number on all their literature; however, the Senior HelpLine number is still not as widely recognized as it could be. Real Choice grants funds were also used to create a public image for the VCIL I&R line, now known as the *I-Line* (*I* is for independence!). More needs to be done to also publicize that number.

Lack of Statewide I/R/A and Case Management for Younger Adults with Physical Disabilities

There is no readily identifiable, consistent, statewide source of information about LTC services and supports for younger adults with physical disabilities, nor is there a case management system that can respond to short-term needs, much less case management for more complex cases. AHS has just released a new web-based screening tool called the "Screen Door". Consumers can enter information about their current situation and receive information about programs for which they might be eligible and where to apply for services. However, this tool is not a substitute for individualized one-to-one information, options counseling and assistance that is fundamental to informed consumer choice of LTC supports.

Lack of Independent Information and Referral for People with Development Disabilities

Vermonters with developmental disabilities (DD) are served by 12 Designated Agencies (DAs) and four Special Services Agencies through a capitated payment system. These provider organizations are also the major source of I&R for individuals with DD and their families. No independent source of information and assistance has been developed for this population -- a critical need identified in the October 2004 I/R/A report.

Need for Streamlined Application Process for Medicaid and Medicaid Long-term Service Eligibility

Although various agencies and organizations help consumers complete their applications for community and LTC Medicaid, Vermont has not developed methods to streamline or better coordinate the application process so that consumers can start receiving services in as timely a manner as possible. The Commissioner of DAIL chairs an intra-agency task force that is examining ways to improve the processing of applications for LTC Medicaid financial eligibility, including co-locating the DAIL regional staff with the DCF LTC Eligibility Specialists and expediting verification using electronic bank searches.

Under the new LTC Waiver, DAIL regional staff will complete initial assessments for HCBS LTC clinical eligibility and Level of Care determinations. Most community-based organizations help consumers complete applications for Medicaid and other public benefit programs. Paper copies of applications for LTC Medicaid and community Medicaid are forwarded to the Department for Children

and Families for processing. Although Vermont plans to implement a common intake tool, after 12 years, the tool is still not available.

Need for Statewide Consistency in Management Information Systems, IR&A Software and Professionalism of IR&A Staff

Three out of the five AAAs use REFER as their I&A software. The other two AAAs would like to purchase the software, but do not have the resources to do so. If they are to become part of a Resource Center, I/R/A providers serving younger people with disabilities must use the REFER system as well, or be able to meet the reporting requirements of this project. All I/R/A providers need to move toward obtaining AIRS certification for their staff. All participants in a co-located or virtual ADRC will also need a common management information system.

Need for Outreach to Vermonters Who Can Use Private Pay Long-term Care Resources

AAAs focus primarily on individuals with limited means, although access to their services is available to anyone age 60 and over, their families and caregivers. People in this age group who do not need support from public resources do not necessarily identify the AAAs as a place to receive information and counseling about planning for their long-term care needs, such as purchasing private insurance for long-term support and using reverse mortgages.

III. Target Population

For this initiative, Vermont will focus on four target populations (including individuals with higher income who use private pay services), their families and caregivers: older citizens; younger adults with physical disabilities; younger adults with traumatic brain injuries and individuals with developmental disabilities. These populations all fall under the umbrella of the Department of Disabilities, Aging and Independent Living (DAIL) and currently are using or potentially will need long-term care services. As noted above, I/R/A services are not well developed for populations other than the age 60 and over cohort.

In Year 1 Vermont will concentrate on improving I/R/A services to citizens age 60 and over (112,345 individuals). Although the Senior HelpLine is recognized for providing excellent service, the AAAs and

DAIL have identified ways to make the system even better. These strategies include purchasing licenses and training for the REFER software for the two AAAs who are not yet using that system and providing access to AIRS training and certification for additional I/R/A staff.

