



# VERMONT STATE PLAN ON AGING

FFY 2023 – 2026

October 1, 2022

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## Verification of Intent

The State Plan on Aging for the State of Vermont is hereby submitted for the four-year period of October 1, 2022 through September 30, 2026.

The plan includes assurances and plans to be conducted by the Vermont Department of Disabilities, Aging, and Independent Living (DAIL) under the relevant provisions of the Older Americans Act, as amended during the 2020 reauthorization.

DAIL has been given the authority to develop and administer the State Plan on Aging in accordance with all of the State activities related to the purpose of the Act, including the development of comprehensive and coordinated systems for delivery of supportive services, such as multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for older adults and family caregivers in Vermont.

This plan is hereby approved by the Commissioner of DAIL, designee of the Governor, and constitutes authorization to proceed with activities under the Plan upon approval by the U.S. Assistant Secretary on Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all federal statutory and regulatory requirements.

Authorized Signature \_\_\_\_\_



Monica White, Commissioner

Date: \_\_\_\_\_

29 June 2022

## MISSION STATEMENT AND CORE PRINCIPLES

**MISSION:** Make Vermont the best state in which to grow old or to live with a disability - with dignity, respect and independence.

The Department of Disabilities, Aging and Independent Living (DAIL) is committed to fostering the development of a comprehensive and coordinated approach to the provision of community-based systems of services for older adults and people with disabilities. Our goal is to enhance the ability of these Vermonters to live as independently as possible, actively participating in and contributing to their communities. As we approach this work, we are guided by the following core principles:

- **Person-centered:** the individual is at the core of all plans and services.
- **Respect:** individuals, families, providers, and staff are treated with respect.
- **Independence:** the individual's personal and economic independence are promoted.
- **Choice:** individuals will have options for services and supports.
- **Self-determination:** individuals direct their own lives.
- **Living well:** the individual's services and supports promote health and well-being.
- **Contributing to the community:** individuals are able to work, volunteer and participate in local communities.
- **Flexibility:** individual needs guide our actions.
- **Effective and efficient:** individuals' needs are met in a timely and cost-effective way
- **Collaboration:** individuals benefit from our partnership with families, communities, providers, and other federal, state, and local organizations.

## **PURPOSE OF THE STATE PLAN ON AGING**

To plan for the ongoing and future needs of older adults in Vermont and to meet the requirements of Section 307 of the Older Americans Act (OAA), the Department of Disabilities, Aging and Independent Living (DAIL), the designated State Unit on Aging (SUA) for Vermont, has prepared this State Plan for submission to the federal Administration for Community Living (ACL). Vermont has opted to create a four-year State Plan from October 1, 2022 (FFY23) through September 30, 2026 (FFY26).

The State of Vermont is required by federal regulation to:

1. Develop a State Plan for submission to the Assistant Secretary on Aging;
2. Administer the State Plan in accordance with Title III of the OAA, as amended;
3. Be responsible for planning, policy development, administration, coordination, priority setting, and evaluation of all state activities related to the objectives of the OAA;
4. Serve as an effective and visible advocate for older individuals by reviewing, commenting on, and recommending appropriate action for all State plans, budgets, and policies that may impact older Vermonters; and
5. Provide technical assistance and training to any agency, organization, association, or individual representing the needs and interests of older individuals.

The State Plan aligns with DAIL's broader vision and goals, assuring a focus on strategic priorities and outcomes. Additionally, the plan addresses the fulfillment of OAA responsibilities, including the enhancement of Vermont's comprehensive and coordinated community-based systems resulting in a continuum of services to older persons with particular emphasis on older individuals with the most significant economic or social needs. The State Plan offers a framework for the ongoing operations of programs funded through the OAA. It describes the coordination and advocacy activities the state will undertake to meet the needs of older adults, including integrating health and social services delivery systems. In addition, this plan reflects the Vermont Agency of Human Services' vision that Vermonters are healthy and safe and achieve their greatest potential for well-being and personal independence in healthy, safe, and supportive communities.

## Narrative

### EXECUTIVE SUMMARY

The aging network's response to COVID-19 in Vermont brought a unique look into the depth of community-based organizations and the services they orchestrate. The network service providers who traditionally operate under the social services umbrella pivoted their operations overnight. This immediate shift to social distancing put much attention on infection rates and the protocols needed to contain the spread of the virus. As organizations shifted their service delivery models to meet the social distancing requirements, services evolved to help address the impact of the new rules. The aging network swiftly adopted numerous practices to engage older Vermonters in social activities, including, but not limited to, friendly callers, virtual art programming, technology lending, and vaccine campaigns.

As case counts rose and fell, the impact of COVID-19 on the aging network ebbed and flowed. There were months when levels of normalcy began to shine through. However, service delivery models quickly returned to utilizing appropriate mitigation measures as case counts rose again with the COVID-19 variants. Fortunately, Federal and State leadership were responsive to the financial demands that the COVID-19 response was putting on operations. Stimulus funding was instrumental in stabilizing service delivery and bringing the aging network into vaccine education and access. The network's connection to Vermont's older adults and Vermonters who could not leave their homes was crucial to increasing education about the vaccination and helping to boost Vermont's vaccination rate. The collaboration between the Vermont Department of Health (VDH), DAIL, and the aging network demonstrated the strength and breadth of Vermont's community-based organizations and service system.

COVID-19 caused varying degrees of destabilization, rebuilding, and ongoing maintenance to Vermont's service systems. The 2023-2026 Vermont State Plan on Aging addresses the collocation of critical services that support older Vermonters in the greatest social and economic need. Underneath each of the goals, objectives, and strategies is an aim to continue the advancement of Vermont's aging services system and ensure that Vermont's growing population of older adults will have the necessary infrastructure embedded directly into their communities to support their ability to age in place. The challenges brought on by COVID-19 to the aging network produced new approaches to collaboration and delivery of services that, in time, will strengthen the aging network and benefit those they serve. The plan that follows represents the ongoing work towards continuing collaboration between State and local partners to improve the lives of older Vermonters.

The main goals in the plan are:

**Goal 1: Promote the health, safety, and well-being of older Vermonters.**

**Goal 2: Ensure Vermont's OAA programs are inclusive of all older Vermonters.**

**Goal 3: Bolster the recognition and support of unpaid caregivers in Vermont.**

## CONTEXT

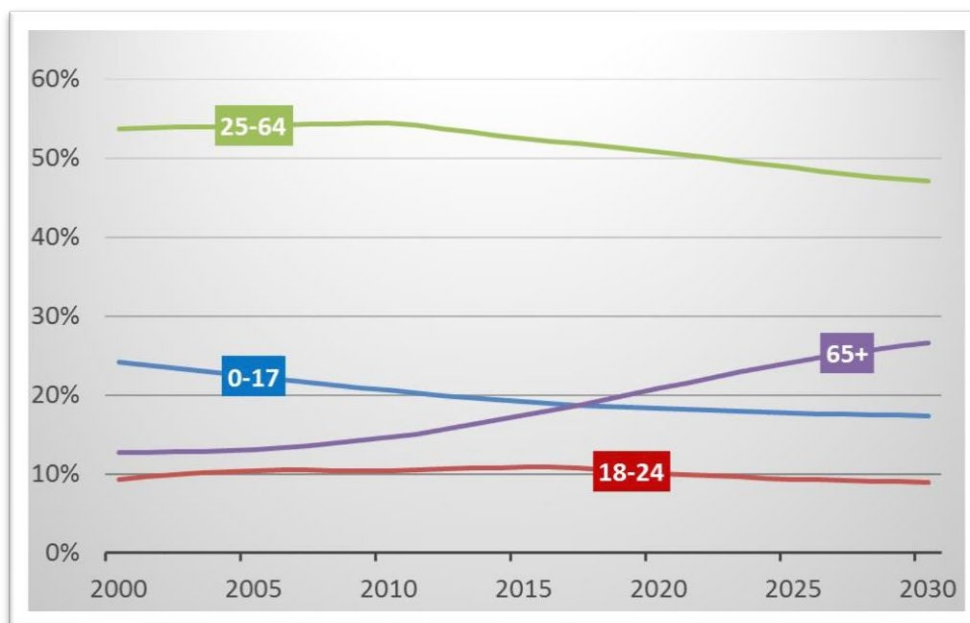
Consisting of 14 counties, 279 cities and towns, and 159 special districts, approximately a quarter of Vermont's 643,077 residents are gathered in Chittenden County, including Burlington, Essex, South Burlington, and Colchester (United States Census Bureau, 2021). Most Vermont towns are comprised of less than 5,000 people and reflect small-town living through a dedication to supporting local business and maintaining the values set by those who came before them. As a reference, Chittenden County has 313.3 people per square mile, while the next closest is Washington County, with 87.1 people per square mile. Anecdotally, Vermont towns often define themselves through their town center, local high-school sports teams, and recreation.

Additionally, Vermont's 331,106 housing units tend to be older, with 1 in 4 homes being built before 1939 (Vermont Housing Finance Agency, 2020). Outside town centers and municipalities, real estate is spread apart, and most road systems are two-lane or dirt roads. Underpinning Vermont's culture is a strong sense of individualism reflected in its towns. Elected officials lead Vermont municipalities and towns, including town clerks and select boards. Participation at the local level is strongly encouraged. This is best reflected in the state-wide holiday, Town Meeting Day, which occurs the first Tuesday of every March.

Understanding the makeup and history of Vermont is essential for enhancing the State's comprehensive and coordinated service system. Due to the emphasis on local control, developing a dynamic and resilient service system begins locally. Engaging communities and understanding the needs of each community is central to the development process. What works for one town may not necessarily work well in surrounding towns.

The development of Vermont's 2023-2026 State Plan on Aging started with the five Area Agencies on Aging (AAAs) and the SUA administering the [Older Vermonters and Family Caregiver Needs Assessment](#). The needs assessment informed the AAAs' 2022-2025 Area Plans and this State Plan. The SUA then used these Area Plans to inform the State Plan. The goals, objectives, and strategies laid out in the State Plan must align with what is happening at the community level. Otherwise, implementation is hindered at the onset.

Figure 1



*Note:* Vermont population by age group, 2000-2030. 2000-2017 data from U.S. Census. 2018-2030 from Consensus Administration and Joint Fiscal Office projections

By 2030, it is projected that 47 percent of Vermonters will be between the ages 25 and 64, down from 54% in 2000 and 2010 (Brighton, Kleppner, & Trenholm, 2019). Over the coming decades, it is expected that older Vermonters will outnumber children by an increasing margin. As Vermont's demographic trends shift towards a more aging population, the attention placed on responding to social determinants of health and the variations in older people's health increases. As reported by the World Health Organization, maintaining healthy behaviors throughout life, mainly eating a balanced diet, engaging in regular physical activity, and refraining from tobacco use, all contribute to reducing the risk of non-communicable diseases, improving physical and mental capacity, and delaying care dependency (World Health Organization, 2021).

