## Abstract

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) requests a three-year $750,000 grant to strengthen the VT Aging and Disability Resource Connection (ADRC) statewide and develop a five-year operational plan and budget in collaboration with its ten core partner agencies. Project objectives include: (1) develop a five-year operational plan and budget; (2) develop "warm transfer" capability among partner agencies to facilitate timely and efficient referrals; (3) build a marketing strategy to bring the ADRC statewide to the public and key stakeholders; (4) establish AIRS I/R/A professional staff capacity at each ADRC core partner agency; (5) improve person-centered hospital discharge planning in collaboration with the Community Living Program (CLP) project efforts; (6) pilot a new model(s) of discharge planning in at least two regions of the state; (7) identify and develop effective partnership strategies with the State Medicaid Office re: eligibility determination processes; and (8) develop a quality improvement plan including vehicles for ongoing consumer involvement.

Project outcomes include: (1) a statewide fully-functional ADRC; (2) a sustainable five-year operational plan and budget; (3) professionally-staffed I/R/A service capacity in the ten partner agencies; (4) enhanced options counseling and decision support functions with the VT ADRC that incorporates the Community Living Program (CLP) goals and consumer preference to remain at home for as long as possible; (5) a collaborative, person-centered discharge planning process in partnership with the CLP, local hospitals and nursing homes; and (6) a quality improvement plan supporting a five-year ADRC operational plan.

Project deliverables include a five-year plan and budget, project reports, training materials, and conference presentation materials, such as abstracts.

# Current Status of State's ADRC

## Past Accomplishments and Remaining Barriers

*VT's Aging and Disability Resource Connection*

In October 2005, DAIL received a three-year $800,000 Aging and Disabilities Resource Center (ADRC) grant from the US Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) to improve Information, Referral & Assistance (I/R/A) capacity within selected Area Agencies on Aging (AAAs), the Vermont Center for Independent Living (VCIL), the Brain Injury Association of Vermont (BIAVT), VT 2-1-1 and developmental service (DS) providers to ensure that consumers have access to the right information at the right time, to make informed decisions regarding long term services and supports. In 2007 the HowardCenter, a developmental service agency, and the Vermont Family Network (VFN), a statewide organization serving individuals of all ages with disabilities, particularly families with children with special health needs, were added as core partners. The project goals included exploration of ways to improve Vermont's Medicaid eligibility processes to make a more efficient and consumer/user-friendly process. Vermont's ADRC target population included elders age 60 and over, adults with disabilities, individuals with traumatic brain injury, and persons with developmental disabilities.

Over the course of the project, we learned the following: (1) developing a true partnership is key to a successful ADRC model, especially when bringing together existing agencies serving different consumer groups; (2) partner members participate most readily when a clearly defined process connects participating partners to shared goals; (3) a shared mission and infrastructure to provide comprehensive I/R/A services can be the connective tissue for a well defined, mutually held ADRC vision and goal; and (4) flexibility in model design and perseverance are critical at both the State and local levels to achieve a functioning, effective ADRC.

The VT ADRC project realized several key goals: (1) expansion to a ten partner ADRC that includes three additional AAAs; 2) joint purchase of a statewide Refer license by the ten partners; 3) partner buy-in to hire a .50 FTE centralized Refer database coordinator; (4) cross training of the partner agencies' staff and development of common I/R/A taxonomy terms and protocols; and (5) execution of a ten partner MOU to sustain ADRC operations at grant term's end.

The Vermont ADRC model has been most successful in building a commitment to and implementation of a comprehensive, professional I/R/A system. At present, each ADRC partner has much of the required infrastructure and a commitment to the provision of quality I/R/A. In addition, each delivers some measure of benefits and options counseling, desires to further streamline consumer access to long term services and supports and, to a varying degree, can provide long term care planning and guidance to consumers, including Medicaid eligibility determination processes. While we still have much work to do to achieve a fully functional ADRC, we have made significant progress towards that end.

