

Vermont Nursing Home Diversion Modernization Grant Program Narrative

Summary/Abstract

The Vermont Department of Disabilities, Aging and Independent Living (DAIL) requests an eighteen month \$500,000 grant to develop a comprehensive nursing home diversion program targeting individuals age 60 and over who currently are clinically-eligible for the Medicaid-funded Choices for Care program but do not yet meet the Medicaid long-term care financial eligibility criteria. Caregivers of the target population will also be served. The goals of this initiative are to build upon the new provisions within the Older Americans Act, supporting Area Agencies on Aging, in partnership with DAIL, to build consumer-directed flexible supports that enable Vermonters to live independently in the community and avoid unnecessary nursing home placement.

Project objectives are to: (1) develop a non-Medicaid Flexible Choices PLUS cash and counseling program administered through selected Area Agencies on Aging; (2) develop targeting criteria to ensure services are available to those individuals most at-risk of Medicaid spend-down; (3) expand existing support brokerage functions used for the current Flexible Choices option; (4) expand/modify the role of current AAA staff to perform options counseling for the targeted population; (5) develop a comprehensive options counseling curriculum based upon the work completed by the National Association of State Units on Aging and the Independent Living Resource Utilization to facilitate the development of an interactive and informed decision making process; and (6) develop a training program on consumer self-directed care to support AAA and other aging network staff to translate into practice and service delivery the new language in the Older Americans Act regarding “self-directed care”.

Project outcomes are to: (1) establish an effective and sustainable nursing home diversion program that can be expanded statewide; (2) transform and modernize funding to support flexible, consumer-directed services; (3) strengthen the capacity of the state to reach older adults before they enter a nursing home, supporting choice in long-term care options and self-directed care.

ATTACHMENT B: NURSING HOME DIVERSION MODERNIZATION PROGRAM NARRATIVE

Current Status of Vermont's Long-Term Care Rebalancing and Nursing Home Diversion Efforts

Background

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” and is expected to be 8th highest in the nation in 2030, with individuals age 65 and over comprising nearly a quarter of the state’s citizens.² Over the next ten years, the projected increase for individuals age 85 and older will be 24%. Even though the “oldest old” are relatively small in number, they have the greatest need for long term care services, and are at high risk of nursing home placement.³

Vermont 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. Vermont’s 1996 landmark legislation (Act 160) allowed the State to alter the balance between institutional and home and community-based services. The Act required the State to take saved dollars from reduced Medicaid nursing home utilization and shift those funds to home and community-based care. Vermont’s aggressive efforts to improve and expand home and community-based services have led to a shift away from nursing home care. Since 1992, Vermont has witnessed a steady decline in the use of nursing homes with the sharpest declines seen in Vermont’s oldest old—those 85 years and older. This decline is expected to continue throughout the next ten years.⁴ The award of this nursing home diversion modernization grant will position the State to fulfill its mission to make Vermont the best place in which to grow old or to live with a disability-with dignity, respect and independence.

¹ U.S. Census 2000

² ³ ⁴ Shaping the Future of Long Term Care and Independent Living, State of Vermont, DAIL, 2006 - 2016

Current and Past Efforts and Activities to Facilitate Nursing Home Diversion

Over the past decade and more, Vermont has implemented a number of programs which provide frail and at-risk elders with choices to remain independent in the community. Many of these programs started as a result of federal grant funding; others began as a result of State leadership, vision, and ingenuity.

The Vermont Choices for Care Program

Vermont took a dramatic step in reshaping its long term care system through implementation of the Choices for Care 1115 Medicaid Waiver in October, 2005. Under Choices for Care, enrollees have the option of choosing whether they receive their Medicaid long-term care in the community or in a nursing facility. This is the first program of its kind nationally and since its implementation, has enabled 1,974 Vermonters in need of long term care to “age in place,” substantially reducing the state’s long-term care expenditures. Highlighted accomplishments through this program include:

- An option to permit spouses to be paid caregivers;
- A 24-hour Care option which will provide an alternative for people who previously had no choice other than a nursing facility or residential care home;
- A pilot “cash and counseling” option (Flexible Choices), which provides even greater consumer direction;
- The opening of Vermont’s first PACE center (Program for All-Inclusive Care for the Elderly)

While this program has been very successful in providing nursing facility or home and community-based options for individuals who meet both clinical and financial eligibility criteria, gaps still exist for individuals who are clinically eligible for the Choices for Care program, but are not yet financially-eligible for Medicaid long term care. It is estimated that in the next ten years in Vermont, the projected users of Older Americans Act case management services will increase 31%, homemaker service users will increase 22%, adult day by 23% and mental health and aging by 23%.⁵ Vermont needs to

⁵ Shaping the Future of Long Term Care, State of Vermont, DAIL 2006 – 2016

continue to build the capacity in the community in order to serve individuals who would otherwise move into a nursing home. This will require strategic targeting of services to those most in need and a sustainable and expanding revenue base to develop more services.