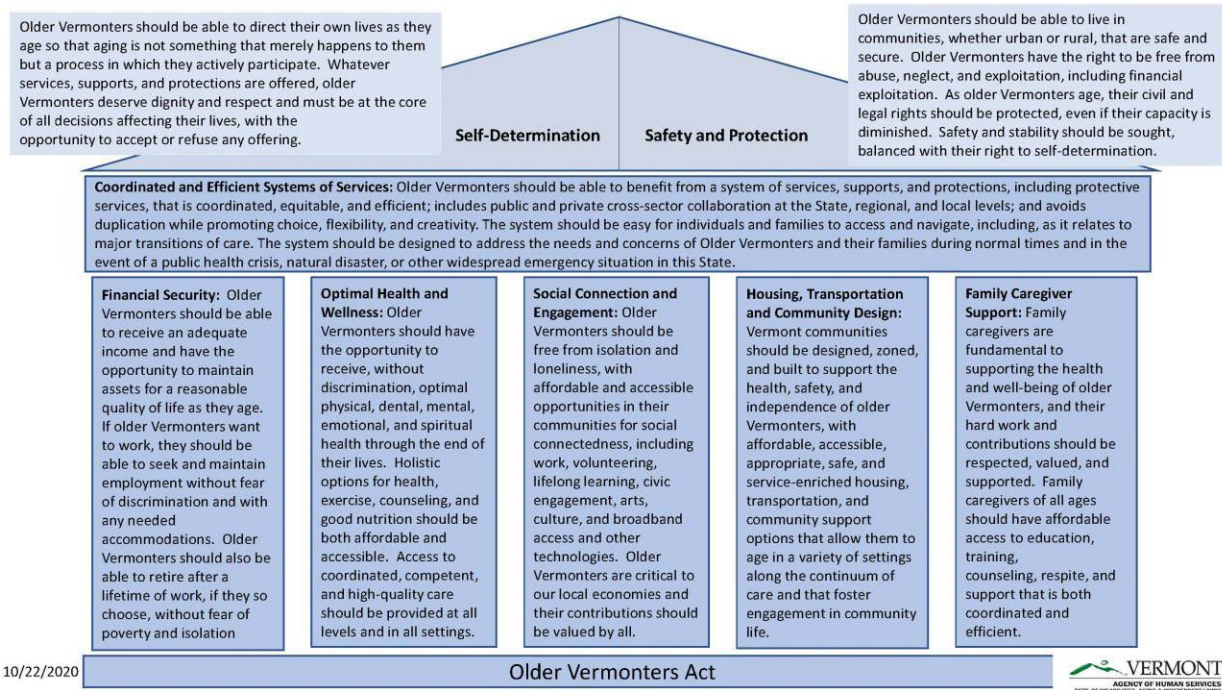
The most current 2020 American Community Survey reported that 27.1 percent of Vermonters are 60 years or older, and 7.8 percent of that population are below the poverty level, totaling approximately 13,366 people. Vermont's 2021 OAA data report shows that 4,779 individuals with incomes below poverty received OAA funded services. Research shows income as one of the most influential factors on health (Krisberg, 2016). As such, there is quantitative support for Vermont's OAA programming to expand awareness of services and supports, including, but not limited to, nutrition, health promotion, disease prevention, and caregiver support.

In recognition of the need to bolster service systems to address social determinants of health, in 2018 the State of Vermont passed [Act 172](#) to create an Older Vermonters Act Working Group. The working group developed nine charges and recommendations to inform the development of the Older Vermonters Act. The formation and passage of [Act 156](#) in 2020, the Older Vermonters Act, aligns with the OAA by putting in statute a set of core principles for Vermont's services,



supports, and protections for older Vermonters. In addition, the Act outlines the duties of DAIL and the AAAs. Finally, it expands the State Plan on Aging to include all long-term services and supports for older Vermonters.

**Figure 2**



*Note: Core principles of the Older Vermonters Act*

The work performed by the Older Vermonters Act Working Group and the creation of the Older Vermonters Act builds upon Vermont's pathways towards a holistic, community approach to healthy aging.

In particular, the Act sets statutory requirements calling on AAAs to support efforts to improve how the service system responds to issues facing older Vermonters. In addition to responsibilities required of AAAs, the Act states that AAAs shall:

1. Promote the principles established by the Act across the agencies' programs and shall collaborate with stakeholders to educate the public about the importance of each principle;
2. Promote collaboration with the network of service providers to provide a holistic approach to improving health outcomes for older Vermonters; and
3. Use their existing area plans to facilitate awareness of aging issues, needs, and services and promote the system principles.

The Act sets into statute that older Vermonters be represented across different sectors, and the principles build a common standard for how older Vermonters are embraced.

## KEY TOPIC AREAS

In addition to the findings from the needs assessment discussed later, the SUA is incorporating the ACL's [new guidance](#) for developing state plans on aging. The guidance provided by ACL reflects changes to the OAA as codified through the [Supporting Older Americans Act of 2020](#). The guidance also incorporates Federal Administration priorities as reflected in various Presidential Executive Orders and other priority-setting documents. In this direction, ACL broke out five key topic areas to be addressed, including OAA core programs, COVID-19, equity, expanding access to home and community-based services, and caregiving. Inclusive of each key topic area is special attention to focusing resources on serving older adults in the greatest social and economic need.

### Older Americans Act (OAA) Core Programs

The OAA and the complementary Older Vermonters' Act lay out a wide range of initiatives for the SUA and AAAs. A coordinated service system includes the following for individuals and families:

- Knowing where and how to access information and resources.
- Assistance with understanding the resources available.
- Ongoing support with accessing and monitoring services.

Additionally, the service system consists of numerous community partners providing in-home support services, case management, nutrition and wellness programs, transportation, and caregiver support programs. Finally, both Acts require that support be targeted to those in most significant economic and social need, charging community providers receiving Older Americans Act funds to reach people who cannot afford equal access to housing, food, transportation, healthcare and social engagement.

The SUA uses qualitative and quantitative data to monitor and evaluate targeting services to individuals with the greatest economic and social need. The State Plan cycle will emphasize having consistent and reliant practices for delivering services to the targeted populations. Particular attention will be placed on supporting individuals and families impacted by Alzheimer's and related dementia, engaging older Vermonters in a manner that emphasizes meaningful connection, and protecting older adults from abuse, neglect, and financial exploitation.

### COVID-19

In response to the COVID-19 pandemic, DAIL adopted and will maintain an active role in the State's emergency response to protect Vermonters at the highest risk of becoming seriously ill or dying from the virus. DAIL continued to provide technical assistance with support from VDH, assisted in the State's efforts to roll out Vermont's vaccine program, maintained program flexibilities to better support consumers and families, and awarded Coronavirus Relief Funds (CRF) to a variety of providers in need of emergency financial stabilization. As the Department looks to the future, areas of focus are preparedness for outbreaks and enhancing the role of the Aging Network in public health. The American Rescue Plan Act funds have provided an excellent opportunity for the Aging Network. DAIL will be working closely with its partners to monitor the impact.

AAAs and their partners saw increases in volunteers, funding, and innovations with their approach to service delivery. Projects directing technology to older adults to increase engagement and positively impact social isolation were piloted. Initial findings show positive responses from older adults who participated, and additional work in this area is needed to better understand the effectiveness of newer technologies.

Vermont is still learning the full effects of the pandemic at the State and local levels. While we are proud of Vermont's nation-leading COVID-19 response efforts, we are saddened by the lives lost in our state and beyond. In considering the broader impacts beyond deaths, research at the national level indicate that despite the disruption to day-to-day living as we knew it, there are positive takeaways. In 2020, a study was conducted by Edward Jones, Age Wave, and the Harris Poll to get a national representation of the impact of COVID-19 on retirement. The final report found that older generations have faced far less financial and emotional disruption than younger generations despite being at greater health risk (Edward Jones, Age Wave, The Harris Poll, 2020). The study surmised from the research that older adults have the experience, perspective, emotional maturity, and resilience that comes with decades of meeting life's challenges. Therefore, the ongoing approach responding to impacts of COVID-19 will be to focus on the strengths of older adults and service delivery models that build upon those strengths.

## Equity

Internally, the DAIL Diversity, Equity, and Inclusion Task Force (DEITF), composed of staff from each division and the Commissioner's office, was formed in October 2020 in service of the Agency of Human Services' (AHS) commitment to diversity, equity, and inclusion. The purpose was to provide recommendations to Departmental leadership for advancing equity across DAIL's internal and external policies, procedures, and programming. A focused environmental scan of DAIL's internal operational efforts and workforce characteristics revealed areas of strength and opportunity. As a result, recommendations based upon evidence-based research and national best practices regarding the recruitment and hiring of employees and equity-focused employee training and education were brought to DAIL's Operations Unit for review. Additionally, DAIL is represented on the AHS Health Equity Advisory Commission, a commission to promote health equity and eradicate health disparities among Vermonters, particularly people of color, LGBTQ individuals and people with disabilities. AHS and DAIL are committed to the ongoing process of ensuring equity across the Agency and setting an example for others to follow.

Externally, Vermont's geographic and population make-up makes accessing robust social opportunities challenging. Living in the most rural parts of the State desiring to participate in organized activities requires a flexible, often informal, service delivery system. Enhancing the coordinated service delivery in Vermont's most rural communities will be an area of focus for the SUA and AAAs. In addition, the SUA will direct attention towards consistent practices for prepared meals to increase choice regarding cultural preferences and medical needs. In summary, the SUA will focus on best practices for supporting older individuals' health and economic welfare.

Lastly, targeted outreach will be implemented to build upon existing efforts to engage Vermont's diverse populations, including BIPOC, LGBTQIA+, New Americans, and Abenaki. Although not a federally recognized tribe receiving federal Title VI funding, the Abenaki in Vermont is a

distinct group deserving culturally appropriate programming funded through the OAA. In addition, the needs assessment pointed out the SUA and AAAs are not reaching diverse populations. Outreach will establish relationships with groups representing Vermont's diverse populations to better target programming toward their wants and needs. Examples of work being done to increase diversity include expanding representation on local advisory councils, greater representation of diverse groups in outreach materials, senior nutrition programs preparing meals tailored to New Americans, and the establishment of diversity, equity, and inclusion workgroups.

### **Expanding Access to Home- and Community-Based Services**

The growing number of older adults living in Vermont is expected to increase the need for assistance with living independently. Ensuring Vermonters receive needed care will require expanding the availability of in-home services, transportation, broadband, and other supports to improve social determinants of health. Social determinants of health include social, economic, and environmental conditions that help older adults maintain their health and well-being. AAAs and the aging network are well-positioned to develop mechanisms for reporting their collective impact on social determinants of health and expanding their programming into other areas such as contractual relationships with healthcare payers.

AAAs respond to social determinants of health through care management and coordinating services, including, but not limited to, transportation, nutrition services, financial assistance, wellness activities, and family caregiver support. There is an opportunity to support healthcare systems with the experience community-based organizations have with addressing the social factors that negatively impact older adults' health. Additionally, expanding capacity to assist with care transitions is needed. Vermont's workforce shortage compounded with the demand for hospital services during high incidences of COVID-19 highlighted the need for better response to individuals unable to safely exit acute care. There are a number of initiatives through the Money Follows the Person demonstration grant to improve care transitions and decrease rehospitalization.

The workforce shortage presents a real challenge to expanding the systems of care as they currently exist but also presents opportunities. For example, there is growing interest in adopting and expanding programs that use volunteers to provide respite and companionship. Additionally, Vermont's [Enhanced FMAP Spending Plan](#) includes efforts to improve workforce recruitment, retention, and training, improve infrastructure, make capital improvements, expand services, and focus on quality care.

### **Caregiving**

According to data collected from the 2015-2019 Behavioral Risk Factor Surveillance System survey conducted by VDH, Vermont is home to an estimated twenty-five thousand family caregivers for people with Alzheimer's and other dementias. Vermont's unpaid, informal support network provides approximately thirty-six million hours of care annually, valued at 717 million dollars. The health care system is not positioned to absorb the cost of care that family caregivers provide.

Research shows that the long-term stress and burden of caregiving can negatively impact the caregiver's own health. In recognition of the need to support family caregivers, Congress passed the [RAISE Family Caregivers Act](#), which directs the development of a national family caregiver strategy. Raising awareness of family caregivers and their care activities is needed to enhance their support. In particular, the bridge between family caregivers and the healthcare system needs modifications. Too often, caregivers are not active members of care planning teams but they are required to provide care for which they were not prepared.

