

DIVISION OF DISABILITY AND AGING SERVICES  
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WATERBURY, VT 05671-1601

**October 24, 2008**

**Final Narrative Report**

**Vermont's Cash and Counseling Project**

**National Cash and Counseling Expansion Program**

**RWJF Identification Number: 052110**

**Award Amount: \$249,416**

**Project Goal:** To allow Vermont to establish Cash & Counseling as a service option for elderly and physically disabled Vermonters who receive long term care services.

**1. What measurable goals did you set for this project and what indicators did you use to measure your performance? To what extent has your project achieved these goals and levels of performance?**

The goal of Vermont's Cash and Counseling grant was to develop a Cash and Counseling option within Vermont's 1115 Waiver program for the elderly and disabled. (This larger program came to be known as Choices for Care.) The primary performance goals related to enrollment and those targets were

1. 50 by the end of year 1
2. 150 by the end of year 2
3. 250 by the end of year 3
4. 500 by the end of year 5.

Simply put, the overall goal was met but the enrollment goals were not. Although the grant was awarded in October 2004, serious work did not begin on the project until the summer of 2005. This came about because the State of Vermont grant acceptance process can be cumbersome and grant acceptance did not come until the spring, 2005. Second, since the Cash and Counseling program was imbedded into the larger Choices for Care waiver, work on Cash and Counseling was dependent upon approval of the Choices for Care waiver, which came about in June 2005.

That said, Vermont's Cash and Counseling program, dubbed Flexible Choices, started in July 2006, the second of the expansion states to start up. Despite that early start, enrollment has been a challenge for the duration of the project. Actual enrollment numbers by year are as follows:

End of year 1 – 0  
End of year 2 – 2  
End of year 3 – 33.

During year 4, the department started a second Cash and Counseling option as part of the Children's Personal Care Program called Children's Creative Connection or C3. This program started in June 2008. Including the enrollment for C3, the enrollment for end of year 4 is

Flexible Choices	=	75
C3	=	119
Total	=	194

The development of the Flexible Choices and the Children's Creative Connection (C3) programs occurred in very different ways. In each case, however, activities to meet these goals fell into three general areas:

- Program design
- Program infrastructure
- Marketing

*Flexible Choices - Program Design:* Since Vermont already had a significant history of a consumer directed option within its long-term care Medicaid program, the focus of the program design was around developing a budget authority program with considerable flexibility and not around the nuts and bolts of consumer direction. This, in turn, required that we develop a methodology for calculating the allowance and rules about allowable expenditures.

Since the Choices for Care Home Based Service Plan sheet had already assigned a cash value to each service element (e.g., personal care or case management) it was fairly easy to determine the overall cash value of a participant's plan. As we looked at current Service Plans, it became clear that most of the variation in the value of these plans was in how many hours of personal care the participant was allowed. Working from that, we decided to establish a "base rate," a minimum allowance amount, that was based on the bi-weekly value of all the elements of the service plan except personal care; specifically, case management, respite and companion services, personal emergency response systems, equipment and home modifications and Fiscal ISO (fiscal/employer services) services. To complete the allowance, we would add the value of the personal care hours to the base rate.

This, in turn, led to one of the critical decisions (or errors) the project. Since the average consumer directed (called "consumer or surrogate directed" in Vermont) participant spends only 75% of the allocation annually, we were concerned that a plan as flexible as Flexible Choices would allow participants to spend closer to 100% of their allocation and thus make the option prohibitively expensive for the state. To respond to this concern, Flexible Choices began with an 85% "discount rate" built into the allowance. So, if a participant's Service Plan had a bi-weekly value of \$1,000, their Flexible Choices allowance would be \$850. This was, to say the least, a non-starter. Consumers who found the Flexible Choices concept appealing were very put off by the discount rate to the point that the consultants who were talking to consumers about the program said to the state staff "we're tired of consumers getting mad at us." As a result, we dropped the discount rate six months into the program and utilization rates have since been over 90%. This has not been an overall budgetary issue since the program has remained small, but it remains an issue we are monitoring carefully.

Since we started the program as a pilot, we made a decision to have allowable purchases be as flexible as possible and to have as many decisions as possible made on a case-by-case basis. The first set of program policies, which were in the form of a chapter in the *Choices for Care Highest/High Needs Manual* (see attached), listed a fairly short list of non-allowable items and determined other items on an individualized basis. This led to considerable conversation between the project director and the consultant staff early on in the project but, in general, was well received by staff and consumers alike. One issue was constantly problematic was transportation, which led to the development of transportation guidelines two years after the program began. (See bibliography.)