Vermont Flexible Choices

The Robert Wood Johnson Foundation funded cash and counseling program called Flexible Choices became another service option under Choices for Care in July 2006. It allows people to convert their plans of care for home-based services into a dollar-equivalent allocation. Working with a consultant, people develop a spending plan for that allocation, which allows them to purchase their care and meet their needs more flexibly. Since this pilot began, a support broker and fiscal intermediary now provide services as an intermediary service organization (ISO) including consultation services, and case managers and State staff are trained in the Flexible Choices option.

The Flexible Choices program provides a proven infrastructure including the cash and counseling model, the support broker fiscal intermediary and counseling supports, and the technical expertise to assist in expanding this model to the non-Medicaid eligible target population. Should Vermont be awarded this grant, it will build upon and expand this successful model to non-Medicaid eligible at-risk elders administered through the AAAs. This would be a first of its kind in the state.

Vermont Dementia Respite Grant

Started as a small state-funded pilot and building from a prior Alzheimer's Disease Demonstration grant, Vermont makes available Dementia Respite grants that can be used for a range of services that give family caregivers a break from their caregiving responsibilities. Funds can be used to hire in-home caregivers or to assist with payment for out-of-home services such as Adult Day Programs. Respite gives family caregivers the opportunity to reduce stress, remain healthy, and maintain overall well-being. In FY '06, 370 individuals and their family caregivers were served. Respite grants are available to family members or other unpaid primary caregivers providing day-to-day in-home care for a person of any age who has been diagnosed with Alzheimer's Disease or a related disorder and meets

certain financial criteria. Priority is given to those who are ineligible for other programs and who anticipate needing out-of-home placement if they do not receive respite services.

The respite program model supports the goals of the nursing home diversion modernization initiative in assisting individuals who do not currently qualify for many State- and Medicaid-funded programs by giving their families much needed support in order to continue to provide the critical informal supports to their loved ones in order to remain out of a nursing home. This grant opportunity will support the respite program as an important component of flexible services and supports, and will provide even greater flexibility in how dementia respite grant funds can be used to best support family caregivers.

Real Choice Comprehensive Systems Reform Grant: Health and Long-Term Care Integration Project:

The work of the MyCare project extends the success of the PACE model to a broader population than can currently be served through PACE. The model supports the goals of diverting individuals from nursing home placement and is another important option that will be made available in the near future to support consumer choice and self-direction.

In September 2004, Vermont was awarded a \$2.1 million Real Choice Comprehensive Systems Reform Grant. Much work has been accomplished over the past three years to integrate funding streams and integrate acute/primary and long-term care service delivery as a choice for older persons who are frail, at-risk or chronically ill, including adults with physical disabilities. The MyCare Vermont program will, when fully developed and implemented, provide person-centered care for individuals over the age of 18, integrate primary/acute and long-term care services through an interdisciplinary team, and will operate through community networks. Additionally, it will provide another important option for individuals to avoid unnecessary nursing home placement.

Aging and Disability Resource Connection(s):

In October 2005, Vermont was awarded a three-year \$800,000 grant from the Administration on Aging and Centers for Medicare and Medicaid Services to develop visible, trusted places in the

community where Vermonters can turn for information about and access to long-term services and supports. Vermont's "no wrong door" decentralized model is being piloted in two regions of the state. The AAAs were the original sites to come on board providing the core functions of an ADRC, including the important service of information, referral and assistance. The ADRC is an integral part of the long term care system, playing a pivotal role in ensuring that all individuals, regardless of age or income, have access to the right information at the right time, in order to make informed decisions.