VDH is the recipient of a 2021-2023 Building Our Largest Dementia (BOLD) Infrastructure for Alzheimer's Act grant provided by the Centers for Disease Control (CDC) to enable public health programs to address Alzheimer's disease and related dementias (ADRD). The grant requires VDH to focus on changing systems, environments, and policies to promote risk reduction, improve early diagnosis, prevent and manage comorbidities, and avoid hospitalizations. The shift to a public health approach to Alzheimer's disease is accomplished by using data to set priorities, develop public health actions, address social determinants of health, and provide support for caregivers who care for people with dementia.

The OAA recognizes individuals of any age with Alzheimer's disease and related disorders with neurological and organic brain dysfunction as a population to be prioritized. The SUA participated with VDH as part of the statewide effort to update Vermont's Action Plan on Alzheimer's and Healthy Aging. A public health approach to dementia will inform and enhance the work undertaken by AAAs to assist individuals and families impacted by the disease. In addition, OAA programming will help reach the goals of improving early detection and increasing prevention through health promotion and disease prevention programming.

## NEEDS ASSESSMENT

As part of the development of the State Plan on Aging, DAIL embarked on a statewide survey targeting older Vermonters and family caregivers providing care for individuals sixty and older. The needs assessment results serve as a critical source of information to guide DAIL's planning for the development of services and responses to the needs of these populations for the 2023 through 2026 four-year period. In addition, AAAs have used this data to develop their 2022-2025 Area Plans. In total, 2,716 Vermonters 60+ surveys were sufficiently completed to be included in analysis, 2,634 of which included zip codes, enabling assignment to AAA region. Additionally, 357 family caregivers were completed.

### Methodology

In July 2020, DAIL contracted with Flint Springs Associates (FSA), a Vermont-based consulting firm, to conduct an assessment of the needs of older Vermonters, i.e., persons sixty years and older, and their family caregivers, and an assessment of community services and supports available to assist older Vermonters and their family caregivers.

Vermont's five Area Agencies on Aging along with the [counties](#) they serve are listed below:

- Age Well: Addison, Chittenden, Franklin, and Grand Isle
- Northeast Kingdom Council on Aging (NEKCOA): Caledonia, Essex, and Orleans
- Central Vermont Council on Aging (CVCOA): Lamoille, Orange, and Washington
- Southwestern Vermont Council on Aging (SVCOA): Rutland and Bennington
- Senior Solutions: Windham and Windsor

FSA developed a set of structured interview questions reviewed and refined these with SUA project staff, and used them in gathering input from stakeholders. Relying on DAIL's guidance, FSA conducted interviews with representatives from the following organizations:

- Vermont Department of Health, Division of Health Promotion and Disease Prevention
- Vermont Attorney General's Office
- Vermont Association of Area Agencies on Aging
- Associates for Training and Development
- Vermont Association of Adult Day Service Providers (VAADS)
- Visiting Nurses' Association, Home Health Agencies
- University of Vermont Medical Center - Center on Aging
- Vermont Association of Senior Centers and Meal Providers
- Cathedral Square – Support Services at Home (SASH)
- Vermont Care Partners – Elder Care Clinicians
- Community of Vermont Elders (COVE)
- AARP VT

To design and administer relevant statewide surveys for completion by older Vermonters and family caregivers, FSA conducted initial, exploratory telephone interviews with individuals in each of the five geographic regions served by Vermont's AAAs. This initial step was intended to

reveal conditions and concerns that might fall outside commonly understood needs held by these populations and subsequently weave these into survey questions. As a result, FSA developed a set of structured interview questions for each population.

Each AAA region was given a target number of surveys to collect to ensure high confidence in the findings. FSA used VDH and US Census data to estimate the population numbers for Vermonters age 60+, statewide, and county. These population numbers and Confidence Intervals of  $\pm 2$  and  $\pm 3$  percentage points were used to set numeric sample size targets for each AAA region and individual counties within each region.

<b>AAA REGION</b>	<b>TARGET NUMBER SURVEYS TO ACHIEVE <math>\pm 2</math> C.I.</b>	<b># SURVEY RESPONSES</b>	<b>PERCENT OF TARGET</b>
<b>AGEWELL</b>	565	695	123%
<b>NEKCOA</b>	185	399	216%
<b>CVCOA</b>	290	661	228%
<b>SVCOA</b>	265	477	180%
<b>SENIOR SOLUTIONS</b>	295	402	136%
<b>TOTAL</b>	1,600	2,634	165%

To pilot test the two survey instruments, each AAA was asked to recruit one older Vermonter and one family caregiver to complete surveys and provide written feedback to FSA regarding the clarity of instructions and questions, and the ease of survey completion. Feedback from this pilot test resulted in minor changes to the survey instrument, none of which impacted the content of questions.

A high level of communication and collaboration occurred between DAIL's SUA, FSA, and the five AAAs, all towards developing meaningful surveys to assess the needs of older Vermonters and family caregivers and identifying and implementing survey distribution and collection methods.

Those methods varied across regions, based on each AAA's connections and capacity to cast the wide net needed to gain representative input from these two populations. For example, in some but not all AAA regions, hard copy surveys were sent to all Meals on Wheels recipients. The findings below that emerge from the analysis of each survey type (online and hard copy) should

guide future efforts to gain feedback from all Vermonters and increase participation from all Vermonters.

## **Vermonters 60+ Survey Findings**

### **Prior to the COVID-19 pandemic, older Vermonters felt they were living the life they desired most of the time.**

The needs assessment found that COVID-19 has negatively impacted several quality-of-life issues. Social connections have been disrupted, leading to more isolation and difficulty engaging in activities that give one pleasure. Hard copy respondents were less likely to express satisfaction with their lives before COVID-19 and had more difficulty attaining life quality during the pandemic.

### **More than 50% of older Vermonters report their physical health has impacted their ability to live life as desired.**

The responses varied significantly based on the type of survey used. For example, three-quarters of hard copy respondents noted impacts to their life due to physical health. In contrast, 46% of online respondents reported the same.

Regardless of region or type of survey, most people care for their overall physical health through medical appointments, including eye care. However, significant gaps exist in the number of older Vermonters who seek care for mental health and hearing issues.

Across the state, two-thirds of persons sixty and over report having taken steps to address the risk of falling. Notably, three-quarters of hard copy survey respondents say they have acted in this direction compared to 57% of online respondents. As hard copy respondents tend to be older and have more reported interaction with services, including Meals on Wheels, it is likely that prompts from services providers who connect with them may be associated with this difference.

### **The vast majority (91%) of older Vermonters responding to this survey live in their own home.**

The survey revealed that when considering future living situations, most respondents, regardless of region or survey type, identified the need to feel safe in their surroundings and the ability to afford the costs of staying in their homes as most important.

Significant differences, however, emerged between online and hard copy responses when rating other issues that go into the calculation of where to live as one gets older. For example, people who completed hard copy surveys identified the availability of food/meal services, public transportation, and walking distance to needed services at higher rates than online respondents. This can most likely be attributed to the differences in household income associated with each survey type.

When asked what is needed to enable one to live in his/her own home, help with home maintenance, housekeeping, and home modifications was cited by all respondents as the most important forms of assistance required to age in place. However, the findings revealed across all regions and types of the survey that difficulties experienced in getting needed help were most



associated with an individual's unwillingness to ask for help and/or their ineligibility for programs or services

**83% of older Vermonters drive their own car, making the ease of getting to friends, shopping, appointments, etc., relatively simple.**

This finding, however, differed between those who completed online surveys versus hard copies. The former group was more likely to have their own cars, while the latter were more likely to depend on other forms of transportation, e.g., friends, relatives, public services, to get where they wanted and needed to go. More than 50% and as high as 85% of respondents have sufficient income to keep their cars running. Again, differences in responses were associated with the type of survey completed. Greater ability to maintain a car was associated with online respondents who, in turn, reported higher household incomes than hard copy respondents.

Regardless of the type of transportation used, most older Vermonters were satisfied with the ease and accessibility of needed transportation. However, when disaggregated by the AAA region, nearby public transit was less accessible for respondents living in the southeast, served by Senior Solutions, and the northeast, served by Northeast Kingdom Council on Aging.

**More than three-quarters of Vermonters age 60+ rely on Social Security as a source of income.**

Among hard copy respondents, 49% rely solely on Social Security compared to 14% of persons completing online surveys. Additionally, less than one-half of persons completing hard copy surveys report having enough money to pay expenses with extra funds leftover, compared to 71% of online respondents who report their income is sufficient.

Across all regions, large percentages of respondents claim Social Security as an income source, with the highest rates in the Northeast Kingdom and Southwest Vermont. In addition to Social Security, nearly two-thirds of respondents receive income from retirement savings and/or pensions and nearly one-quarter still earn income through employment. When disaggregated by AAA region, the percent of income coming from retirement and current employment is higher where online survey responses were highest (Age Well, CVCOA, and Senior Solutions) and lower in the two regions (NEKCOA and SVCOA) where more hard copy surveys were completed. Again, it can be inferred that online responses are associated with higher household income while hard copy responses are associated with lower household income – and thus fewer income sources and of a lower amount.

**Nearly all older Vermonters have health insurance coverage, but responses regarding the extent of coverage vary by income level and type of survey completed.**

Ninety-nine percent of respondents have some type of health care insurance. Medicare covers between 78% to 84% of respondents within the five AAA regions. Rates of supplemental Medicare coverage drop to between 25% and 39%.

Significantly fewer respondents from Northeast Kingdom Council on Aging and Southwestern Council on Aging have Medicare supplemental plans than those from Age Well, CVCOA, and Senior Solutions. Thirty percent of Southwestern Council on Aging respondents have Medicaid insurance, a rate much higher than the other four AAA regions. Across the state, a small percent

is covered by Veterans' benefits. Finally, between 28% to 41% of respondents report having private health insurance.

### **Older Vermonters misunderstand how long-term care services if needed, will be paid for.**

In response to how people would pay for long-term care, should they need it, nearly half (47%) of respondents identified Medicare as a possible payment option. Forty-six percent reported they did not know how these services if needed, would be paid. Therefore, educational efforts are required to reduce misconceptions and increase knowledge about how to pay for long-term care so that this population can make informed, accurate plans for future needs.

The survey revealed that 12% of respondents currently have long-term care insurance. This group was older respondents with higher household incomes, who primarily completed online surveys.

### **Food Insecurity, as evidenced by the use of food programs, is significantly more present in respondents who completed hard copy surveys.**

Meals on Wheels (MOW), Three Squares VT, Commodity Supplemental Food Program (CSFP), and community food shelves are used significantly more by hard copy than online respondents. In each of these program categories, higher utilization rates were reported in regions served by Southwestern Vermont Council On Aging and Northeast Kingdom Council On Aging, aligning with their higher rates of hard copy responses. 45% of respondents from Northeast Council On Aging and 36% from Southwestern Vermont Council On Aging use MOW compared to 1% of respondents in the Age Well's region, 5% in the Senior Solutions region, and 6% in Central Vermont Council On Aging's area. As noted above, lower household income was reported at higher rates amongst those who completed hard copy surveys.

### **Knowledge of resources focused on older Vermonters varies widely and by specific programs.**

The survey found that higher percentages of respondents *know all or something about* Senior Centers (84%), AAAs (78%), volunteer opportunities (71%), and transportation services (70%).

However, those reporting *no knowledge* of programs increases significantly when asked about the following: Senior Helpline (45%), Legal Aid assistance (47%), 2-1-1 (48%), Adult Protective Services (53%), Respite care for family caregivers (54%) and family caregiver support groups (58%). Across Vermont, opportunities are ripe for increasing older Vermonters' knowledge of and participation in the vast array of programs and resources available to them.

## **Family Caregiver Survey Findings**

### **The majority of family caregivers provide care to their family member between 20 hours and round-the-clock on a weekly basis.**

Twenty-eight percent of respondents provide care twenty-four hours, seven days a week, and half of those caregivers are spouses to the family member.