In the first quarter of Year 2, we will add the population of younger adults with physical disabilities (approximately 1,300 individuals age 18-65). This number reflects the estimated number of community-dwelling individuals in this age category who need help with two or more Activities of Daily Living (ADLs).² We will add individuals with Traumatic Brain Injuries (6,000 – 8,000 individuals across the lifespan – the number will be smaller for adults) by the end of Year 2.

During Year 3 we will add individuals with developmental disabilities (estimated number across the lifespan is 11,500). Time is needed in Year 1 to work through the list of issues that will allow us to create an integrated system so we are positioned to bring in the second and third populations in Year 2. Additional planning in Year 2 will be needed to bring in the fourth population in Year 3.

IV. Proposed Interventions

In Year 1, project activities will focus on three main areas:

- improving the I/R/A system for older Vermonters;
- planning for the development of two pilot ADRCs serving additional populations; and
- designing streamlined access to Medicaid and long-term care Medicaid.

Year 2 and 3 interventions, for the most part, will flow from the Year 1 planning activities.

Improving the I/R/A system for Older Vermonters

During Year 1, improvements will be made to the current I/R/A system for older Vermonters. We will provide funding for the following: licenses for the REFER software for the Northeastern Vermont Area Agency on Aging (NEVAAA) and the Council on Aging for Central Vermont; training on using REFER, initial data entry to populate REFER, and purchase of the AIRS taxonomy to be used in

² *Shaping the Future of Long-Term Care and Independent Living, Department of Disabilities, Aging and Independent Living, May 2005.*

the REFER database. We will also provide funding for AAA I&A Specialists to attend AIRS training and for eligible Specialists to become AIRS-certified.

Planning for Pilot ADRCs

Vermont plans to develop two ADRCs over the three years of this project. These efforts will provide a roadmap to expand the initiative to rest of the state. The main planning vehicles will be the Statewide and Local Planning Councils described in Section IV. One ADRC will be located in the Champlain Valley, the four-county planning and service area for the Champlain Valley Agency on Aging (CVAA) with a population of 234,863. Burlington, Vermont's largest city (pop. 39,824 U.S. Census 2000) is located in this "urban" area. The second ADRC will be located in the northeastern part of the state, referred to as the Northeast Kingdom. This region covers the three-county planning and service area for the Northeastern Vermont Area Agency on Aging (NEVAAA). This is the most rural area of the state with a total population of 62,438. Focusing first on these two areas will allow us to identify and work through the issues associated with developing an ADRC in both a very rural and a more populous area of the state. The Area Agencies on Aging in these two regions will provide the base on which to develop the ADRCs.

CVAA operated the Senior HelpLine for the entire state until about 10 years ago, when the system was improved to provide easy access to the local AAAs through the single toll-free number. This agency is already using the REFER database and has one AIRS-certified I&A Specialist, with others on their way to being certified. CVAA has been an active participant in the three LTC Coalitions in its planning and service area, has built strong relationships with providers and other community organizations and is well respected by consumers. CVAA is very interested in continuing to improve its capacity to deliver quality I/R/A services and in finding ways to streamline access to services for the populations identified in this proposal. CVAA has had years of experience working with younger adults with disabilities, providing case management for these participants in the current 1915(c) HCBS waivers.

NEVAAA will also provide a strong base on which to build an ADRC. NEVAAA chairs the LTC Coalition in its region, has experience providing Waiver case management for younger adults with

disabilities, has forged strong alliances with providers and other community organizations and is well-respected by consumers in the area. NEVAAA also has a very strong I&A program and both of the I&A Specialists are AIRS-certified.

During Year 1, the project will focus on identifying all the challenges, opportunities and issues that will need to be analyzed and solved in order to achieve fully operating ADRCs by the end of Year 3.