We are committed to essential next steps that will take the ADRC deeper within each partner agencies' operations, to build a public image that brands individual agencies and our statewide ADRC as 'the' Vermont ADRC. Defining what that means and how to make it happen will be important work under this grant opportunity, as will efforts to ensure connectivity via organizational websites. A key project goal will be to harness the power of technology to support ADRC operations, particularly as it relates to connecting the partner agencies and their efforts to better serve Vermonters.

*The Vermont Flexible Choices PLUS Program*

With 2007 Nursing Home Diversion Program (NHDP) funding awarded by the AoA, Vermont implemented a Flexible Choices PLUS Program in 2008 with the Central Vermont Council on Aging (CVCOA) and the Council on Aging for Southeastern Vermont (COASEV). These two AAAs serve five of Vermont's fourteen counties and are now members of the statewide ADRC and its Leadership Team.

An important component of the NHDP has been training for the two AAAs' case management staff in consumer self-direction and advanced options counseling/decision support (OC/DS) delivered by Wisconsin ADRC and State level experts. The training experience inspired the two AAAs' Executive Directors to explore how they might adopt a Wisconsin-like model of OC/DS within their own organizations. Should Vermont be awarded both an ADRC and CLP grant, our ADRC initiative will be closely integrated with the CLP to adopt best practices related to the provision of OC/DS to individuals at high risk of nursing home admission, and in conjunction with the CLP, will explore effective, person-centered discharge planning practices that result in home-placement.

## Goals and Objectives

Vermont's goal is, working through and in collaboration with our partner agencies, to develop and implement a sustainable five-year plan and budget that reflects growing consumer demand for long term care services and supports that enable consumers from across the life span to remain at home.

Project objectives include: (1) developing a five-year operational plan and budget; (2) developing "warm transfer" capability to facilitate efficient referrals among partner agencies; (3) building a marketing strategy that brands the ADRC statewide; (4) developing AIRS I/R/A professional staff capacity at each ADRC partner agency; (5) improving person-centered hospital discharge planning in collaboration with the CLP; (6) piloting one or more models of discharge planning, such as the Coleman Transition Team Model, in at least two regions of the state; (7) identifying opportunities to streamline access to public benefits via partnership with the Department of Children and Families' Eligibility Determination Unit (DCF/ESD) and the Office of Vermont Health Access (OVHA); and (8) developing a quality improvement plan with an emphasis on vehicles that promote consumer involvement.

## Proposed Project

In order to realize the objectives listed above, Vermont will carry out the following activities.

*Strategic Planning Process*

VT will develop a Strategic Planning Workgroup consisting of State leadership that at a minimum includes: DAIL, the DCF/ESD, and OVHA as well as the ten ADRC partner agencies and the VT Association of Hospitals and Healthcare Systems (VAHHS), and consumers.

The Workgroup will develop a Strategic Plan that incorporates the following elements: (1) a statewide mission and vision; (2) a strategy for marketing and ADRC 'branding' to establish the public image of VT ADRC; (3) business practices that support the core functions of I/R/A; options counseling and decision support; streamlined access to clinical and financial eligibility determination processes for long term care and person-centered hospital discharge planning; (4) technology to further the ADRC vision; (5) a budget and the resources required to achieve a sustainable ADRC; and (6) quality improvement that incorporates a strong role for consumer involvement. A detailed 5-year Plan will be developed within 18 months of receipt of grant funds that will include a time-line for implementation, to commence upon endorsement of the Strategic Planning Workgroup.

*Creating a Public Image*

The VT ADRC Leadership Team will identify the common threads that link the partner agencies together and promote a public image that is easily recognized throughout the state. In collaboration with the Workgroup's strategic planning process, the ADRC project staff will conduct the following activities: (1) contract with a technical consultant to enhance partner agencies' websites, creating consumer-accessible, user-friendly resources; create linkages among ADRC partner agencies' websites to facilitate easy access to regional resources; and explore the capacity of each partner agency to add a publicly-searchable Refer resource database function; (2) contract with a consumer-based organization to conduct consumer focus groups designed to elicit input on how to 'brand' the ADRC and conduct outreach activities that resonate with the consumer target groups; (3) design and market an ADRC public image.