The ADRCs, by providing comprehensive information and assistance and streamlined access to long term services and supports, will assist the efforts of this grant in identifying individuals at risk of nursing home placement and spend down to Medicaid long term care as well as providing the options counseling necessary to ensure individuals are aware of the full range of choices available to facilitate community-based living. Moreover, the conceptual model has built important relationships across many key agencies and individuals, including the DAIL Long Term Care Clinical Coordinators responsible for conducting clinical eligibility for the Choices for Care program and the Department for Children and Families (DCF), Economic Services Divisions responsible for conducting Medicaid financial eligibility. The relationships already established among these partners will be critical to helping any nursing home diversion program identify those individuals most at-risk, educate consumers about all of their options, and support them in making decisions about their lives.

Area Agencies on Aging and Older Americans Act Services

The AAAs have been in existence in Vermont for over three decades. Their role in the local communities in serving older Vermonters and family caregivers cannot be understated. The AAAs provide information, referral and assistance, 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.

Through the availability of Older Americans Act (OAA) funds, AAAs are able to provide a range of programs that offer services and opportunities for older Vermonters to remain as independent as possible and to be active and contributing members of their community. Additionally, AAAs provide a range of services to family caregivers to support them to continue in this essential role. The OAA focuses on improving the lives of older adults and family caregivers in areas of income, housing, nutrition, health, employment, retirement, and social and community services.

Under the OAA, case managers play a vital role in helping older adults and family caregivers build upon their strengths, seek and obtain new resources, and achieve their goals. The Division of Disability and Aging Services (DDAS) within DAIL works closely with the AAAs and Home Health Agencies to develop a comprehensive approach to training staff and to the provision of case management services. Services are provided by certified case managers in accordance with established DDAS Case Management standards. The Standards require that a case manager annually participate in at least twelve hours of relevant education and training in order to retain certification.

DAIL also makes available to AAAs a small amount of State general Flexible Funds on an annual basis to support elders to remain independent in the community. These flexible funds are not tied to any eligibility criteria, but are prioritized to serve those individuals most in need who are at risk of going into a hospital or nursing home. Flexible funds have been a very successful tool for AAAs to augment existing services and supports. It supports the concept of flexible services and supports as envisioned by Vermont's nursing home diversion modernization program. Vermont plans to incorporate and expand the availability of such flexible services and supports to divert individuals from unnecessary nursing home placement within its nursing home diversion program.

Residential Alternatives

Vermont has spent many years building the appropriate array of residential alternatives so that consumers have choices in the types of living arrangements available. Over the past fifteen years, options have expanded—both with Medicaid and non-Medicaid funding, to support aging in place. Examples include:

- Enhanced Residential Care
- Assisted Living Residences
- HomeShare Vermont
- CMS funded Real Choices Supportive Housing Grant
- Housing and Supportive Services Program (HASS)

Quality Improvement Activities

DAIL is one of nine 2004 CMS Real Choice Systems Change Quality Assurance/Quality Improvement grantees. This funding from CMS is being used to develop a comprehensive quality management system across the Department's Division of Disability and Aging Services (DDAS) waivers over a 3-year period that began in September, 2004. The quality management system is based on the expectations contained within the CMS HCBS Quality Framework. The home- and community-based services available under these waivers are provided to individuals with developmental disabilities, older adults, individuals with physical disabilities, and individuals with traumatic brain injuries.

The goals of the grant are to effect enduring systems change that fulfills Vermont's commitment to ensure the health and well-being of individuals receiving waiver services within Vermont's home-and community-based, long-term care system; and to provide a comprehensive quality assurance and quality improvement management system in the HCB waivers utilizing the CMS Quality Framework.

It is the intent of this project to collaborate with the work accomplished already in the development of outcomes and indicators for home and community-based services, and to augment that work with additional outcomes and indicators that specifically address diversion activities.

Goals and Objectives

The goals of this initiative are to build upon the new provisions within the Older Americans Act, supporting Area Agencies on Aging, in partnership with DAIL, to build consumer-directed flexible supports that enable Vermonters to live independently in the community and avoid unnecessary nursing home placement.

Project objectives are to: (1) develop a non-Medicaid Flexible Choices PLUS cash and counseling program administered through selected Area Agencies on Aging; (2) develop targeting criteria to ensure services are available to those individuals most at-risk of Medicaid spend-down; (3) expand existing support brokerage functions used for the current Flexible Choices option; (4) expand/modify the role of current AAA staff to perform options counseling for the targeted population; (5) develop a comprehensive options counseling curriculum based upon the work completed by the National Association of State Units on Aging and the Independent Living Resource Utilization to facilitate the development of an interactive and informed decision making process; and (6) develop a training program on consumer self-directed care to support AAA and other aging network providers to translate into practice and service delivery the new direction in the Older Americans Act regarding “self-directed care”.