These include:

- determining the best methods for ensuring that consumers' expertise is part of each stage of planning, implementation and evaluation;
- assessing various models of expanding I/R/A services to younger adults with disabilities, e.g. co-location or virtual connections with another organizations or developing "in-house" expertise;
- developing a business plan for each ADRC, including analyzing the most efficient and effective model for delivering ADRC services (virtual, co-location, etc.);
- developing methods to streamline LTC clinical eligibility and Level of Care determinations in coordination with the ADRCs;
- developing methods for expediting Medicaid financial eligibility determinations, including presumptive or "fast track" eligibility;
- developing effective and efficient data collection strategies, including using REFER and a common management information system;
- developing methods for continuous quality improvement informed by data gathered by the ADRCs;
- ensuring HIPAA compliance and attention to the even more rigorous AHS information sharing policies;
- implementing standards for I/R/A (building on the recommendations of the 2004 I/R/A report);
- developing policies and procedures for ADRC member organizations;
- developing social marketing strategies that promote awareness of ADRCs as trusted sources of I/R/A;
- developing services for private-pay citizens;
- developing training and cross-training curricula for ADRC members;
- developing appropriate formative and programmatic evaluation methodologies that will help improve the functioning of the pilot ADRCs, lay a firm foundation for other Vermont ADRCs and help inform other states who are interested in developing ADRCs; and
- exploring mechanisms to ensure sustainability of the ADRC model.

V. Major Barriers and Plans to Address Them

DAIL has identified several barriers and major issues, which we must overcome before we can realize the vision that AoA/CMS and Vermont have for full implementation of the ADRCs.

Streamlined Access to Medicaid Financial Eligibility for LTC

The process to determine Medicaid financial eligibility is lengthy and is a major barrier to consumers being able to quickly access home and community based services. AHS has already convened an intra-agency taskforce to examine the current procedures. We have discovered what some other states already know, i.e. eligibility staff time is often taken up first with processing applications for food stamp benefits and applications for other services for women and children. LTC eligibility is not always the priority for these specialists. We must now widen the discussion to include other organizations and discuss ways to streamline the process. Information technology could offer some solutions for us, e.g. web-based applications, electronic signatures and a common in-take tool. Co-location of DAIL regional staff with the LTC eligibility specialists will also help ensure the LTC applications are tracked and receive the attention they need. Using presumptive eligibility or a “fast track” methodology is another option to help ensure that consumers are able to receive much needed services as soon as possible. The AAAs and Home Health Agencies’ case managers and social workers are skilled at helping individuals complete their Medicaid LTC applications and are comfortable predicting which individuals will be financially eligible. We will examine the processes used by states such as Washington, Kansas, Michigan, Nebraska, Ohio, Pennsylvania and others cited in the Technical Assistance Exchange issue brief on *“Expediting Medicaid Financial Eligibility”*.

Expanding I/R/A to Consumers of Private Pay Long Term Care and Supports

Defining services that will attract the private pay market and then developing and implementing a marketing plan for this group will be important to the sustainability of the ADRCs. We will contract with a social marketing firm to help us define and market our public presence.

Overall Marketing of ADRC Services

Another critical element of sustainability will be to define the ADRC itself. What is it? What does it offer? How do we design a message and services that will be comfortable and trusted by our older citizens and their caregivers and families, and also by younger adults with physical disabilities, developmental disabilities or traumatic brain injuries? The AAAs and DAIL have spent a considerable amount of time and money marketing the Senior HelpLine. How do we move forward to develop an ADRC without losing the public recognition for that excellent I&A service? These discussions will need to include our Planning Councils (local and statewide) and the skills of a social marketing consultant.

Collaboration between Health Support and Human Service Agencies

Vermont has received three additional New Freedom Initiative grants -- Integrating Housing and Supportive Services, System Transformation, and Quality Assurance/Quality Improvement. The expanded resources and collaboration fostered through these grants will help us move toward a fully operational ADRC. As described in Section VI, stakeholders from these initiatives will be included on the collaborative Statewide and Local Planning Councils for the grant.