Adult children represent one-half of Family Caregiver survey respondents. At the same time, spouses make up 31% of responses, and “other” relatives constitute 18% of respondents.

**Caregivers devote years of their lives to providing care to their family member.**

Fifty-three percent of respondents have been caring for their family members for no fewer than four years. Among those who have cared for their family member for more than six years, spouses make up 37%, followed by other relatives, e.g., grandchildren, cousins, etc., (29%) and adult children (23%).

**Family caregiving negatively impacts the caregiver on a range of personal dimensions.**

Emotional health, ability to pursue individual interests and hobbies, sleep, and social connections were cited as negatively impacted by three-quarters to one-half of respondents. In most areas, the negative impact on spouses giving care was significantly higher than on adult children or other relatives. Along with that, individuals providing 24/7 care reported significantly higher adverse effects on all nine dimensions of inquiry.

**Despite reports of negative impacts associated with caregiving, slightly less than a quarter of family caregivers use respite services.**

Of those who would like to but currently do not use respite, the following reasons stood out across the five AAA regions. First, people do not know where to find respite care; second, they feel they cannot afford it. Finally, but critically, the person being cared for will not accept it.

**More than half of family caregivers expressed interest in gaining information and/or education around self-care, medical benefits, long-term care, estate planning, and medical conditions.**

Caregivers’ responses were relatively consistent across the five AAA regions, showing strong interest in learning how to take care of oneself, gaining information about health coverages, including Medicare, Medicaid, and SSI, being better informed to plan for future care needs and wills, and learning more about medical conditions of their family member. Slightly less than one-quarter of respondents said that information addressing how to deal with behavior issues, such as those resulting from dementia, of the family member being cared for would be helpful.

**Engagement and/or interest in individual counseling or caregiver support groups as a helpful form of support varies.**

Approximately one-third of respondents reported participating in individual counseling as helpful. An almost equal amount noted that they expected it would be beneficial while not engaging in counseling to date. Engagement in caregiver support groups was much lower. Only 16% of respondents said they’d found it helpful, yet 46% said that although they hadn’t tried it, they’d expect it would be beneficial. Given the degree to which family caregivers reported a high incidence of negative impacts on their lives, determining ways to engage caregivers in support activities potentially could improve outcomes for both caregivers and their family members.

**Friends, family members, health care providers, and the Internet are the most common sources of support and information that family caregivers rely on.**

While the above comprised between one-half and two-thirds of responses identifying where family caregivers look for needed information, and support, much smaller percentages identified the following formal organizations as information sources: Home Health Agencies (27%); Senior Help Lines/AAA's (23%); social media (11%); libraries (7%); and Vermont 2-1-1 (4%).

## ADDITIONAL AREAS OF FOCUS

### Older Adult Suicide

Data and research indicate a high rate of suicide among older adults and a higher rate of social isolation. According to Vermont's 2018 Behavioral Risk Factor Surveillance System (BRFSS), 13% of adults aged 65 and older report rarely or never getting social and emotional support, significantly higher than other adults. Additionally, between 2017 and 2018, some of the most recent data show that the suicide rate in the United States increased 2%. Still, for adults aged 55 to 74, the rate increased by 6%. For older Vermonters, this rate increased 11%, the highest among the fifty states for this age group. In Vermont, the older adult suicide death rate is consistently higher than the national average. Most recent data from Americas Health Rankings shows suicide death per 100,000 amongst adults ages 65 and older is 20.5 compared to the US average of 16.9 (United Health Foundation, 2022). The research supports the idea that suicide is largely preventable at every age. Therefore, it is vital to engage older adults in activities and opportunities that promote healthy aging and promote a sense of social connectedness and life purpose.

Prevention strategies need to focus on building protective factors that address or counteract risk factors. Activities to increase protective factors related to suicide prevention will include:

- Promoting healthy aging, resiliency, and independence.
- Promoting awareness of the impact of loss.
- Supporting meals on wheels.
- Promoting the use of age-appropriate screening tools and age-appropriate interventions.
- Promote firearm safety and safe storage of medications

In summary, strategies will be implemented to detect and treat depression, optimize independent functioning, increase social connectedness, and educate to reduce ageism and promote gun and medication safety.

### Support for People who are Deaf, Hard-of-Hearing, or Deafblind

Under DAIL is the Director of Services for Deaf, Hard of Hearing, and DeafBlind (DHHDB), acting as the single-entry point for information, referral and assistance. In addition, the Director works with various stakeholders, including the DHHDB Advisory Council, to identify service gaps and advise on program development to meet identified gaps. Types of information and assistance include guidance describing how to use American Sign Language (ASL) interpreters and captioning services on different virtual platforms, guidance on how and when to use transparent masks at COVID vaccination clinics, advocacy for DMV Visor cards to help those who are Deaf or hard of hearing when pulled over while driving, educational presentations to a variety of community members, technical assistance to several state agencies such as DMV, AOT, DPS, and DOL on how to improve communication access for DHHDB community members, and community forums with the Agency of Education to bring in working professionals and community members to learn about the new vendors serving DHHDB school-age children.

The SUA is fortunate to have access to the unit for support and guidance related to training and compliance with accessibility. DAIL's work around advocating and supporting DHHDB is enhanced by collaboration with the unit. The 2019 Behavioral Risk Factor Surveillance System

reports that 19,804 Vermonters aged 65 and over say having a hearing disability (Centers for Disease Control and Prevention, 2022). The state plan needs assessment identified gaps in the number of older Vermonters who seek care for hearing issues. As a result, the number of older Vermonters experiencing hearing loss is anticipated to be under-identified. The State Unit on Aging collaboration with the Director of Services for DHHDB informs the need to combat the stigma associated with hearing loss. Lastly, increasing evidence of hearing loss associated with dementia adds to the need for the SUA to be responsive to supporting older adults finding themselves experiencing hearing loss. Raising public awareness of the impact of hearing loss on older adults and the need for hearing accessibility is a critical part of the SUA's work to promote healthy aging.

## GOALS, OBJECTIVES, AND STRATEGIES

### Goal 1: Promote the health, safety, and well-being of older Vermonters.

#### Objective 1.1: *Information and Referral/Assistance (I&R/A): Strengthen the coordination and awareness of OAA and related services*

##### Strategies

1. Support the dissemination of outreach promoting the aging network, including AAAs, Senior Centers, State Health Insurance Assistance Program, State Medicare Patrol, and Adult Protective Services.
2. Leverage the aging network to promote the Senior Community Service Employment Program (SCSEP) and the professional growth opportunities such as workshops, computer classes, and participation in community college and technical education center programming that qualifies them for in-demand jobs, connects them with hiring employers, and better utilizes the mature worker population to expand the state's workforce.
3. Circulate advertising for Vermont's Aging and Disability Resource Centers, options counseling, and the statewide Helpline.
4. Establish standardized protocols for information, referral and assistance (I&R/A) teams to identify callers' needs and connect to services offered through the aging network.

##### Performance Measures

- # of outreach addressing the aging network and the programs under the OAA.
- # of people enrolled in the Senior Community Service Employment Program.
- #/% of people contacting the AAA Helpline.
- #/% of people receiving OAA services.

##### Outcomes

- Short-term: Older Vermonters will increase their knowledge of programs and services offered through the aging network.
- Intermediate: Older Vermonters will contact the AAA Helpline for assistance accessing services and support.
- Long-term: Older Vermonters will be connected to services for which they qualify.

#### Objective 1.2: *Case Management: Improving the quality of life for individuals accessing person-centered case management services*

##### Strategies

1. Implement and maintain person-centered framework training for AAA service and coordination teams.
2. Explore the adoption of screening tools to identify health factors, including immunization status, dementia, fall-related TBI, and suicide.

3. Explore a variety of approaches to improve successful care transitions for people relocating from an institutional setting to a community setting, including enhancing mental health counseling, wellness programs, and family caregiver support and collaboration with the Vermont Ombudsman Project.
4. Monitor the impact of case management services by delivering a standardized survey implemented by AAAs.

### **Performance Measures**

- #/% of AAAs using person-centered planning tools
- #/% of AAAs adopting screening tools to assess immunization status, risk of dementia, fall-related TBI, and suicide
- # of care transitions completed by AAAs
- #/% of survey respondents reporting case management increased their quality of life

### **Outcomes**

- Short-term: AAAs operate care and service teams using the person-centered framework for care.
- Intermediate: Case management clients are screened for risks impacting their health and wellbeing.
- Long-Term: Older Vermonters are supported to live in the setting they prefer.
- Long-Term: Individuals receiving case management services report in the case management survey the service helped to improve their quality of life.

### **Objective 1.3: *Nutrition*. Improve the nutritional health status of older adults participating in the senior nutrition program.**

### **Strategies**

1. Train aging services staff and volunteers that malnutrition is an indicator and vital sign of older adult health risk.
2. Plan activities for Malnutrition Awareness Week.
3. Improve quality and availability of all OAA NSP meals, including therapeutic meals.
4. Increase availability of nutrition education and nutrition counseling.
5. Integrate validated malnutrition screening tools into assessments.
6. Monitor client progress and quality of nutrition, case management, and information and referral services.
7. Leverage existing partnerships and engage in new community partnerships to provide access to programs and services to prevent and address malnutrition.
8. Explore creating hospital service area malnutrition coalitions to address root causes of malnutrition.

### **Performance Measures**

- #/% of trainees reporting increased knowledge of malnutrition
- #/% of people enrolled in nutrition counseling



- #/% senior nutrition providers offering a therapeutic meal option
- #/% of AAAs screening for malnutrition

### **Outcomes**

- Short-term: Older adults and caregivers will increase their knowledge malnutrition is, its impact, prevention, treatment, and available resources.
- Short-term: Aging services staff and volunteers will increase their knowledge of malnutrition, its impact, prevention, treatment, and available resources.
- Intermediate: The aging service staff will improve collaboration and coordination of services to address malnutrition through an interdisciplinary approach.
- Long-term: The AAAs and SUA will have improved understanding of the prevalence of malnutrition within the senior nutrition program.

### **Objective 1.4: *Family Caregiver Support*: Increase awareness of social isolation and the available resources to combat the adverse effects.**

### **Strategies**

1. The SUA, in collaboration with VDH, will distribute educational material on the association of caregiving and social isolation.
2. The SUA, in partnership with AAAs and Senior Centers, markets and promotes the availability of support services available to caregivers addressing social isolation, including Vermont Assistive Technology and the Senior Companion Program.
3. Expend the American Rescue Plan funds through community grants to support programming for family caregivers.
4. Collaborate with AAAs to provide access to an innovative web-based platform for older adults to engage in social activities.
5. Review and make recommendations for addressing transportation needs for older adults living at home and in facilities.

### **Performance Measures**

- # of outreach to caregivers addressing social isolation as a health issue.
- # of outreach targeting unpaid caregivers on the availability of support services.
- # of recommendations adopted to address the transportation needs of older adults.
- # of projects funded through the American Rescue Plan to enhance social supports for family caregivers.
- # of people enrolled in GetSetUP, a web-based social platform.

### **Outcomes**

- Short-term: Caregivers will understand the impact social isolation has on health.
- Short-term: Vermonters will understand services available to help combat social isolation.
- Intermediate: Older Vermonters participate in programming made available to create meaningful activities and connections.
- Long term: Older Vermonters have access to transportation services.