*Strengthen ADRCs to become Fully-Functional*

To fulfill our goal to establish a fully functional ADRC, we will use grant resources to provide support for the AIRS certification of I/R/A staff within each partner ADRC. We had good success in this regard via our 2005 ADRC and provided funding for three AAA staff to become AIRS certified. We want to expand this capacity to several other ADRC partners to ensure they too employ at least one AIRS-certified I/R/A staff person.

We will also collaborate with the CLP to adopt best practices in the delivery of OC/DS services. We will offer ADRC core partner staff the same training opportunities afforded the CLP case management group, share training materials, and provide opportunities for train-the-trainer peer relationships that will sustain ADRC efforts in the long term.

*Person-Centered Hospital Discharge Planning*

We will collaborate with the CLP project to begin a process of hosting regional meetings among those groups involved in hospital and/or nursing home discharge planning. In partnership with VAHHS we will engage parties identified as key to discharge planning (AAAs, ADRC, and social work/discharge staff) to build a mutual understanding of their respective role(s) in and influence on discharge planning process outcomes, create an opportunity to discuss each provider's goals and perspectives re: perceived barriers to an older person's return home, and develop long-term, collaborative relationships that support home-based discharges from hospital.

This ADRC initiative will create an opportunity to study national models of discharge planning, such as the Coleman Transition Team Model, with a short-term goal of piloting one new model in two regions of the state during the grant period, and a long term goal to expand that model statewide. In particular, Vermont's project will provide support for the BIA-VT, VCIL and the AAAs' to participate in the discharge planning processes to obtain positive discharge planning outcomes for Medicare and

Medicaid beneficiaries. VCIL, in particular, has stated its desire to work with the project staff to support nursing facility transitions back to the community.

*Harnessing the Power of Technology*

The VT ADRC project staff and the ADRC Leadership Team will explore the feasibility and implementation of 'warm transfer' capability among the ten partner agencies, so that consumers make fewer calls to get the information they need. With 'warm transfer' capacity, the partner agencies will no longer have to ask the consumer to hang up and call the referral source number. Rather, they'll be able to directly transfer the consumer to a partner agency.

To further support the warm transfer capability, the Leadership Team will explore development of a common referral form, which would be built using the RTM Designs' Refer software (recently purchased by the VT ADRC). This innovation will not only reduce the number of calls a consumer must make, but also result in fewer questions asked of the consumer, without sacrificing accuracy in the transfer of information from the I/R/A provider to the referral agency.

*Enhance Collaboration with Medicaid*

ADRC project staff will develop formal referral protocols among the ADRC partner agencies and their local Medicaid offices, so that a referral is always made to an ADRC partner when an elder or person with a disability is denied Medicaid. This protocol will facilitate the delivery of cross training between ADRC partner staff and their Medicaid office counterparts to build and sustain long term working relationships.

*Quality Improvement and Consumer Involvement*

The ADRCs will develop a quality improvement plan, including strategies for ensuring ongoing consumer involvement in quality improvement activities. We will incorporate the existing national measures established by AoA, and develop new measures that support the direction of the ADRC statewide vision and five-year operational plan. These measures will look at: (1) consumer

responsiveness and satisfaction; (2) efficiencies and effectiveness of ADRC service delivery; and (3) the impact of ADRC functions on nursing home diversion and transition of consumers to their homes.

## Involvement of Key Stakeholders

In addition to the creation of a Strategic Planning Workgroup responsible for the development of the five-year operational plan and budget, the DAIL Advisory Board will assume responsibility for functioning as the overall advisory body for the grant's project activities. The DAIL Advisory Board has a diverse membership that will bring a variety of perspectives to this role- with representation from State leadership, community service organizations, advocacy organizations and consumers.