The housing grant will allow us to expand our current integration of housing and supportive services (the HASS program), which operates in 26 sites. The HASS program is working to 1) preserve, develop and enhance supportive housing projects (improving access) 2) establish suggested practices for medication assistance to support early aging in place in unlicensed congregate housing and 3) plan for two Program for All-Inclusive Care for the Elderly (PACE) sites that will coordinate services with supportive housing to meet later, high care needs. Through these combined efforts, we will strengthen the continuum of aging in place supports in housing and fulfill our state objective of "helping elders and adults with disabilities live independently and with dignity in settings they prefer."

The Quality Assurance/Quality Improvement grant will provide the resources to 1) develop a Quality Management Plan addressing all four HCBS waiver programs 2) include consumers, their families and community members as active participants in Vermont's quality management activities 3) develop and implement quality management activities to improve supports and services to Vermont's

elder citizens and those with disabilities 4) develop a technology-based system to manage and analyze critical incidents and 5) develop an ongoing system of technical assistance to all providers of services across age and disability and provide training to service recipients and relevant staff.

Our System Transformation grant is focused on creating a system to better manage the acute, primary and long term supports for older Vermonters and younger adults with physical disabilities. The lack of coordination of these systems means that consumers often do not receive the care and services they need, resulting in a decline in the quality of life and reliance on more costly care in the future. The ADRCs may be a logical entry point for consumers who are struggling to find information and assistance and manage multiple needs.

Our 1115 LTC Waiver, *Choice for Care*, will also afford us opportunities to manage acute, primary and long-term care to improve the quality of life and health for consumers and control costs.

IT Tools to Streamline and Coordinate ADRC Functions

In order to fully realize the ADRC vision, Vermont understands that streamlined and coordinated functions will be key to successful ADRC operations. We will examine how to best use information technology to achieve our goals; e.g. web-based applications, electronic signatures, zip files sent as password protected e-mail attachments, seamless phone transfers from 2-1-1 to the ADRCs, database sharing and use of the AHS Screen Door services screening tool.

VI. Involvement of Key Stakeholders

Consumer Involvement

Consumers representing the target populations participated on the Vermont I/R/A Task Force and were interviewed as part of the assessment of Vermont's I/R/A systems under the Real Choice Grant. Many of the recommendations of the I/R/A Task Force report form the basis for Vermont's vision of a well-functioning ADRC. Ongoing consumer involvement in ADRC planning and implementation is built into the Statewide and Local Planning Councils for this proposal.

Statewide Planning Council

A state level planning council that includes key stakeholders will be convened. The Statewide Planning Council will include many of the long term care providers, advocates, consumers and state agencies personnel who have worked successfully on other cross-age/cross-disability initiatives such as the Professional Caregivers Task Force, the Real Choice Advisory Board, the I/R/A Task Force and the Traumatic Brain Injury Advisory Board and the DAIL Advisory Board (which also functions as the advisory body for the 1115 Long Term Care Waiver). In addition to its advisory role, the Statewide Planning Council will use workgroups to focus on specific issues. Ad hoc members may be added to workgroups where additional input or expertise is needed. The focus of the workgroups will evolve and change over the three-year course of Project implementation. Potential areas of focus for Year 1 include: statewide infrastructure (e.g., consistent data base and management information systems, training, state wide linkages among I&A systems); outreach, public education and marketing; template for pilot site business plans; seamless links to Medicaid and LTC Medicaid eligibility determinations; and ADRC sustainability. The Statewide Planning Council will meet quarterly as a whole and workgroups will meet at least monthly. Meetings of the whole Council will be professionally facilitated to ensure that consumer input is solicited. Using lessons learned from our experiences with the Real Choice Consumer Task Force, other states and information from the ADRC issue briefs, Vermont will develop methods to ensure that consumers are well-grounded in the content of the discussions so they feel comfortable participating on the Council and workgroups. Consumer members will be provided with a stipend and reimbursed for transportation and attendant care costs or respite costs associated with meeting attendance.