**Objective 1.5: *Elder Justice*: Increase collaboration to prevent and protect vulnerable older adults against financial exploitation.**

**Strategies**

1. Recognize National Consumer Protection Week (March 6-12) and collaborate with the Attorney General's office, Community of Vermont Elders' Senior Medicare Patrol, and media outlets to communicate strategies for avoiding scams.
2. Leverage Vermont's "Stay Savvy Vermont" PSA videos to engage the public in awareness of financial exploitation and strategies to protect against scams.
3. Support the development of projects and programs that expand supported decision-making.
4. In partnership with Vermont Legal Aid and the Office of Public Guardian, provide public education on advance directives, power of attorney, representative payees, and how legal safety guards protect from exploitation.
5. Collaborate with Vermont Department of Financial Regulation to expand education on frauds and scams related to insurance, banking, and how to make a report.

**Performance Measures**

- # of outreach addressing financial scams and exploitation
- # of reports filed with APS under the category of financial exploitation
- # of education events focused on legal issues, including advanced directive, power of attorney, and payee services

**Outcomes**

- Short-term: Increase the adoption of statewide outreach addressing financial scams and exploitation.
- Intermediate: Older Vermonters are knowledgeable about financial scams and equipped with the knowledge to avoid them.
- Intermediate: Increase Vermonters' understanding of legal tools designed to protect vulnerable adults.
- Long-term: Older Vermonters have access to legal support to protect them from financial exploitation.

**Goal 2: Ensure that Vermont's OAA programs are inclusive of all older Vermonters.**

**Objective 2.1: Bolster training and collaboration across State departments to strengthen the aging network's response to trauma and mental health.**

**Strategies**

1. Support the establishment of trauma-informed training for the aging network providers to increase the provision of trauma-responsive care.
2. Collaborate with VDH to implement gatekeeper training to inform volunteers and professionals interacting with older adults to identify risks for suicide.

3. Explore opportunities to enhance the eldercare clinician services.
4. Enhance emergency planning with VDH and the aging network to improve responsiveness to older adults in the greatest economic and social need during health emergencies.

### **Performance Measures**

- # of aging network staff trained in trauma-informed services.
- # of aging network staff and volunteers completing gatekeeper training.
- # of people enrolled in the eldercare clinician program.

### **Outcomes**

- Intermediate: Vermont's aging network workforce is trauma-responsive in their service delivery.
- Intermediate: Vermont's aging network workforce and volunteers are prepared to identify the risk for suicide.
- Intermediate: Older Vermonters have access to mental health services and supports.
- Long-term: Vermont's aging network is responsive to the needs of all Vermonters.

### **Objective 2.2: Determine services needed and effectiveness of programs, policies, and services for all Vermonters, including LGBTQ+, Abenaki, BIPOC, and New Americans.**

### **Strategies**

1. Identify and build relationships with groups and organizations representing Vermont's populations, including LGBTQ+, older adults living with HIV, Abenaki, and New Americans, to participate and inform strategic planning.
2. Involve individuals with lived, cultural expertise in service planning, including nutrition services, to ensure meal options meet cultural preferences.
3. Generate marketing and development content that reflects and supports diversity and inclusion using images of BIPOC, New Americans, Veterans, and other cultural groups.

### **Performance Measures**

- # of strategic planning sessions involving organizations representing specific groups of Vermonters.
- # of marketing initiatives created to represent all Vermonters.

### **Outcomes**

- Long-term: All older Vermonters are represented and served under the OAA programming.

### **Goal 3: Bolster the recognition and support of all caregivers including unpaid caregivers.**

#### **Objective 3.1: Increase public awareness and recognition of the diverse needs, issues, and challenges faced by family caregivers**

##### **Strategies**

1. Partner with the AAAs, Alzheimer's Association Vermont Chapter, and VDH to recognize and promote National Family Caregiver Months.
2. Publicize and share stories addressing the dynamics of family caregiving.
3. Distribute tip-sheets throughout the aging network on best practices related to supporting caregivers.
4. Leverage the recommendations from the RAISE family caregiver act to raise awareness of the needs of family caregivers.

##### **Performance Measures**

- # of public engagements focused on unpaid caregivers.
- # of programs operated in Vermont supporting family caregivers.

##### **Outcomes**

- Short-term: Increased awareness of unpaid caregiving and its impact on families.
- Intermediate: Unpaid caregivers have access to programs specifically designed to support their needs.
- Long-term: Unpaid caregivers in Vermont are recognized as a critical part of the care and services system infrastructure.

#### **Objective 3.2: Increase collaboration across the aging network to support Grandparents raising grandchildren**

##### **Strategies**

1. Collaborate with stakeholders and community members to coordinate a respite coalition to pursue the Lifespan Respite Care program.
2. Utilize the National Technical Assistance Center on Grand Families and Kinship Families for strategic planning.
3. Collaborate with Vermont Kin as Parents to raise awareness about supporting grandparents raising children.

##### **Performance Measures**

- # of public engagements focused on grandparents raising grandchildren.
- # of programs operated in Vermont supporting grandparents raising grandchildren.

**Outcomes**

- Short-term: The aging network and public are aware of the resources available for grandparents raising grandchildren.
- Long-term: Grandparents raising grandchildren have access to readily available services and supports to meet their needs.

**Objective 3.3: *Family Caregiver Support*: Ensure family caregivers have a support system in place to meet them where they are in their caregiving journey.****Strategies**

1. Support family caregiver specialists using an evidence-based assessment tool to work with caregivers to develop unique service plans, including recommended strategies for improving well-being.
2. Partner with VDH to increase the availability of dementia training for aging network staff, including paid caregivers.
3. In partnership with AAAs and volunteers, increase the usage of trained volunteers for providing respite to family caregivers.
4. Monitor the impact of services on the caregivers' level of stress and burden.

**Performance Measures**

- #/% of AAA staff trained in using the evidence-based assessment.
- # of professionals in the aging services field trained in dementia capable.
- # of volunteers providing respite to family caregivers.
- #/% of caregivers who show decreased stress and burden levels after regular reassessment intervals.

**Outcomes**

- Short-term: AAA caregiver support staff are trained and certified using an evidence-based caregiver assessment tool.
- Medium: Professionals who support family caregivers are trained in dementia capable practices.
- Medium: Family caregivers have access to respite support regardless of where they live in the state.
- Long-term: Family caregivers participating in family caregiver support programming will decrease stress and burden.

## **EMERGENCY PREPAREDNESS**

As part of Vermont's Agency of Human Services (AHS), DAIL has a Continuity of Operations Plan (COOP). Under leadership at AHS, the plan is reviewed annually with necessary revisions. DAIL also participates in the State of Vermont Emergency Operations Plan, reviewed annually in coordination with AHS. In addition, DAIL requires AAAs to have Emergency Preparedness Plans in their Area Plans updated annually as needed and approved by DAIL. AAA Emergency Preparedness Plans address critical functions, outreach to vulnerable individuals, and coordination efforts with local and state emergency response agencies. In the event of an emergency, DAIL staff reach out to each of Vermont's AAAs to offer support, ensure critical functions are possible and that AAAs can contact the most vulnerable older Vermonters and adults with disabilities with whom they work. AAAs least affected by an emergency may offer support and staff to AAAs most impacted.

Since the onset of the COVID-19 pandemic, DAIL has maintained an active role in the State's emergency response to protect Vermonters at the highest risk of getting sick or dying from the virus. Throughout SFY22, DAIL has continued to provide technical assistance to providers with support from VDH, assisted in the State's efforts to roll out Vermont's vaccine program, maintained program flexibilities to better support consumers and families, and actively participated in emergency outbreak response to long-term care facilities need emergency staffing, PPE, and N95 fit-testing support. The reaction to COVID-19 has strengthened DAIL's ability to respond to health emergencies due to the collaboration with VDH. DAIL and the aging network benefited from the technical assistance provided by VDH and will continue to engage them as emergency response plans evolve.

## QUALITY MANAGEMENT

The SUA's quality management approach is grounded in the theory of change. Quality management is an opportunity to understand how well an intervention, product, or system works. The SUA assumes that evaluation is more than the judgment of ultimate success or failure but is a process that involves assessing, valuing, interpreting, and engaging the stakeholder community. The quality management activities undertaken by the SUA are intended to inform improvement or modification both in the future and as work is unfolding.

The SUA uses data and information pulled from the State Program Report (SPR) and Area Plan reports submitted by AAAs biannually to track progress at the highest levels of programming. The SUA is informed on where to take a closer look through the use of 2-year and multi-year SPR comparison reports tracking trends such as service increases, decreases, stagnant service utilization. The service recipients' demographic information is analyzed to inform whether the OAA's priority populations are served. The SUA will compare each AAA's demographic data to the corresponding service region's census data. Findings will better understand how the target populations can be reached.

The Area Plans implemented by AAAs outline regional goals, objectives, strategies, and measurable outcomes in the Results-Based Accountability format. AAAs' four-year Area Plans are updated, reviewed, and approved each year by the SUA. DAIL requires the AAAs to submit RBA updates twice a year to demonstrate progress and describe obstacles. In addition, the SUA, at minimum, conducts annual meetings with each AAA to discuss progress and challenges. The sessions are an opportunity to examine whether the expected changes are occurring. For example, if a AAA is expecting to increase services to the BIPOC community by targeting outreach, the meeting is a chance to discuss whether the intended outcomes are happening. Lastly, DAIL staff meet with the AAA Executive Directors monthly to review different areas of programming, policies, funding, and any anticipated changes.

Additionally, the SUA uses the CMS Home and Community Based Services Quality Framework to organize quality initiatives and monitoring as part of our relationship with the aging network and, more specifically, with the AAAs. The SUA also provides quality oversight via annual monitoring visits by the Quality and Program Participant Specialist. This staff person reviews the agency through the lens of case management using an approved standard for AAAs against an established review grid that follows the standard requirements.

At each site, a random selection of charts is pulled with representation from as many case managers as possible to ensure timely and appropriate care through review of assessments, plans of care, goals, strategies, needs, and follow-up as needs change. Great care is taken to ensure that the participants and family caregivers have input into the plan such that opportunities for choice/flexibility are emphasized in the process. The reviewer looks at the initial documents for each record and then follows case notes, team conference notes, progress, barriers, changing strategies, utilization of community resources, vocational rehabilitation, and other applicable interventions. Reviewers also check for ongoing supervisory interface and evaluations, training, orientation, tracking lists, and updated background checks. All applicable AAA policies and procedures are also reviewed.

If an AAA has standards, policies, and procedures that are “unmet”, there is a written request for a plan of correction that must be submitted within an allotted timeline. If the plan of correction is deemed acceptable, a letter stating such is sent. If a plan is insufficient, a further request is made with follow-up technical assistance. Once the plan of correction is accepted, the Specialist will conduct a follow-up visit to assure that the corrective action has been operationalized.



## SUMMARY OF PUBLIC INPUT PROCESS

On April 11, 2022, DAIL notified the public of the availability of the draft State Plan on Aging for review and comment. DAIL provided notice on the website via Facebook, emails to community partners, and press releases to the media. In addition, the press release was published in several newspapers, including the statewide online paper, VT Digger ([https://vtdigger.org/press\\_release/public-input-vermonters-encouraged-to-give-feedback-on-next-state-plan-on-aging/](https://vtdigger.org/press_release/public-input-vermonters-encouraged-to-give-feedback-on-next-state-plan-on-aging/)). According to its website, VT Digger reaches an average of 200,000 individual readers each month.

The public comment period began on Monday, April 11, 2022, and continued through Friday, April 29, 2022. In addition, DAIL invited people to provide comments in writing, by phone, or during the monthly DAIL Advisory Board meeting. The hybrid meeting was held on Thursday, April 14, 2022, from 10:00 am to 12:30. Attendees joined the meeting online or in person at the Waterbury Office Complex. Lastly, the DAIL Advisory Board convened a five-person subgroup to review and comment on the draft plan.

DAIL received a total of 22 comments from individuals and organizations.

Below is a summary of the comments received and DAIL's response:

### Category: Affordable Housing

Summary of Comments: DAIL received six comments about affordable housing for older adults and the need to increase its availability across the State. Comments included the need to increase development, particularly housing targeted at older adults on a fixed income.