While consumers have generally spent their allowances on personal care, with most of them increasing their workers' wages, there have been a number of very creative uses of the new flexibility. Specific examples would include making major renovations to a house so it would be accessible to someone with a new disability, the purchase of exercise equipment for someone who could not reliably get to a gym, the purchase of a computer so a participant could more easily manage her caregivers' schedules and several purchases of dentures. One participant is using his Flexible Choices allowance to purchase a high-end wheel chair, a move which has significantly increased his independence. In one really remarkable situation, an individual with a significant disability (total care and on a ventilator) was able pair Flexible Choices with the Medicaid High-Tech program and use his Flexible Choices allowance to salary a husband and

wife caregiver team who would live-in with him while High-Tech paid for the medical equipment and nursing oversight.

*Program Infrastructure:* Since Vermont has a long history with consumer direction across four separate programs, the state already had a Fiscal ISO in place, ARIS Solutions, with several years experience. There were, however, several technical issues which plagued Flexible Choices from the perspective of the ISO. Since ARIS' software was set up for either annual or semi-annual allocations, the bi-weekly allowance with a savings option was difficult for them to set up, and remains fraught with problems. For similar reasons, their software has not been 100% reliable in catching over-spending which has led one consumer to fall in debt by over \$2,000. These issues, and others across ARIS' system, have led the state to begin work with ARIS to make significant updates to their software, which we will expect will address these concerns. While these problems are significant, in the program-establishment stages, locating and training a Fiscal ISO was not a major task.

This was not the case for the consultant services. That original Request for Proposals for consultant services received no bidders. The RFP was then revised with a particular eye to attracting the current Choices for Care case management agencies, but the only bidder (who had been courted by the project director) was a small agency, Transition II, who was currently providing a somewhat similar service in the department's Developmental Services programs. This agency had the advantage of being very strong in the areas of person centered planning and consumer-employer support. It was not well versed, however, in issues around aging and physical disabilities and the vagaries of long-term care Medicaid. As a result, training for the start of Flexible Choices centered on these areas and was conducted semi-formally as a series of meetings with the Transition II staff and the project director. Flexible Choices participants have consistently responded positively to the services provided them by Transition II and their services have been renewed for two more years for this option.

*Marketing:* The State spent considerable time and resources educating stakeholders (but few or no consumers) about Cash and Counseling even before the grant proposal was written. Venues included a statewide conference followed by three interactive television sessions about the Cash and Counseling concept. However, these efforts did not lead to a consensus about what Cash and Counseling meant. Also, potential stakeholder interest in Cash and Counseling was sidetracked by their interest in the State's initiative to develop and implement the Choices for Care program. When Flexible Choices program began serious planning, in June 2005, the mood among providers was that Choices for Care posed a potential threat; but other than expressing concerns that the program "wouldn't work," they were not able to articulate their concerns. With regards to Flexible Choices, in addition to general concerns about how it would work, providers were also concerned that the program would have a negative impact on their financial status by taking away their clientele.

In this environment, project director conducted numerous activities to educate stakeholders, listen to their concerns and attempt to address them. The Project Director met with key stakeholders, including, AAAs, Executive Directors of Home Health Agencies, and consumer groups including the Community of Vermont Elders, Vermont Center for Independent Living, the Vermont Disabilities Rights Council, AARP and the Alzheimer's Foundation. Project staff

developed an advisory group, comprising representatives of the stakeholders listed above and three consumers. The group met twice in the fall of 2005 and then was kept informed of developments periodically via e-mail, but the group never really coalesced and did not play a major role in developing the program.

The project director also met with “Waiver Teams” in each of the state’s 12 regions to educate them about the new program and their role in it. These Waiver Teams were a holdover from the 1915(c) HCBS waiver which preceded Choices for Care and their purpose was to facilitate communication with case managers across the Choices for Care system. Since case managers, initially, would be the primary referral source for Flexible Choices, the project director made two presentations to each Waiver Team; once in Spring 2006, shortly before Flexible Choices began enrollment and another in that Fall. These meetings were not particularly successful and, overall, seem to have raised provider anxiety about Flexible Choices rather than alleviate it. Unfortunately, no champions for the program emerged during the course of these meetings.

In January, 2006 we contracted with Flint Springs Associates to conduct some quick turn-around telephone focus groups to elders about the design of Flexible Choices. These two groups, with a total of 12 participants, revealed some skepticism about the program, with the two messages being 1) we need more services, not a different format and 2) getting help is hard enough, we are worried this just going to make it harder.