In addition to consumers from the various populations to be served by the ADRCs, the Statewide Planning Council will include: AAAs; VCIL; the Vermont Coalition for Disability Rights; the SHIP; Long Term Care Ombudsman; the Assistive Technology Project; Vermont 2-1-1; the Office of Vermont Health Access (the Medicaid division); the Department of Children and Families/Economic Services Division; Vermont Health Care Association (nursing facilities); the Vermont Assembly of Home Health Agencies; Senior Centers; Adult Day Centers; the Community of Vermont Elders; the Developmental

Disabilities Council; Green Mountain Self-Advocates; hospital discharge planners; the Vermont Public Transportation Association; Housing and Supportive Services (HASS) Service Coordinators; public housing authorities; the Division of Vocational Rehabilitation; the Division for the Blind and Visually Impaired and/or the Vermont Association for the Blind and Visually Impaired; the Deaf and Hard of Hearing Services Coordinator and the Autism Specialist.

Local (Pilot Site) Planning Councils

For over the six years, Vermont has had 10 local Long Term Care Coalitions to assist in planning for and meeting the local long-term care needs of elders and younger people with physical disabilities. Membership includes: housing providers; transportation providers; hospital discharge planners; AAA; VCIL; nursing home providers; residential care home providers; home health agencies; adult day programs; consumers; advocates and HASS Service Coordinators.

The Project will use the existing Long Term Care Coalitions in the two pilot ADRC sites as Local Planning Councils (LPCs). These coalitions have a history of working together to address community long term care needs and create formal and informal linkages that will provide a foundation for ADRC functions. The local planning councils will serve both an advisory and a planning function. In Year 1, their main focus will be to work with a consultant to complete the business plan for the pilot ADRC, identify barriers to full implementation and propose solutions, provide advice on what it constitutes excellent customer service by the ADRCs and participate in the quality loop concerning the operations of the ADRC. The LPCs, with assistance from a consultant, will also use the workgroup model to complete the various components of the business plan template. Ad hoc members will be added to workgroups as needed. The LPCs will meet as a whole at scheduled meeting of the Long Term Care Coalitions and workgroups will meet at least monthly during the Year 1 and probably less frequently during Years 2 and 3. Meetings of the LPCs will be professionally facilitated. Consumer members will receive a stipend and will be reimbursed for transportation, attendant care and respite costs associated with meeting attendance.

VII. Evaluation

Vermont will contract with a consultant to evaluate both the process of developing the ADRCs (formative evaluation) and also evaluate the project's progress toward meeting the measurable goals and objectives. Vermont will follow the guidelines that appear in the Issue Paper titled "*Assessing ADRC Projects' Progress and Accomplishments: State Project Evaluation Guidelines*" and will most likely use the consumer satisfaction survey included in that paper. Additional tools and data sources for evaluation may include REFER and the SAMS2000 database across the AAA/ADRC system. SAMS2000 is already used by DAIL and the five AAAs. Data will be available from the Medicaid EDS database.

VIII. Dissemination

Vermont agrees to fully participate with the Technical Assistance Exchange and to participate in at least two conferences per year, related to the development of ADRCs. We will submit proposals to present at these conferences in Years 2 and 3. We will also participate in any research interviews and reviews of Vermont's efforts to implement the ADRC concept.

We will also disseminate information about our success and challenges through a variety of statewide venues: the Medicaid Advisory Board; the DAIL Advisory Board; the Developmental Services Standing Committee; the Vocational Rehabilitation Advisory Board; the Advisory Board for the Division of the Blind and Visually Impaired; the VCIL Board of Directors; the Community of Vermont Elders, AARP-Vermont chapter and at the Agency of Human Services Policy Executives meetings.