DAIL's response: The Older Americans Act funds distributed to Area Agencies on Aging are to establish a catalyst in bringing together public and private resources in the community to ensure the provision of a full range of efficient, well-coordinated, and accessible services for older persons. Additionally, the funds are intended to provide services to the greatest number of people and target services to those in the most significant social and economic need. As such, the funding allows the opportunity to stimulate advocacy and bring key stakeholders together to address issues around affordable housing for older adults but comes short of being able to fund housing development. The State Plan addresses DAIL's partnerships to enhance housing options for older adults, including SASH and Vermont HomeShare. In addition, DAIL recognizes the need for affordable housing options tailored to older adults. DAIL will continue to address this work by developing Vermont's Action Plan for Aging Well (Master Plan on Aging) and working with partners across state government.

### Category: Workforce/Training

Summary of Comments: DAIL received five comments regarding the need to prioritize recruiting new workers into the aging and disability field and increasing training for the existing workforce. Comments included the workforce in the medical and non-medical sectors.

DAIL's Response: Objective 2.1 in the Plan is to bolster training and collaboration across State departments to strengthen the aging network's response to trauma and mental health. The strategies that DAIL and its partners will undertake to achieve the objective will include increasing the availability of mental health services and growing training that will improve Vermont's response to older adults experiencing mental health needs. Additionally, under objective 3.3, there are strategies to collaborate with the Vermont Department of Health to

increase the availability of dementia training for the workforce to improve the dementia capableness of Vermont's system of care. Lastly, on pages 37-39 of the plan, a priority is workforce recruitment and retention in the LTSS system, focusing on direct care workers, such as licensed nursing assistants and personal care attendants.

Category: Access

Comment: The state plan on aging should recommend a review of whether eligibility criteria for services are too restrictive.

DAIL'S Response: Under S. 285, Act 167, the Vermont Legislature charged the Agency of Human Services to consider extending access to long-term home-and-community-based services and support to a broader cohort of Vermonters who would benefit from them. The work includes convening a work group to recommend setting clinical and financial eligibility criteria for the extended support, including ways to avoid requiring applicants to spend down their assets to qualify. In addition, this work is anticipated to include reviewing eligibility criteria and recommendations for expanding access to services.

Category: Caregiving

Comment: Include assessing, updating, and increasing information available to caregivers on commonly requested topics.

Comment: Goal 3 seems very specific as compared to the first two goals, and I would advocate that all caregivers need recognition and support, not just unpaid – including LTC caregivers, so I would suggest removing unpaid. But if you want a specific focus on unpaid which I can understand, maybe it's "Bolster the recognition and support of all caregivers including but not limited to unpaid caregivers."

DAIL Response: S. 206, Act 113 requires that the Department of Disabilities, Aging, and Independent Living work jointly with the Department of Health to develop and maintain easily accessible electronic, print, and in-person public education materials and programs on Alzheimer's disease and related disorders that shall serve as a resource for patients, families, caregivers, and health care providers. The materials developed will address commonly requested topics. Additionally, goal 3 was adjusted to adopt the recommendation to expand the focus to all caregivers, including unpaid caregivers.

Category: Transportation

Comment: Include reviewing and addressing transportation needs for elders living at home and in facilities.

DAIL's Response: A strategy under Objective 1.4 to increase awareness of social isolation and the available resources to combat the adverse effects is to review and make recommendations for addressing transportation needs for older adults living at home and in facilities.

Category: General

Comment: Please consider including outreach to and collaboration with the Vermont Ombudsman Project in the State Plan on Aging. We believe strong partnerships between our organizations will help Vermont better support elders.

DAIL's Response: Under objective 1.2, Improving the quality of life for individuals accessing person-centered case management services is to explore a variety of approaches to improve successful care transitions for people relocating from an institutional setting to a community setting, including enhancing mental health counseling, wellness programs, and family caregiver support and collaboration with the Vermont Ombudsman Project. In addition, a number of the priorities noted on pages 37-39 will benefit from the input of the Ombudsman.

Category: Older Adult Suicide

Comment: How does the baseline of suicide rates among elders in Vermont compare to other states? Is VT lower to begin with? About equal? Already higher? If you have that information, please include it.

DAIL's Response: Vermont's older adult suicide rate is consistently higher than the national average. DAIL added information to the Older Adult Suicide section of the plan to reflect this point. Additionally, Object 2.1, to bolster training and collaboration across State departments to strengthen the aging network's response to trauma and mental health, will improve response to suicide prevention.

Comment: Please consider promoting ways to increase social connectedness, such as increased access to transportation, caregiving services, and group activities.

DAIL's Response: Objective 1.4 is to increase awareness of social isolation and the available resources to combat the adverse effects. The work undertaken to achieve the objective will include addressing needs around transportation, caregiving, and group activities.

Comments from DAIL Advisory Board

Comment: The language that reflects the populations most likely to benefit and/or receive the services and interventions listed is vague and occasionally misleading. While the programs might serve any older adult in Vermont, the reality is that the vast majority of program recipients will be low-income or with significant social and emotional needs, including disability, dementia, and/or caregivers. The limitation of the work, based on the OAA funding priorities, should be more explicit, outlining the goals of serving those with the highest social and economic needs who are living in their communities.

DAIL's Response: Language was added to different sections of the plan to emphasize that the target population for services funded through the Older Americans Act are older adults in greatest social and economic need. The charge to community providers receiving Older Americans Act funds to reach people who cannot afford or gain equal access to housing, food, transportation, healthcare, and social engagement is supported by the Older Americans Act and Older Vermonters Act. Additionally, it is worth noting Area Agencies on Aging serve approximately 60,000 older Vermonters a year of many income levels. Indeed, the "high-touch" programs like nutrition services, case management, and transportation help those with significant needs. Still, services such as Information & Assistance, State Health Insurance Support Program (SHIP), and evidence-based programs at senior centers serve a much broader audience.

Comment: The program activities and partners should be limited to only the work that is accomplished with OAA funding. It is confusing to include some, but not all, of the activities

and partnerships of the AAAs that fall outside of OAA funding. Since this plan is specific to the OAA funds received by the State, it should be limited to those programs and interventions that are relevant to the funding stream in question. Additional work is undertaken by the AAAs and DAIL that impacts older adults should be reflected in the Master Plan on Aging.

DAIL's Response: Older Americans Act (OAA) cannot afford to be the sole funding source for coordinating home and community-based services for older adults. As a result, several funding streams come together to support the aging services network. Some aspects of the State Plan exceed the scope of the Older Americans Act. Additionally, the Older Vermonters Act requires a comprehensive evaluation of the services available to older Vermonters across the State, including home- and community-based services, residential care homes, assisted living residences, nursing facilities, senior centers, and other settings in which care is or may later be provided. Thus, programs and services are addressed in the plan that the Older Americans Act does not fund.

Comment: In general, the subcommittee feels that engagement of a substantive nature at this point in the process is limited. We recommend to the State Unit on Aging that the DAIL Advisory Board participate in this process more consistently. Participation in the Needs Assessment and Priority Areas, as well as reviewing the final draft, would allow for more useful engagement. The DAIL Advisory Board is made up of experts and individuals with one of the broadest understandings of the needs of older adults. As such, the subcommittee feels that the State Unit on Aging and this plan would benefit greatly from engaging this group in robust conversation and engagement early on to gain as much benefit as possible from this collective of knowledge and experience.

DAIL's Response: There are several points in the state plan planning and development where the DAIL Advisory Board can be more involved. The challenge of building the plan during a state of emergency was most pronounced when it came to extensive group collaboration. Knowing the interest of the DAIL Advisory Board to be more involved in future planning and development will simplify engaging with the group. The State Unit on Aging will seek to involve the DAIL Advisory Board early in future State Plan work.

Comment: The subcommittee feels strongly that this plan should be integrated into the Vermont Action Plan for Aging Well (VAPAW-Master Plan on Aging that is currently in development) to represent better and recognize that this work is a segment of a broader body of work around aging services in Vermont. Integration would give a consumer a comprehensive picture of aging services while separating specific programs, funding streams, and target populations. This work should be engaged collaboratively with the VAPAW to reduce duplication, strengthen partnerships, and break down silos that limit our ability to serve the aging population of Vermont effectively and efficiently.

DAIL's Response: Vermont Action Plan for Aging Well, Vermont's Master Plan on Aging, is in the early stages of development, and the plan's structure has not yet been developed. However, examples from other states demonstrate the positive outcomes of incorporating existing efforts laid out in the state plan into the master plan. As the work to create a master plan progresses, numerous opportunities will be made available to engage in prioritizing what goes into the plan.

## **COMPREHENSIVE SYSTEM OF SERVICES, SUPPORTS AND PROTECTIONS FOR OLDER VERMONTERS: LONG-TERM SERVICES AND SUPPORTS (LTSS) SYSTEM**

### **Introduction:**

In addition to the State Plan on Aging requirements described in the federal OAA, the 2020 Older Vermonters Act (33 V.S.A. §6206) now requires that the State Plan on Aging also include:

- Priorities for continuation of existing programs and development of new programs
- Criteria for receiving services or funding
- Types of services provided
- A process for evaluating and assessing each program's success

The Act further states that program priorities shall be based on the following:

- Information obtained from older Vermonters, their families, and their guardians, if applicable, and from senior centers and service providers
- A comprehensive needs assessment that includes:
  - demographic information about Vermont residents, including older Vermonters, family caregivers, and kinship caregivers
  - information about existing services used by older Vermonters, family caregivers, and kinship caregivers
  - characteristics of unserved and underserved individuals and populations; and
  - the reasons for any gaps in service, including identifying variations in community needs and resources
- A comprehensive evaluation of the services available to older Vermonters across the State, including home- and community-based services, residential care homes, assisted living residences, nursing facilities, senior centers, and other settings in which care is or may later be provided
- Identification of the additional needs and concerns of older Vermonters, their families, and their caregivers in the event of a public health crisis, natural disaster, or other emergency

### **Needs Assessment**

#### **Demographics:**

According to the US Census American Community Survey, there are approximately 175,000 Vermonters 60 years old and older in Vermont. That is approximately 27% of the total population. Of the 175,000:

- 97.7% live in the community (2.3% live in a nursing home)
- 65% live in rural areas.
- 25% live alone.
- 42% are not married (divorced, separated, widowed or never married).
- 28% have a disability.
- 28% live below 200% FPL (11% live below 100% FPL).

Source: [\*US Census, American Community Survey, 2018\*](#)

### **Information from Older Vermonters and Family Caregivers:**

As noted in the Context Section of this State Plan on Aging (pages 11-13), a survey of older Vermonters and family caregivers was conducted in 2020 to gather information to inform the plan. 2,716 Vermonters 60+ and 357 family caregivers responded to the survey, sharing information about their health and well-being, housing and access to transportation, financial security, food security and more. Many older Vermonters are thriving, but a percentage of older Vermonters are struggling to find information, access services, and get the care they need to remain independent. See the full [Needs Assessment of Vermonters Age 60+ and Their Family Caregivers](#) for more details.

### **Existing Services:**

The Adult Services Division (ASD) at DAIL supports older Vermonters and adults with physical disabilities to live as they choose, pursuing their individual goals and preferences within their chosen communities. ASD is responsible for managing a full array of long-term services and supports (LTSS) for older Vermonters and adults with physical disabilities. Vermont Medicaid, the federal OAA and State General Funds are the primary sources of funds for these services.