Several mailings directly to consumers comprised the bulk of the marketing. These consisted of a mailing in the spring of 2006 announcing the program was coming, one in the summer of 2006 saying it was ready to enroll, one in the fall of 2006 in a FAQ format and finally one in the summer of 2007 entitled “What Vermonters Are Saying about Flexible Choices.” (See bibliography.) We also published an advertisement in *Vermont Maturity* the winter of 2006. While the first two mailings generated some interest, probably 70 calls in total, both the advertisement and the last mailing generated no calls at all.

In July 2007, project staff worked with the Cash and Counseling National Program Office (NPO) to conduct focus groups with case managers and eligible non-enrollees to determine what issues might be interfering with enrollment. The case manager focus group revealed on-going lack of understanding and suspicion of the program. The non-enrollees focus group revealed considerable suspicion of the State, in general, and thus the program.

These results led us to essentially abandon formal marketing and move to a word-of-mouth/slow growth strategy. If one looks at the enrollment numbers for Flexible Choices, this approach has certainly been as successful, and probably more successful, than our marketing efforts.

*C3 – Program Design:* By Spring, 2007, despite its enrollment issues, the department saw Flexible Choices as, in many ways, a success. It had demonstrated that such a budget authority flexible option was manageable and that for some people it provided an avenue to significantly enhance their care. Thus, when consumer dissatisfaction with Children’s Personal Care Services (CPCS), a traditional Medicaid entitlement program, continued to grow, the department decided to explore a Cash and Counseling option for that program. Since all Vermont’s Medicaid programs operate under one of two 1115 waivers, the department felt, and the state Agency of

Human Services agreed, that Vermont had the authority to develop a Cash and Counseling option within CPCS without getting a new waiver. The department then authorized a working group of Jenifer Garabedian and April Green from the CPCS staff and the Cash and Counseling project director to develop a budget authority option for Children's Personal Care.

The design of the CPCS program is fairly simple. It allocates a certain number of care hours per six month period based on a needs assessment. All program functions are carried out centrally by a small number of program staff. Further, 1,200 of the 1,500 recipients of the program are already consumer (that is to say, family) directed. In early summer of 2007, CPCS staff sent out 1,200 surveys to recipients asking for feedback on the proposed changes. (See survey attached) We received almost 500 returns with overwhelming support for a more flexible option within Children's Personal Care. (See Report attached.) With need and interest clearly established, the three issues that we needed to tackle were:

- 1) Budget development, including once again discussing a discount rate
- 2) Pilot numbers including regional sites and support broker recruitment
- 3) Program guidelines development.

*Budget development:* The fundamentals of budget development were easy: all program recipients received an allocation of hours for a six month period and were required to pay their care givers the state defined wage of \$10/hour. Since the average utilization rate of those hours is about 70% per authorization period (up from 50% 4 years ago), there was, however, considerable concern that a flexible program would lead to a utilization rate of closer to 90% (as is the case Flexible Choices) and would thus be unaffordable. On the other hand, the experience with a discount rate in Flexible Choices was fresh in our minds, so we thought that any discount that was too obvious would seriously decrease enrollment. After much discussion and crunching of numbers we decided that we would cash out the allocated hours at \$10 per hour. Given that the actual cost per hour of the program is around \$11.50, inclusive of employer taxes, this represented a discount rate of 13% but still cashed out the hours at a rate that was easy to understand and to calculate. As the program has gotten underway, this method of calculating the allowance has not been controversial, although several participants have noticed the loss. Recruitment for this program has also explicitly stated that it might not be a good option for people who currently use most or all of their hours.

*Pilot Issues:* Since the Agency of Human Services remained concerned about costs, and we were concerned about our ability to manage a large program, we agreed that we would pilot the program to a maximum of 150 participants in four regions. We selected the regions based on their being traditionally underserved areas and representing small populations so we would not run the risk having many more people interested in the program than we could serve. These four regions were 1) Essex/Orleans counties in the northeastern part of the state, 2) Franklin/Grand Isle counties in the northwest part, 3) Addison County in the central part and 4) Bennington County in the far southwest corner of the state. There are approximately 450 CPCS program participants totally in these four regions and our survey results suggested that we could fill our 150 quota from that number. As it has turned out, while we received around 125 responses to our invitation to join the program, that winnowed down to closer to 80 participants. In response to that, CPCS program staff began to quietly recruit statewide. That has led to a steady increase in enrollees and we expect to be at our 150 maximum in a matter of weeks.