Proposed Approach

Vermont will develop a comprehensive nursing home diversion program in partnership with identified AAAs that includes several key components:

- (1) Development of consumer-directed flexible services and supports, called the Flexible Choices PLUS program, that is not tied to any particular program or service offered by AAAs or other aging network service providers. This program is modeled after the existing Flexible Choices, a cash and counseling option being piloted within the Choices for Care program. DAIL, in partnership with the AAAs, plans to develop a monthly allocation for each individual to build an individual support plan, based upon the individual’s needs. Options counselors will assist in identifying the needs, services, and individual support plans in collaboration with consumers and family members. Funding for the services offered within this program will come from grant funds, State general funds and local funds awarded to AAAs.

Shift from status quo: While the AAAs have managed flexible funds for many years to support individuals in need of gap-filling services in order to remain independent in the community, the

implementation of a formal consumer-directed program that builds upon existing resources within the OAA Title III-B and III-E funds, as well as State general funds to support the ability of the AAAs to utilize those resources more flexibly, has never existed before. AAAs utilize their Title III-B and III-E funds to provide a myriad of services to individuals age 60 and over. Many of the individuals served are those who are not eligible for Medicaid-funded services. The implementation of the Flexible Choices PLUS program will enhance and refine the AAAs to utilize funds in ways that follow the needs of the individual, rather than following the funding restrictions of dollars assigned to specific programs and services.

- (2) Expansion of support brokerage and fiscal intermediary services to support this new program. Under this expansion, the AAAs will subcontract with a support brokerage agency to provide fiscal intermediary services including payroll for hired caregivers and attendants and processing of service payments to providers of service under the Flexible Choices PLUS program. Funding for this service will come from grant funds.

Shift from status quo: The AAAs have never contracted with a support broker or fiscal intermediary service to process payroll for consumer-directed services or to provide payments to service providers under the OAA or other State funded programs. Under the Flexible Choices PLUS program, the AAAs will now have the ability to directly contract for these services, enhancing their ability to offer consumer-directed flexible services to support nursing home diversion and independent living.

Partnering with an experienced infrastructure learned through the Choices for Care program, Attendant Services Program, and Flexible Choices, the AAAs will gain a value-added service to offer to individuals in the community who desire to direct their own services.

- (3) Expansion/modification of role of existing AAA staff to perform the role of options counselors as defined by the NASUA/ILRU concept paper. Funding for this service will come from a retooling of how AAAs use their Title III-B monies to pay for case management, information, referral and assistance, and funds for the National Family Caregiver Support program. Identified case managers and other AAA staff funded out of the Title III-B program will function as options counselors—a real

transformation and sustainable use of OAA money to support nursing home diversion and the new language in the OAA.

Shift from status quo: AAAs have offered quality case management services for many years. The skills that the case management staff bring to their respective positions is commendable. Case managers must be certified and must meet specific skill sets, with an expectation for ongoing continuing education. The case managers provide services to the general population of individuals age 60 and over seeking services through the AAA. DAIL also contracts for case management services for the Choices for Care program. There are varying opinions regarding the definition of options counseling and to what extent current case management staff and practices embrace the concept of options counseling. If we look specifically at the concepts put forth by NASUA and ILRU and options counseling practices as part of ADRCs, we will see variations from one AAA to the next in the implementation of those practices. It is the desire of the nursing home diversion program to identify and implement a discrete options counseling role for existing AAA staff that follows the best practices and ideas put forth in the NASUA/ILRU concept paper. This is a shift in existing practice, and by using funds in a more creative way, will be a self-sustaining service into the future.

- (4) To support the expansion of AAA staff to function as options counselors, the program will develop a comprehensive Options Counseling Training Program targeting AAA staff, long term care clinical coordinators currently performing clinical eligibility for the Choices for Care program, hospital discharge planners, Dementia Respite and National Family Caregiver Coordinators at the AAAs, and other aging network service providers. DAIL will seek the input and recommendations of The Lewin Group to assist in identifying national experts who have experience in implementing Options Counseling programs and the development of high-quality training curricula. DAIL intends to implement a competitive bidding process for the development and implementation of the Training Program.