Medicaid Funded Long-Term Services & Supports (LTSS) programs include:

- Adult Day Health Rehabilitation
- Adult High Technology Program
- Attendant Services Program
- Brain Injury Program
- Choices for Care

Older Americans Act (OAA) services include:

- Supportive Services, including Case Management, Legal Assistance, Transportation, etc.
- Nutrition Services (congregate and home-delivered meals, counseling and education)
- Health Promotion and Disease Prevention
- Information, Referral and Assistance
- Family Caregiver Support
- State Long-Term Care Ombudsman Program

Other initiatives, programs and services for older Vermonters that are supported by ASD include:

- Commodity Supplemental Food Program
- Dementia Respite Grants for Family Caregivers
- Elder Care Clinician Program
- Employer Payroll Support for Self-Directed Services
- Health Insurance Counseling & Support (SHIP/MIPPA)
- Money Follows the Person Project
- Self-Neglect Initiative
- Senior Farmers' Market Nutrition Program
- 3SquaresVT (SNAP) Outreach to Older Vermonters

### **Provider Network:**

To provide services, the Long-Term Care System relies on a large and diverse network of approximately 45 community-based organizations and 160 long-term care facilities across Vermont. Agencies are certified by DAIL to provide certain services; some are regulated by the Division of Licensing and Protection; others have quality oversight provided by the Adult Services Division. In addition, thousands of independent direct support workers outside of agencies provide direct care to Choices for Care participants at home.

Providers include:

- 11 Home Health Agencies
- 5 Area Agencies on Aging
- 11 Adult Day Centers
- 14 Authorized Agencies
- 1 agency authorized to provide Flexible Choices consultants
- 106 Residential Care Homes
- 17 Assisted Living Residences
- 37 Skilled Nursing Facilities

More detailed descriptions of providers in the aging network can be found in Attachment D.

### **Unserved/Underserved Individuals and Populations:**

Several groups and populations tend to be underserved in Vermont's LTSS system including:

- People experiencing homelessness
- People experiencing self-neglect
- People with severe mental illness
- People with substance use disorders
- People with advanced dementia
- People with complex medical needs
- People who are deaf, hard of hearing, or deafblind

- People who do not qualify for long-term care Medicaid but struggle financially to afford services
- People who experience multiple factors above combined

In addition, the unserved also include those who may be eligible for programs but waiting to be served, including those on the Moderate Needs Group waiting list, referenced below, and individuals unable to access Brain Injury Program services due to provider capacity.

### **Reasons for Gaps in Services:**

- **Workforce Crisis:** Across the LTSS system, service providers report serious staffing shortages, limiting their ability to serve current participants or new participants. Shortages are impacting long-term care facilities' ability to admit new residents, home health agencies' ability to provide personal care and homemaker services, Authorized Agencies' ability to find shared living home providers, and Adult Days' ability to increase census capacity. People self-directing services also have difficulty hiring independent caregivers.
- **Lack of Provider Capacity and Financial Stability:** Many service providers within the LTSS system not only struggle with a workforce shortage but also with financial stability due to limited revenue and resources.
- **Rurality of Vermont:** Being a rural state creates challenges for Vermonters seeking services. For example, many people struggle to find transportation to the regional Adult Day Center. Also limited access to broadband service in many rural areas of Vermont prevents more use of telehealth and tele-activities.
- **Disconnected Service Systems:** Vermont has a system of providers serving people experiencing homelessness, a system to serve those with mental illness, another system to serve people with substance use and still a separate system to serve people needing long-term care. These systems are funded separately, administered by different departments, and have historically evolved separately, not connecting services across systems very easily.

### **Overview of Programs and Services**

The following table seeks to provide an overview of Vermont's Long-Term Services and Supports (LTSS) programs for older Vermonters and Vermonters with physical disabilities, including basic criteria for receiving services and types of services provided.



Program	Eligibility	Services
<b>Choices for Care (High/Highest)</b>	<ul style="list-style-type: none"> <li>• Financially eligible for Long-Term Care Medicaid</li> <li>• Clinically eligible for nursing-home level of care</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Personal Care Services</li> <li>• Companionship</li> <li>• Respite</li> <li>• Adult Day</li> <li>• Assistive Devices/Home Modifications</li> <li>• PERS (Personal Emergency Response System)</li> <li>• Flexible Choices Option</li> <li>• Adult Family Care Option</li> <li>• Facility-based services:</li> <li>• Enhanced Residential Care</li> <li>• Skilled Nursing Facility Care</li> </ul>
<b>Moderate Needs Group Program</b>	<ul style="list-style-type: none"> <li>• Financially eligible based on 300% of SSI; \$10,000 resource limit.</li> <li>• Clinically eligible based on need for support with Instrumental Activities of Daily Living (IADLs)</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Homemaker Services</li> <li>• Flexible Funds</li> </ul>
<b>Brain Injury Program</b>	<ul style="list-style-type: none"> <li>• Financially eligible for Medicaid</li> <li>• Clinically eligible based on diagnosis of brain injury</li> </ul>	<ul style="list-style-type: none"> <li>• Case Management</li> <li>• Rehabilitation Supports with Life Skills Aides</li> <li>• Community Supports</li> <li>• Environmental and Assistive Technology Services</li> <li>• Crisis Supports</li> <li>• Respite Services</li> <li>• Psychology and Counseling Supports</li> </ul>
<b>Attendant Services Program</b>	<ul style="list-style-type: none"> <li>• Financially eligible for Medicaid</li> <li>• Clinically eligible based on a ‘severe and permanent disability’</li> </ul>	<ul style="list-style-type: none"> <li>• Personal care services</li> </ul>

<b>High-Tech Nursing Program</b>	<ul style="list-style-type: none"> <li>• Financially eligible for Medicaid</li> <li>• Clinically eligible based on the need for medical technology to survive</li> </ul>	<ul style="list-style-type: none"> <li>• Skilled nursing care, including coordinating treatments, medical supplies and sophisticated medical equipment</li> </ul>
<b>Older Americans Act Programs</b>	<ul style="list-style-type: none"> <li>• All Vermonters age 60 and older; targeting those in greatest social and economic need</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive services</li> <li>• Nutrition services</li> <li>• Health Promotion/Disease Prevention Programs</li> <li>• Family Caregiver Support Services</li> </ul>
<b>Supports and Services at Home (SASH)</b>	<ul style="list-style-type: none"> <li>• All Vermonters on Medicare</li> </ul>	<ul style="list-style-type: none"> <li>• Care Coordination</li> <li>• Wellness Nurse Visits</li> <li>• Access to a range of group supports and activities</li> </ul>
<b>Long-Term Care Ombudsman</b>	<ul style="list-style-type: none"> <li>• All Vermonters on Choices for Care both in facilities and in home</li> </ul>	<ul style="list-style-type: none"> <li>• Participant-directed support to resolve conflicts with facilities or providers, promote resident/individual rights, and ensure individual needs are met</li> </ul>
<b>Assistive Community Care Services</b>	<ul style="list-style-type: none"> <li>• Financially eligible for Medicaid</li> <li>• Clinically eligible below nursing home level of care</li> </ul>	<ul style="list-style-type: none"> <li>• 24/7 residential services, including in-house case management, personal care services, nursing assessment and routine tasks, medication assistance, on-site therapy, restorative nursing.</li> </ul>

Note that of the above programs, most are entitlement programs. However, the Moderate Needs Group Program is not an entitlement and has an average waiting list of 500 people statewide. SASH is also not an entitlement and capped at serving approximately 5,400 individuals total statewide.

More detailed information about eligibility and services can be found on the [ASD Website](#), in the program [regulations](#), and in the various [ASD Program Manuals](#).

Current rates by program and service type are in the [Adult Services Division Medicaid Rate Table](#).

### **A Process for Evaluating and Assessing Program Success**

All Medicaid services, including Choices for Care, are managed through the [State Global Commitment to Health 1115 Waiver](#) and the accompanying [Comprehensive Quality Strategy](#).

DAIL provides accountability monitoring and oversight for ASD Medicaid funded long-term services and supports programs in the following ways:

- Annual Assessment and Eligibility Reviews
- Annual Consumer Surveys
- Certification of Case Management Agencies, Adult Day Providers and Brain Injury Providers
- Critical Incident Reporting and Review
- Oversight of the Fiscal Employer Agent
- Contract with the Long-Term Care Ombudsman
- Designation and Monitoring of Home Health Agencies and DAs/SSAs
- Adult Protective Services
- Licensing of Long-Term Care Facilities
- Monitoring of authorized services and Medicaid claims, including Electronic Visit Verification
- Stakeholder Engagement

More detailed information on quality oversight of programs and services can be found in the **Quality Overview** within [ASD Quality Management](#).

Success of programs is also tracked via [ASD's Performance Scorecard](#). The Scorecard is an online and publicly available set of dashboards with updated data and information. The Scorecard can be used to learn about how Vermonters are doing in relation to important conditions of health and well-being and to learn about how the Agency of Human Services is contributing to doing better by improving outcomes for the people who benefit from our services, programs, resources, and support. The Results Scorecard tool is built according to *Results Based Accountability*<sup>™</sup> (RBA).

### **Priorities Looking Forward**

As DAIL considers priorities for continuation of existing programs and development of new programs, we are guided by the information from older Vermonters and family caregivers, the needs assessments, the evaluation of services and available resources.

Important initiatives of focus during this State Plan on Aging time period that will impact older Vermonters in the LTSS System include:

**Workforce Recruitment and Retention:** With staffing shortages reported by almost all LTSS community providers and cited as a major reason for current gaps in services, DAIL is working hard to address this challenge and support workforce recruitment and retention efforts across our provider network, with a strong focus on direct care workers such as Licensed Nursing Assistants and Personal Care Attendants.

- DAIL worked with a Vermont Certified Public Managers Program consultancy project to hear directly from direct care workers. Report findings and recommendations will be available in May 2022.

- **HCBS FMAP Funding:** As part of Vermont's [Enhanced FMAP Spending Plan](#), funding will be directed to home- and community-based services providers to support workforce recruitment and retention efforts. The Agency of Human Services will issue grants to providers in 2022; amounts will be dependent on the number of full-time staff at each provider, and providers will have flexibility to use the funding to support workforce in a variety of ways.
- **Training for providers and self-directed/surrogate directed employers and employees:** With recognition that program participants who are self-directing or surrogate-directing their care have significant responsibilities within a complex program, including recruiting and retaining independent employees, DAIL has issued an RFP for a vendor to develop online training for these employers and employees to support them in these roles with a goal of increasing sustainable, quality care.

**Conflict-of-Interest in Case Management:** DAIL is working with the Agency of Human Services and other departments to address conflict-of-interest in case management in home- and community-based programs as required by the Center for Medicare and Medicaid Services (CMS). In December 2021, the Agency submitted a plan to come into compliance with conflict-of-interest rules over the course of the next five years. DAIL will be involved in this effort along with community stakeholders. Learn more about this project here: [Conflict of Interest: Home- and Community-Based Services | Department of Vermont Health Access](#).

**Provider Network Financial Stability Coming Out of the Pandemic:** The loss of revenue during the pandemic, workforce shortages, and cost increases due to inflation have left many LTSS providers struggling financially. DAIL is working with the Agency of Human Services to support providers in a variety of ways, including short-term grants as well as long-term rate increases.

**Addressing Complex Care Needs:** Vermonters with complex needs, especially mental health and/or substance use coupled with long-term care needs, have historically been especially challenging to serve in our system. DAIL is working across agencies/departments to find solutions to better serve Vermonters, including through additional education and training for provider staff, exploration of alternative residential models, and stronger coordination across service systems and providers.

**Self-Neglect Working Group Recommendations:** The Older Vermonters Act of 2020 created a 'Self-Neglect Working Group' tasked with making recommendations to the legislature to address the issue of self-neglect, including prevention and services. A report of recommendations will be available in July 2022, and DAIL will work with the legislature, the Agency of Human Services, providers and communities to move forward recommendations that are most feasible and impactful.