We will partner with AAA staff, who manage the State Health Insurance Program (SHIP) and the Benefits Outreach and Enrollment Centers (MIPPA) under sub-contract with DAIL, to ensure Medicare beneficiaries have streamlined access to enrollment and benefits information.

And, to ensure meaningful consumer involvement ADRC project staff will contract with a consumer-based organization to conduct focus groups with consumers across the state as we implement the first public ADRC outreach and marketing campaign, to solicit consumer feedback and measure the impact on consumers, particularly consumers of long term services and supports.

## Project Outcomes

Project outcomes include: (1) a statewide fully-functional ADRC; (2) a sustainable five-year operational plan and budget; (3) professionally-staffed I/R/A services across all ten partner agencies; (4) enhanced OC/DS functions at all appropriate partner agencies, supporting the goals of the CLP project; (5) collaborative person-centered discharge planning processes with local hospitals and nursing homes; and (6) a quality improvement plan supporting the five-year operational plan.

## Quality Assurance, Evaluation and Reporting

Vermont used an independent evaluator to conduct a formative evaluation of its original ADRC project, which indicated that future efforts would do well to focus on process measures such as building

of trust, agreement regarding core ADRC functions, and decisions related to quality measurement. If awarded this grant, VT will contract with an evaluator to conduct a process evaluation that will incorporate the national measures desired by AoA and CMS, listed in Attachment I of the AoA solicitation. The evaluator will be asked to work collaboratively with the ADRC Leadership Team, Advisory Board, and Strategic Planning Workgroup to design a plan that captures point in time qualitative data to reveal the successes and challenges of evolving a decentralized ADRC model across multiple networks and partnering agencies. The evaluation will incorporate details from interviews with the ADRC partners' staff, information from selected Leadership Team and Strategic Planning Workgroup meetings, and more quantitative analysis of data captured for the Semi-Annual Reporting Tool (SART).

The ADRC Project Director will be responsible for submitting the web-based narrative report. However, a change in current practice will require that each partner agency take responsibility for completing the Excel Data Entry Tool on a semi-annual basis. This will facilitate more timely and accurate data reporting across the core partner agencies.

## Project Management

DAIL's SUA will employ a .5 FTE ADRC Project Director and .25 FTE Administrative Assistant as key staff to provide Project Management, including oversight of work plan, grant reporting, and communication with required technical assistance consultants and AoA project officers. The current ADRC Leadership Team, which includes the Executive Directors of all partner agencies and DAIL staff, will continue to function as the leadership for the project. Furthermore, DAIL will develop an internal team to support the implementation of the five-year ADRC operational plan with representation from Department for Children and Families/ESD and the OVHA. DAIL's Director of the DDAS Data and Planning Unit will support the ADRC Project Manager in responding to Attachment I and data required for the grant.

## Organizational Capability Statement

The Department of Disabilities, Aging and Independent Living has oversight of all State-funded programs that serve older Vermonters and individuals with physical disabilities, developmental disabilities, and/or with traumatic brain injury. The Department has a proven track record for successfully implementing grant funded community-based programs through collaboration with organizations such as the AAAs, Home Health Agencies, DS Providers, the Vermont Department of Health and consumer advocacy groups. DAIL manages a budget of $400 million and has strong IT support, robust project management and data collection and analysis capability. The Department has extensive history in developing consumer-directed program options.

The ADRC leadership will serve as the key organizations in strengthening the VT ADRC "Connection" statewide. In addition, the AAAs bring more than a decade's expertise in the use of SAMS2000 to manage their data collection and analysis functions, and all agencies will use a common statewide resource database, Refer. Vermont's ADRC partners are recognized leaders in the planning, development and delivery of services to Vermonters of all ages, incomes and disabilities and remain committed to this work, and to furthering strategies to collaborate and streamline access to information for all consumers and their families seeking long term care services and supports.