Shift from status quo: Case management training has been a part of the DAIL training curriculum for many years. This training has focused on many topic areas including eligibility for programs, serving

individuals with dementia and other specific diagnoses, working with families, etc. The difference that we envision the introduction of an Options Counseling Training Program to make within the nursing home diversion program is to build a program in the context of the changes within the Older Americans Act, the advent of the ADRCs unfolding across the state, and to support the movement towards consumer choice and consumer direction. Additionally, the invitation to other key aging stakeholders such as hospital discharge planners, home health agencies, adult day programs, long term care clinical coordinators, etc., expands the function of options counseling more broadly. While it does not necessarily mean that all of these entities and agencies would be in the business of performing options counseling as defined by this program, the exposure to the concepts, best practices, and key components assists these aging partners to direct consumers and individuals at-risk to the most appropriate entity.

- (5) Develop a comprehensive Consumer Self-Directed Care Curriculum to support the new language in the Older Americans Act around self-directed care. There exists a paradigm shift in elder services to support a more consumer-directed system of services. Similar to the evolution of the independent living movement within the disability community, the aging network is preparing itself to be able to proactively serve the next generation of baby boomers who come from a very different history and set of expectations. The time is now to prepare our AAAs and other aging network providers in the concepts of self-direction, consumer-direction, and person-centered approaches to service delivery.
Shift from status quo: While AAAs embrace the concept of consumer direction and empowerment, translating concepts into practice is not easy. Using the expertise of consultants, this program will develop a curriculum that will include input from consumers, key aging advocacy organizations in the state, as well as other networks with a long-standing history in self-directed models of services. There is much experience in this area resulting from the recent Real Choice grants, Independence Plus grants, Cash and Counseling models, and Quality Improvement grant activities across the country. We are confident that we will be able to design and build a consumer self-directed curricula that works well for Vermont and Vermonters. This curricula will target not only the AAA staff and

other stakeholders working in partnership to implement the nursing home diversion program, but also consumers, family members, respite and national family caregiver support coordinators. It is just as important for staff to know how to support self-direction as it is for consumers and family members to know how to take responsibility for self-direction and what that means within a cash and counseling model, with flexible services and supports. We envision a system where consumers and families are able to take full advantage of flexible services, and believe individuals should have the choice of self-directing their care.

(6) Development of targeting criteria to ensure nursing home diversion activities are targeting those individuals most at-risk of nursing home placement. The program proposes to build off of the targeting criteria established by the Dementia Respite Grant program:

- a. Age 60 and over
- b. Clinically-eligible for the Choices for Care program
- c. Denied or ineligible for Medicaid long term care
- d. Income at or below 300% of the federal poverty level

It is the desire of this program to also explore a secondary target population of individuals who are currently defined as the Choices for Care Moderate Needs group. These individuals do not currently meet nursing home level of care, and do not meet Medicaid financial eligibility but are at-risk:

- Individuals who require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs or IADLs;
- Individuals who have impaired judgment or decision making skills that require general supervision on a daily basis;
- Individuals who require at least monthly monitoring for a chronic health condition;
- Individuals whose health condition will worsen if services are not provided or if services are discontinued.

Current data indicates that there are 171 individuals on the Moderate Needs Group waiting list as of June 2007. Many of these individuals are waiting for homemaker and adult day services. While these individuals do not yet meet nursing home level of care, it is the belief of the AAAs and of DAIL that this group is an important target group for which to explore nursing home diversion activities. Without necessary services, they may in a short time become clinically eligible for the Choices for Care program. The goals and vision for the nursing home diversion program are to make flexible services available to individuals at-risk of nursing home placement. Should Vermont be able to fold this target population in to its program, it will track the impacts such a program has on delaying institutionalization and the relative costs of providing flexible services.

As a result of these program components, it is anticipated that consumers will benefit from three key areas: (1) options counseling; (2) training in self-directed care and service delivery; and (3) enrollment in the Flexible Choices PLUS program. Using budgetary estimates, it is anticipated that at least 200 consumers over the 18-month grant period will benefit from at least one of the three program components.

DAIL intends to complete the planning of the program in the first nine (9) months of the grant, with program implementation and actual delivery of flexible services and supports to start in month ten. It is the desire to collect data across a nine (9) month period in order to measure the impact of the nursing home diversion program.