IX. Project Management

The lead agency, as designated by the Governor, will be the Department of Disabilities, Aging and Independent Living (DAIL). Within DAIL, the Division of Disability and Aging Services project will managed the project. The Interim Project Director will be Camille George, Director of the Community Development Unit. We will contract with a Project Director and Ms. George will over see that contract. Douglas Thomas, Systems Developer II, will manage data analysis the reporting. The

Medicaid division, the Office of Vermont Health Access (OVHA), will be an active partner. The lead from OVHA will be Brendan Hogan, Director of the Health Programs Integration Unit. DAIL will also work closely with the Department for Children and Families, Economic Services Division on eligibility determination processes. Community partners that have been identified are the Area Agencies on Aging, particularly the two pilot sites – Champlain Valley Agency on Aging and the Northeastern Vermont Area Agency on Aging, Vermont 2-1-1 and the Vermont Center for Independent Living. Two Project Coordinators (to be hired or designated by the AAAs) will be part of the project management team.

X. Organizational Capability Statement

The Department of Disabilities, Aging and Independent Living has demonstrated its ability to manage research, demonstration and development projects of this size and scope many times over. DAIL now is home to all disability populations, except individuals with mental illness. DAIL manages a budget of \$156 million and has strong IT support and robust project management and data collection and analysis capability.

The NEVAAA and CVAA, the proposed ADRC pilot sites, are both strong organizations with excellent management capacity. CVAA and NEVAAA have both used the SAMS2000 system for several years and manage their data collection and analysis functions appropriately. They are both recognized leaders in their planning and service areas and have shown the willingness and capacity to think innovatively and move in new directions to improve services for elders. They are ready to work with DAIL and other community partners to develop ADRCs in their areas and lead the way for the other parts of the state. Vermont does plan to use a number of consultants in the development of our ADRCs, but must go through a competitive bid process before a contract can be executed. Therefore, we cannot supply specific information about any consultants at this time.