In these selected regions, we needed to establish a network of support brokers to help participants develop and monitor their budgets. It is interesting to note that this population had, previously, no case management support as part of their CPCS participation so this is a circumstance where Cash and Counseling program participants received more, not less, oversight as they developed their programs. Since participants would be paying for support broker services out of their already discounted budgets, we set the reimbursement rate low at \$35/hour and required only 3 hours of services per 6-month period. We also established a system that a participant could opt out of having a support broker after three successful allocation periods on the program. Support brokers have come from a variety of sources. In Essex/Orleans and Addison, we are using a local agency (in both cases, a Developmental Services agency) to provide all the services. In Bennington County, where no agency came forward to provide the services, we developed a network of independent support brokers, and in Franklin/Grand Isle, where we have the largest number of participants, we have both the local Developmental Services agency and a network of independents providing these services. Members of the C3 working group, either singly or as a group, provided one round of training for these brokers. The team then provided a round of follow-up training about two months after the program's start to the independent support brokers in Franklin/Grand Isle and Bennington regions. Training follow-up for the agency-based support brokers has been handled by the agency supervisory staff with input from the C3 team. The CPCS program director has also sent our regular updates to all support brokers.

*Program Guidelines:* Since we were using a range of support brokers, we felt it was necessary to develop a far more detailed set of guidelines for C3 than we had for Flexible Choices. While the working group took responsibility for drafting the guidelines, they were reviewed by many department staff, our cooperating agencies, and the Vermont Family Network, our local parent advocacy group.

Several pressures are at work in these guidelines. (See attached Guidelines.) First, we wanted to allow families as much flexibility as possible to purchase care, goods and services that would meet the needs of their child. Second, we wanted to make sure that the purchases were to primarily support the child and not the family. This was an important shift in thinking since, when dealing with competent adults, program regulations do not need to second guess participant's judgment. In children's programming, however, the participant is not the primary decision maker and there is some incentive for adults, acting on the child's behalf, to rationalize decisions that support the family as a whole as decisions that support the child with special needs. This philosophical point consumed considerable time in the development of the guidelines and the attached draft is fairly rigid in its approach to purchases needing to be for the child and their needs and not for the family as a whole.

Finally, since many of these children are diagnosed with a developmental disability and would, upon turning 21, graduate into the Developmental Services system, we did not want to make the guidelines too incompatible with that system. As a result, some things that seem idiosyncratic, such as the \$500 limit on goods and the distinction between "goods" and "services" mimic the Developmental Services system. That said, there are many things in these guidelines which do not parallel Developmental Services.

**2. Did the project encounter internal or external challenges? How were they addressed? Was there something RWJF could have done to assist you?**

Both the Flexible Choices and Children's Creative Connections (C3) efforts have encountered challenges although for Flexible Choices the challenges were mostly external and for C3 the challenges were mostly internal.

Flexible Choices' challenges have been well documented in other locations, but mostly they revolved around enrollment. As noted early in the answer to question 1, Flexible Choices has never come close to its enrollment goals. As the project (but not the program) draws to a close, this appears to be the result of two barriers. The first was provider resistance. Existing providers, particularly the agencies on aging and the home health agencies, were very skeptical of the program. While these concerns were expressed in words around fears of exploitation and inappropriate use of funds, it became increasingly clear that a foundational concern was the threat to their market share; if participants chose Flexible Choices, they would no longer require case management services through the AAAs and HHAs. To the extent that we tried to meet these concerns through education and marketing, as described on pages 3 and 4, the Foundation offered considerable support. This included training at Cash and Counseling meetings and on TA calls, the Spitfire Communications training and ongoing consultation with the staff from Burness Communications. The Cash and Counseling grant also supported several focus groups with a number of stakeholder groups to try to get at their concerns in order to assist in our developing and focusing our message.

It appears that provider resistance has decreased significantly for a number of reasons. First, ironically, since Flexible Choices has remained small, their concerns about market share have proven unfounded. Second, a number of Flexible Choices participants have actually chosen to purchase case management services, further defusing the market share issue. Finally, the program has provided as-good or better care than the traditional model and witnessing that has put case managers' minds at ease.