DAIL and the AAAs currently utilize the Social Assistance and Management Systems (SAMS) database to manage the information related to Choices for Care and OAA funding and services. The existing SAMS database will be used at the AAAs to track enrolled consumers, individual support plans, and in collaboration with the support broker and fiscal intermediary, a tracking of service costs per enrolled participant.

Project Outcomes

Project outcomes are to: (1) establish an effective and sustainable nursing home diversion program that can be expanded statewide; (2) transform and modernize funding to support flexible,

consumer-directed services; (3) strengthen the capacity of the state to reach older adults before they enter a nursing home, supporting choice in long-term care options and self-directed care.

Key system outcomes to be accomplished include: (1) use of single entry point systems (ADRCs) as pivotal resources to refer consumers to nursing home diversion programs. Because the AAAs are already core partners of the ADRC model in Vermont, this is a highly likely outcome; (2) Serve 200 consumers over an 18-month period in one of three program components: options counseling, consumer self-directed training, and Flexible Choices PLUS services; (3) expansion of program to all AAAs; (4) development of refined targeting criteria serving those individuals at greatest risk of nursing home placement; and (5) overall system and consumer satisfaction with program model.

Project Management

The lead agency, as designated by the Secretary of the Agency of Human Services, will be the Department of Disabilities, Aging and Independent Living (DAIL). Within DAIL, the Division of Disability and Aging Services will manage the project. Veda Lyon, Manager of the Community Development Unit, will be the Project Director. Ms. Lyon manages the administration of the current ADRC grant as well as oversees a number of other grants assigned to her unit. She will supervise compliance with grant objectives and required grant reporting, working closely with the Project Manager, DAIL staff and leadership as well as the AAAs.

The Project Director reports to Camille George, Community Development Unit Director, who will supervise the Project Director's grant activities. The Department's Finance Director will supervise all fiscal services associated with management of this project.

DAIL will contract with a Project Manager who will be responsible for the day to day management of the grant, development of the overall work plan, implementation and grant outcomes, providing direction and facilitation of the grant implementation. This position will review and contribute to the required grant reports, provide project leadership and monitoring of the project's ongoing progress, functioning as liaison among the Grantee (DAIL), AoA, the AAAs and other aging network stakeholders.

The Project Manager will work closely with the AAAs in the development of workplan milestones, timelines, tasks and objectives to assure the successful and ongoing implementation of the program.

Bard Hill, Director of the Information and Data Unit, will collaborate with the Project Director and Project Manager in identifying the appropriate data elements that are available within the SAMS database to support the program.

Maria Mireault, Dementia Project Director, will assist in ensuring that the Respite Grant activities are coordinated with the grant at the local level through the AAAs, as well as assist in identifying respite coordinators who will be a part of the Options Counseling Training Program.

Merle Edwards-Orr, Cash and Counseling Project Director, will provide technical assistance in the implementation of the Flexible Choices PLUS program, including guidance in developing support brokerage and fiscal intermediary services.

Joe Carlamagno, Quality Management Unit Director, will assist in the identification of outcomes and indicators that support the Department's new Quality Management Plan, and define the success of the nursing home diversion program.

A grant management team will be formed that includes the Project Director, Project Manager, key DAIL staff, the AAA leadership and the Council of Vermont Elders (COVE). This team will meet periodically to review the progress of the grant.

The grant will contract with two yet to be identified technical assistance consultants for the following services:

- (1) Development of a comprehensive Options Counseling Curriculum based on the National Association of State Units on Aging and ILRU concept paper written for the Aging and Disability Resource Center grant initiative. DAIL will seek the input of The Lewin Group, the national technical assistance subcontractor for the ADRC grant, to identify consultants

who bring the necessary experience in implementing model Options Counseling programs across the country;

- (2) Development of a comprehensive Consumer Self-Directed Care Curriculum designed for AAA staff, long term care clinical coordinators, respite coordinators, hospital discharge planners, other aging network providers as well as consumers and family members to provide education in facilitating and supporting consumer self-directed care.

Organizational Capability

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 developing and successfully implementing grant funded community-based programs through collaboration with organizations such as the AAAs, Home Health Agencies, Developmental Service Providers, the Vermont Department of Health and consumer advocacy groups. DAIL manages a budget of \$156 million and has strong IT support and robust project management and data collection and analysis capability.