AHS Office of the Secretary

Operations Division

Planning Division

Department for Children and Families

Child Development

Child Support

Family Services

Disability Determination

Economic Services

Economic Opportunity

Field Services

Department of Health

Alcohol & Drug Abuse Programs

Mental Health

Community Public Health

Health Protection

Health Surveillance

Department of Corrections

Administration

Facilities

Program Services

Restorative and Community Justice

Placement Services

Department of Disabilities, Aging and Independent Living

Blind and Visually Impaired

Disability and Aging Services

Licensing and Protection

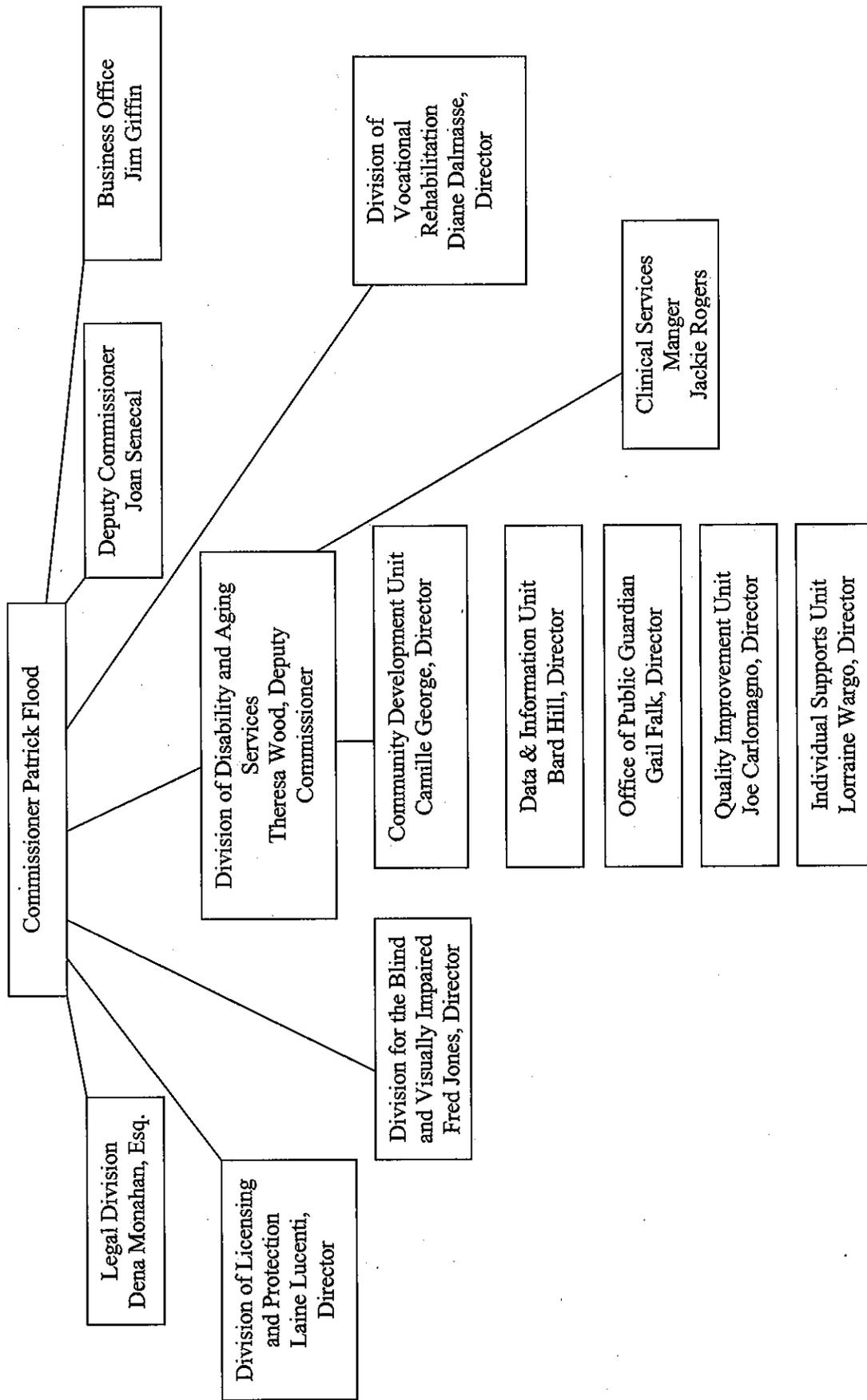
Vocational Rehabilitation

Office of VT Health Access

Clinical

Operations

Department of Disabilities, Aging and Independent Living Organizational Chart



XI. Sustainability

Vermont will pursue several avenues to ensure sustainability. We will 1) examine intake, assessment and eligibility determination processes and streamline these wherever possible, including finding ways to utilize IT tools 2) reinvest savings gained from nursing facility diversions, part of our strategic plan for the 1115 LTC Waiver 3) pursue public/private partnerships 4) find ways to attract the private pay market by offering valued services 5) and examine ways to maximize current resources at the state and local level.

XII. Performance Goals and Indicators/ Milestones

In developing and revising the performance goals, indicators and milestones over the three year grant period, we will rely on input from the Statewide Planning Council and Local Planning Councils, the guidance provided in the issue paper on *State Project Evaluation Guidelines for Assessing ADRC Project Progress and Accomplishments*, and the feedback from ongoing evaluation of project activities. DAIL anticipates using the following performance goals and indicators to measure progress toward achieving the overarching goal of providing seamless long term care information, referral and assistance for older Vermonters and younger adults with physical disabilities or traumatic brain injury and individuals with developmental disabilities.