The second challenge around enrollment has appeared to be a genuine lack of demand among consumers. Choices for Care already has a consumer-directed option and Flexible Choices simply adds budget authority to the existing hiring authority option. Therefore, in order for Flexible Choices to be appealing to participants, they needed to feel a significant unmet need in their plan of care, and one that an increase in flexibility could help. Since Flexible Choices is "not more, just different," if your perceived unmet need required more hours of care, Flexible Choices would probably not offer you much help. People who have chosen Flexible Choices, then, have been people with a specific, unique need; whether it was need for equipment or home modifications or an unusual form of care. For example, one young participant wanted on-going workplace support. Traditional Choices for Care does not offer work support and Vocational Rehabilitation only offers it as a transition, not as an ongoing service. For that person, Flexible Choices works well.

It is interesting to note that this same dynamic appears to be at work in Vermont's PACE program; also a sub-unit of Choices for Care. Enrollment for them, especially in their Burlington site, has been a struggle. While the reasons for this are complicated, one of them almost

certainly is that participants and families are satisfied enough with their current care structure that they do not feel compelled to go through the effort required to change options.

C3's challenges have been almost all internal. (Our having to work on enrollment at all has been a surprise, but not really a challenge.) The first of these challenges has been getting program approval. Since CPCS, and thus C3, falls under Vermont's 1115 Global Commitment waiver, it has had to be approved by the Office of Vermont Health Access (OVHA), the state Medicaid entity, and the Agency of Human Services, of which the Department of Disabilities, Aging and Independent Living is a part. In giving their approval, the Agency, especially since two former DAIL leaders had risen to leadership positions, was less concerned about the design of the program and more concerned about costs. As mentioned earlier, we addressed these issues via the limited pilot and a modest discount system. Approval from OVHA was more problematic since its insurance approach is at odds with person-centered budget authority approach of Cash and Counseling. This was not an unknown problem among Cash and Counseling programs, so building on their experiences and approaches was very useful as we discussed the program with staff from OVHA

### ***3. Have there been other sources of support?***

For Flexible Choices, there have been no other significant sources of support in the development of the program. The funds for operating the program – that is, to provide services to consumers – came out of state Long-Term Care Medicaid funds. Also, state staff, also funded by LTC Medicaid fund, supported the project. But most of the costs directly related to program development, marketing and monitoring came from the Cash and Counseling grant.

The situation is similar in C3, although state CPCS staff has been more actively involved in program planning. The Cash and Counseling project director, funded by Cash and Counseling funds, has served more as a team member and consultant than a primary planner in that effort. Beyond CPCS staff, Vermont Global Commitment funds have also paid for services provided to consumers. The state has, however, picked up the Cash and Counseling project director's position, under the title of Consumer Direction Manager, with responsibilities to oversee the range of consumer directed options offered by the state.

### ***4. What lessons did you learn from undertaking this project?***

Other than learning a great deal about program development in state government, there are a number of more specific lessons that came out of this project.

1. The most powerful argument for a program change is consumer demand. In Flexible Choices, the consumer demand for the program was difficult to document. As a result, arguments to overcome provider resistance tended to the theoretical. On the other hand, in the C3 program, where consumer demand was well documented, we were able to overcome many objections, mostly from within state government, by pointing out that consumers did not find what the state was currently offering to be adequate and they felt the new program would be useful to them.
2. Lesson #1 notwithstanding, consumers and providers need to have new options explained to them frequently and in detail. In many cases, both of these groups harbor a certain

3. The devil, indeed, resides in the details. Too many times projects were sidetracked or almost derailed completely over details. Those details included
  - a. Finding the proper billing code for the C3 program
  - b. Developing the capacity of the fiscal agent to track and report savings accurately
  - c. Developing an effective billing system for Adult Day and Personal Emergency Response System providers in a consumer budget authority system.

These are not major program issues, but each one carried the potential to stop the program in its tracks (if you can't bill, you can't have a program) or to undermine the program's credibility among important stakeholders.

4. Sometimes you just need to sit back and let the program speak for itself. As noted earlier, our active marketing approaches for Flexible Choices seemed to just make consumers and providers more suspicious. Only when we began to let the word about the program spread informally did both consumers and providers become more accepting.

***5. What impact do you think the project has had to date? Who can be contacted a few years from now to follow up on the project?***

The most important impact of the program has been to legitimate the consumer/budget authority program approach within the department. As noted before, the department was not stranger to consumer direction (hiring authority) at the start of the program. It had limited experience with budget authority programs in Developmental Services, but this budget authority was, in truth, quite limited. The success of the Flexible Choices program was its ability to allow consumers access to a much greater range of services with minimal evidence of misuse of funds. (One consumer had to be undergo increased supervision of his purchases because of consistent small misuse of funds – at the rate of \$20 per pay period or less – but that seemed to be the only real problem.) As a result, as the department has looked at modifying existing programs, budget authority models have been high on the list. The clearest example of this is the start of the C3 option within Children's Personal Care Services. While the program has undergone much scrutiny in its development, at no point did anyone question the validity of a budget-authority approach to modify the program.