Vermont's Choices for Care, the 1115 Research and Demonstration Program for Long-Term Care has received national recognition and continues to be a model for other states who are seeking ways to reduce their long-term care expenditures while maintaining services for older adults and adults with disabilities. Of the many reports produced by the Department, the 2007-2010 State Plan on Aging, the Long-Term Care Sustainability Study, and the Shaping the Future of Long Term Care and Independent Living Report 2006-2016 were instrumental in developing this proposal.

The AAA network, as the key partner organizations in implementing the nursing home diversion program, includes strong organizations with excellent management capacity. The AAAs have used the SAMS2000 system for several years and manage their data collection and analysis functions appropriately. They are recognized leaders in their planning and service areas in the planning and development of services to older Vermonters and are very interested in enhancing their capacity to serve

individuals who are at risk for nursing home placement. The AAAs, through their existing case management system, have years of experience as advocates and case managers, assisting individuals in identifying their service needs and helping them navigate the long term care system to put those services in place. They also have extensive experience identifying service gaps and collaborating together to try and fill those gaps, or proactively working through the political system to seek funding to support necessary services that do not exist, or are in short supply to serve the demand.

The AAAs have shown the willingness and capacity to think innovatively and move in new directions to improve services for elders. They are ready to partner with DAIL and other community partners to build a successful nursing home diversion program that moves them in a new direction in the support of consumer-driven flexible supports that are not tied to specific programs and services. They view this grant as an opportunity to utilize their resources in a way that supports flexibility and choice, including enhanced support in making informed decisions about long term service options. Vermont anticipates developing an RFP process to identify 2-3 AAAs best positioned to partner with DAIL to pilot the nursing home diversion program. While all AAAs have expressed an interest to partner in this endeavor, DAIL would like to maximize the ability to serve as many consumers as possible through the Flexible Choices PLUS program during this initial project phase. It fully anticipates expanding the project to all AAAs in the future.

Vermont does plan to use two consultants to develop educational curricula necessary to the successful implementation of its nursing home diversion program, 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.

Vermont is currently implementing ADRCs in two regions of the state to build the capacity for a no-wrong door to long term services and supports for persons of all ages, incomes, and disabilities. The AAAs function as the “single point of entry” to services for the 60 and over population in this decentralized model. The model is now expanding to include additional core partners, extending ADRC services to younger persons with physical disabilities, persons with traumatic brain injury and persons

with developmental disabilities. The AAAs have spent considerable time over the past year building important partnerships and relationships with a number of key agencies who have a responsibility for providing long term services and supports to a broad population including the VT 211 program and the regional resource specialists responsible for ensuring local community resources are reflected and updated in the Refer software resource database. They have built their own internal capacity to utilize Refer software to provide a solid resource database of services for the 60 and over population. As members of the Streamlining Access Workgroup, the AAAs have assisted in developing a long-term strategic plan designed to coordinate and enhance access to long term services and supports from the point of initial contact and the information and referral services, to the development of a more efficient eligibility determination process in collaboration with the long term care clinical coordinators and the regional DCF offices responsible for Medicaid financial eligibility.

The work the AAAs have accomplished as part of the ADRC grant has positioned them solidly to support the components of the nursing home diversion modernization program. The development of a comprehensive Options Counseling Training Program will enhance the ability of the AAAs participating in the ADRC pilots to provide options counseling to individuals based upon the values and recommendations developed by NASUA and ILRU. For those AAAs not yet operating as an Aging and Disability Resource Connection, this training will jump start their capacity to function as an ADRC in collaboration with their other local partners, providing a best practice core function of options counseling well in advance of functioning as a formal ADRC. In this vein, they will be able to serve as a model for their future core partners in the provision of quality, cutting edge options counseling services. The development of the Flexible Choices PLUS program and companion Consumer Self-Directed Care curriculum advances the ADRCs ability to embrace self-direction across all of their services and functions, as well as streamline even further access to long term services and supports that delay unnecessary nursing home placement. Lastly, the relationships that the ADRCs have established with the DAIL long term care clinical coordinators and the regional DCF offices will assist the nursing home diversion program in the identification of individuals who fit the target criteria, and expediting the referral

processes of individuals who are deemed ineligible for Medicaid long term care to the appropriate

AAA/ADRC in the consumer's community.