Initial Measurable Performance Goals and Indicators

Goals	Process/Task	Indicator
<p>Visibility/Trust/ Awareness</p>	<ul style="list-style-type: none"> Define and establish ADRC Determine how identity of ADRC will be promoted Contract with social marketing firm and develop marketing strategy and products with input from local and statewide councils Develop and implement outreach strategies Create website for ADRC 	<ul style="list-style-type: none"> Marketing, public education and outreach plans designed and implemented Increase in # of calls Decrease in calls abandoned # of hits on ADRC website, and increase over the life of the project Demographics of consumers accessing the ADRC
<p>Consumer Focus</p>	<ul style="list-style-type: none"> ADRC staff receive training about various disabilities Statewide and local councils have consumer members with sufficient background and support to actively participate in the meetings Policies and procedures reflect adherence to consumer-centered service 	<ul style="list-style-type: none"> Consumer satisfaction reports show high degree of satisfaction Consumers actively participate in Council meetings. all staff are trained on policies and procedures.
<p>Access to Services & Responsiveness</p>	<ul style="list-style-type: none"> ADRC staff receive all necessary training, including training on the use of REFER software and AIRS standards Examine processes for intake, application, assessment and clinical and financial determinations, determine how to streamline processes and eliminate duplication of data gathering and implement changes Include referral sources on state and local councils and outreach to potential referral sources (e.g. hospital discharge planners, nursing home social workers, adult day centers, residential care homes and other departments within state government) Develop web-based application for LTC services/supports Set up processes for short-term crisis interventions 	<ul style="list-style-type: none"> ADRC staff complete REFER training and are using REFER for all I&A calls ADRC staff are knowledgeable about and use AIRS standards for I&A services Time to process applications is shortened QI follow-up calls with consumers show high satisfaction with services provided Referrals increase from these sources Web-based application successfully used by consumers, case managers and social workers. Time saved. Mechanisms in place for short term crisis intervention
<p>Efficiency</p>	<ul style="list-style-type: none"> Determine if a common assessment tool can be used for all LTC services Create protocols for seamless transfer of consumer information (maintain HIPAA compliance) Use IT tools to transfer data and to avoid unnecessary 	<ul style="list-style-type: none"> Time to process applications is shortened Consumer are able to access services more quickly, avoiding institutional placement ADRC member organizations report satisfaction with improved processes

Goals	Process/Tasks	Indicator
Effectiveness	<p>data entry</p> <ul style="list-style-type: none"> Develop protocols and methods for sharing information in I/R/A databases. Develop protocols and methods for completing and processing applications using IT tools. 	<ul style="list-style-type: none"> Methods are in place to share databases Processes in place to share consumer data, electronically submit applications, or use web-based application that can be completed and printed Time from submittal of application to receipt of services is shorter

Milestones	
Year 1	<p><u>Over all:</u> Project management team in place; contracts with consultants in place; Statewide council convened and meeting</p> <p><u>Improve I/R/A for Seniors:</u> all AAAs have REFER software, training and data is entered in database; increase in number of AIRS-certified staff; planning completed for marketing to seniors (and their families) who have private resources ; ADRC's defined and marketing plan in place.</p> <p><u>Develop 2 pilot ADRCs:</u> Local Planning Council convened and meeting; business plan template developed; pilot site business plans completed; local linkages formalized between ADRC and other points of access; assessment of mechanisms to provide I/R/A to younger adults with disabilities completed.</p> <p><u>Medicaid Eligibility:</u> Councils work with AHS task force to identify ways to streamline intake, assessment and eligibility determination, including IT tools; methods that can be implemented without additional resources will be in place; resources will be identified to achieve additional improvements.</p> <p><u>Training:</u> staff are prepared to work with next ADRC population – younger adults with physical disabilities.</p>
Year 2	<p>2 populations added: First Quarter – younger adults with physical disabilities join the ADRC population by the end of first quarter of Year 2; end of Year 2 – TBI population.</p> <p>IT tools identified and under development</p> <p>Additional staff are AIRS –certified.</p>
Year 3	<p>Staff are prepared to work with Developmental Disabilities population</p> <p>Developmental Disabilities population is added by the middle of Year 3.</p> <p>IT tools in use and seen as valued tools by staff and consumers.</p> <p>ADRCs are sustainable.</p>