In the Choices for Care Moderate Needs Group (a demonstration group looking at offering preventive services to people who are not clinically eligible for long-term care services), when the department received information that there was widespread dissatisfaction in that group, it immediately turned to some kind of budget authority model as the solution. To explore this, and putting into practice the lesson about documenting consumer demand, the department, using RWJF funds, contracted for a follow-up study of the Moderate Needs Group. (See attached.) This study, it is interesting to note, found that consumers seemed to be fairly happy with their services and that a wholesale overhaul of the program probably was not required. Nonetheless, the department is exploring developing a consumer-directed option for some aspects of this program.

Another example of the impact of the budget authority model has been the Credit Union project. Early on in the development of Flexible Choices, department staff entered into conversations with staff of the Independence Fund of the Opportunities Credit Union to develop a system whereby Flexible Choices participants could take out loans from the Credit Union and pay them back using their Flexible Choices allowances. The Credit Union floated a couple of these loans, which are going well, but wanted some more assurances that consumers would, in fact, be able to pay back their loans. As a result, the department, using RWJF funds, attempted to establish a Loan Guarantee Fund at the Credit Union to facilitate these loans. This effort did not ultimately succeed, however, as there turned out to be considerable suspicion at the Agency of Human Services about the capacity of the Credit Union to manage such a project. Despite efforts by the DAIL Commissioner to intervene on behalf of the project, it did not eventually win Agency approval.

Future contact about the project can be directed to Merle Edwards-Orr, the current project director. His position has been converted to a permanent position to continue work with various consumer-direction issues within the department.

**6. What are the post-grant plans for the project if it does not conclude with the grant?**

The projects that were initiated under the grant will continue after the end of the grant. As noted, Flexible Choices is now an integral part of Choices for Care and will continue for the foreseeable future. As part of that continued existence, we project enrollment will continue to grow slowly-but-surely. The contract for the consultant agency has been renewed for two more years and they are aware that recruitment is an integral part of that role. The C3 program will continue through its pilot phase, probably another year, and will be expanded or phased out depending on the outcome of that pilot. Finally, while the marketing materials for the Direct Care Worker Registry (see response to #7) will be developed before contract's end, the Registry itself will not officially open until shortly after the end of the contract. Those materials, or their updated versions, will be used for the two year trial period of the Registry and should be used beyond that time if the Registry is deemed a success.

**7. With a perspective on the entire project, what have been its key publications and national/regional communications activities? Did the project meet its communications goals?**

The communications goals of the project were mostly subsidiary to the program goals; that is, any communications plans that were developed within the boundaries of the project were in service of a communicating the existence of a new program option. The communications efforts around Flexible Choices and C3 are described in the answer to #1. Two other communications efforts are of note, however; the marketing effort in connection with the Direct Care Worker Registry and presentations to other Cash and Counseling states.

*Direct Care Worker Registry:* In the fall of 2008, the department, working with Rewarding Work Resources, launched a Direct Care Worker Registry. This Registry is a web-based product, with telephone support available, which will match willing workers with employers, both consumers

and agencies, who need caregivers. While the majority of funds for this project comes from state and federal funds, the Cash and Counseling grant paid for a significant share of the marketing. Specifically, the grant paid for development and printing of 10,000 worker recruitment brochures, 6,000 worker recruitment posters and a mailing to workers telling them about the Registry. (Copies are attached.) The grant also paid for the development of 30 and 60 second PSAs which will be shown around the state as a part of a second wave of marketing, probably during the winter. (Copies of the DVD are available upon request.) Vermont was also on a on a panel with staff from Rewarding Work and the state of Rhode Island to discuss the development of direct care worker registries at the National Home and Community Based Services Conference in Boston in September.

*Presentations to Other Cash and Counseling states:* In both the Cash and Counseling twice-annual meetings and the bi-weekly technical assistance calls, Vermont made a number of presentations generally as a member of a panel. This included presentations on working with employer/fiscal agents, worker registries, marketing, using focus groups, provider resistance, and budget development. The presentation on budget development is attached. This sharing among states was an important part of the larger grant process so it is probably most accurate to say that Vermont did its share.