**Money Follows the Person Initiatives:** In 2021, Vermont was awarded a \$5 million capacity building grant as part of the Money Follows the Person (MFP) CMS demonstration grant. With this new funding, available through 2025, DAIL is embarking on several pilot projects with community providers to strengthen supports for Money Follows the Person and Choices for Care participants, including: holistic social and mental health supports, expanding volunteer supports, identifying and supporting individuals with brain injury, falls prevention, and home

modifications and peer support to assist community living. In addition, the DAIL Adult Services Division has partnered with HireAbility (Division of Vocational Rehabilitation) and the Assistive Technology Program to conduct the following joint projects: increasing the direct care workforce (PCAs and LNAs) through promotion, scholarships and mentorships, and increasing older Vermonters' access to a range of Assistive Technology supports to support independence and aging in place. Over the next three years, the MFP team seeks to learn from these projects through performance measures and participant outcomes how to better support participants at higher risk of readmission to an institution with a goal of finding sustainable programmatic solutions.

**Housing Accessibility Inspection Pilot:** For Vermonters who receive home supports funded by the state and/or federal government, a housing safety inspection is required. This includes an accessibility assessment in situations where the participant requires the use of an assistive device for mobility needs, or has accessibility needs (e.g. Low vision, hearing loss) that affect the participant's ability to freely navigate the home environment. In the next year, ASD will be piloting a consistent statewide accessibility assessment process to identify changes needed in the home and make adaptations to improve the quality of life of the individuals we serve.

**Moderate Needs Group Improvements:** In the coming year, ASD will be reviewing the way that Moderate Needs Group (MNG) funding allocations are determined and potentially revise the formula to ensure that funding is maximized throughout the year to serve the most people possible.

**Electronic Visit Verification (EVV) Implementation:** Electronic Visit Verification is a CMS requirement for providers of personal care services. DAIL is working within the agency, with the fiscal agent, and with community providers to ensure that employees providing personal care services to Choices for Care participants are compliant with the Federal EVV requirements.

**Lessons Learned from COVID-19:** DAIL will continue to learn from the challenges and successes in serving Vermonters throughout the pandemic so that we can best be prepared for any future public health emergencies or natural disasters. This includes continuing those policies and practices that supported people well. Learn more about participant experiences with services during the pandemic here: [DAIL\\_COVID-19\\_Survey\\_Report\\_April2021\\_FINAL.pdf \(vermont.gov\)](#)

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## Attachments

### ATTACHMENT A: STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES

#### Older Americans Act, As Amended in 2020

*By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.*

#### Sec. 305, ORGANIZATION

- (a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title— . . .
- (2) The State agency shall—
  - (A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general-purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;
  - (B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .
  - (E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;
  - (F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and
  - (G)
    - (i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;
    - (ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;
    - (iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—...

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

#### Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-



income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4) (A)

(i)

(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low- income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items

(aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

prepared —

(I) specify how the provider intends to satisfy the service needs of low- income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

- (V) older individuals with limited English proficiency;
- (VI) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- (VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and
  - (ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and
- (C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.
  - (5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;
  - (6) provide that the area agency on aging will—
    - (A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;
    - (B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;
    - (C)
      - (i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;
      - (ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—
        - (I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or
        - (II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

- (7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—
- (A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;
  - (B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—
    - (i) respond to the needs and preferences of older individuals and family caregivers;
    - (ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and
    - (iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;
  - (C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and
  - (D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—
    - (i) the need to plan in advance for long-term care; and
    - (ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;
- (8) provide that case management services provided under this title through the area agency on aging will—
- (A) not duplicate case management services provided through other Federal and State programs;
  - (B) be coordinated with services described in subparagraph (A); and
  - (C) be provided by a public agency or a nonprofit private agency that—
    - (i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State

Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

- (B) disclose to the Assistant Secretary and the State agency—
  - (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and
  - (ii) the nature of such contract or such relationship;
- (C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;
- (D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and
- (E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;
- (14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;
- (15) provide assurances that funds received under this title will be used—
  - (A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
  - (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;
- (16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;
- (17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;
- (18) provide assurances that the area agency on aging will collect data to determine—
  - (A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and
  - (B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;



- (K) protection from elder abuse, neglect, and exploitation;
- (L) assistive technology devices and services; and
- (M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

- (i) providing notice of an action to withhold funds;
- (ii) providing documentation of the need for such action; and
- (iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

- (1) contracts with health care payers;
- (2) consumer private pay programs; or
- (3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

#### Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

- (1) The plan shall—
  - (A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
  - (B) be based on such area plans.
- (2) The plan shall provide that the State agency will—
  - (A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

- (B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and
  - (C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).
- (3) The plan shall—
- (A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and
  - (B) with respect to services for older individuals residing in rural areas—
    - (i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000...
    - (ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and
    - (iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.
- (4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).
- (5) The plan shall provide that the State agency will—
- (A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
  - (B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and
  - (C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.
- (6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

- (i) public education to identify and prevent abuse of older individuals;
- (ii) receipt of reports of abuse of older individuals;
- (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
- (iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

- (i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and
  - (ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.
- (16) The plan shall provide assurances that the State agency will require outreach efforts that will—
- (A) identify individuals eligible for assistance under this Act, with special emphasis on—
    - (i) older individuals residing in rural areas;
    - (ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
    - (iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
    - (iv) older individuals with severe disabilities;
    - (v) older individuals with limited English-speaking ability; and
    - (vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
  - (B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.
- (17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.
- (18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—
- (A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
  - (B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—



- (i) the projected change in the number of older individuals in the State;
  - (ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
  - (iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
  - (iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.
- (28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.
- (29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.
- (30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—
- (A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;
  - (B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and
  - (C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

## Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

- (i) if all parties to such complaint consent in writing to the release of such information;
- (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
- (iii) upon court order...



Monica White, DAIL Commissioner

6/29/2022

*Signature and Title of Authorized Official*

*Date*

## ATTACHMENT B: INFORMATION REQUIREMENTS

IMPORTANT: States must provide all applicable information following each OAA citation listed below. Please note that italics indicate emphasis added to highlight specific information to include. The completed attachment must be included with your State Plan submission.

### ***Section 305(a)(2)(E)***

*Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;*

RESPONSE: Area Agencies on Aging provide assurances to serve those in greatest economic and social need as part of their Area Plan. The SUA monitors this yearly via State Program Reporting reporting.

### ***Section 306(a)(6)(I)***

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;*

RESPONSE: Area Agencies on Aging provide assurances that they, to the extent possible, will coordinate with the State agency to disseminate information about the State's assistive technology entity and access to assistive technology options for serving older individuals.

### ***Section 306(a)(17)***

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and state emergency response agencies, relief organizations, local and state governments, and other institutions that have responsibility for disaster relief service delivery.*

RESPONSE: Department of Disabilities Aging and Independent Living provides the Area Agencies on Aging with Area Plan Instructions that clearly outline the requirement to include an emergency preparedness plan. The State Unit on Aging reviews the emergency plan during each Area Plan period. Emergency Plan updates are submitted as needed during the annual review.

### ***Section 307(a)(2)***

*The plan shall provide that the State agency will —...*

*(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in*

*section 306(a)(2). (Note: those categories are access, in-home, and legal assistance. Provide a specific minimum proportion determined for each category of service.)*

RESPONSE: Each AAA shall expend at least 65% of Part B funds for Access to Services, 1% of Part B funds for In-Home Services, and 5% of Part B funds for Legal Assistance. DAIL includes this requirement in AAA Area Plan Instructions. The percentages were developed in collaboration and agreement with the Area Agencies on Aging. However, the amounts will be revisited with the AAAs as several years have passed since the agreed-upon amounts were determined. The State Unit on Aging will discuss the minimum proportion of funds to carry out part B during a scheduled meeting in Fiscal Year 2022.

***Section 307(a)(3) The plan shall***

*(B) with respect to services for older individuals residing in rural areas—*

*(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for the fiscal year 2000*

According to the US 2010 Census, approximately 98% of Vermont's land area is defined as rural and 61.1% of Vermont's population lives in rural areas (defined by the US Census as all areas that are not urbanized or urban clusters (<https://www.census.gov/prod/cen2010/cph-2-47.pdf>). Only 17.4% of the population lives in an urbanized area (the greater Burlington area), with the remaining 82.6% living in rural areas, small towns, and small cities. With such a significant rural population, the Area Agencies on Aging target funds to those living in rural areas with all of the services they provide.

Every federal fiscal year DAIL obligates funds for these services. We continue to report that the State resources expended to meet the maintenance of effort requirement (not less than the amount expended in base year FY2000), set forth by Title III of the Older Americans Act, are more than the required level.

*(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services)*

- FY23 Fed: \$6.2M, State: \$5.1M, Total: \$11.3M
- FY24 Fed: \$6.2M, State: \$5.1M, Total: \$11.3M
- FY25 Fed: \$6.2M, State: \$5.1M, Total: \$11.3M
- FY26 Fed: \$6.2M, State: \$5.1M, Total: \$11.3M

*(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

Response: DAIL obligates all OAA funds to Area Agencies on Aging, targeting older Vermonters in greatest social and economic need, focusing on those in rural areas. Only 1 of the 5 Area Agencies on Aging serves an urbanized area and a rural area. The remaining four Area Agencies on Aging serve only rural populations in rural areas. DAIL and the Area Agencies on Aging continuously seek to maximize OAA funds to meet needs in rural areas, collaborating with other state agencies, community partners, and volunteers to ensure access despite the rural landscape and dispersed population.

**Section 307(a)(10)**

*The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.*

RESPONSE: As a result of Vermont's substantially rural population, the IFF does not distribute funds to the rural population. However, the Area Agencies on Aging must prioritize those in greatest economic and social need, including those living in very rural areas. Therefore, Agencies on Aging work closely with rural transportation providers and community organizations in very rural areas to maximize transportation options and access to services at focal points, such as rural health clinics, in each rural community.

**Section 307(a)(14)**

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

*(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency;*

Response: Using the best available data from the US Census American Community Survey Special Tabulations for Vermont 2019:

- 11,776 Vermonters age 60 or older have incomes below the poverty level.
- 4,385 Vermonters age 60 or older identify with minority status.
- 768 Vermonters age 60 or older speak English “not well” or “not well at all.”

*(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.*

Response: See IFF Attachment B, including allocation for low-income, minority, and limited English proficient (LEP) older individuals. Most minority and LEP older individuals reside in one Area Agency on Aging service area. That Area Agency on Aging has designated two LEP case managers who speak the language of the older LEP population.

**Section 307(a)(21)****The plan shall**

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

RESPONSE: Vermont has no federally recognized Native American tribes receiving OAA funds but has tribes recognized by the state within the last five years. DAIL is building a relationship with the Vermont Commission on Native American Affairs and tribal leaders to determine how to best meet the needs of older Native Americans with OAA services and support.

**Section 307(a)(27)**

*(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.*

*(B) Such assessment may include*

*(i) the projected change in the number of older individuals in the State;*

*(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;*

*(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and*

*(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services*

RESPONSE: DAIL contracted with the University of Massachusetts Medical school to provide population and service utilization projections to help the Department plan for the long-term care service needs of older Vermonters with Disabilities. The report projects out to 2030. A link to the Demographic Projections is can be found here:

<https://dail.vermont.gov/sites/dail/files/documents/vt-population-projections-2010-2030.pdf>

**Section 307(a)(28)**

*The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.*

RESPONSE: See page 28 of the plan. See also the State Emergency Operations Plan, located here: <https://vem.vermont.gov/sites/demhs/files/SEMP/SEMP%20Base%20Plan.pdf>

**Section 307(a)(29)**

*The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.*

RESPONSE: The State Emergency Operations Plan State Support Function Grid identifies the Agency of Human Services as the Lead Agency for emergency operations related to human services: <http://vem.vermont.gov/sites/demhs/files/pdfs/plans/state/Appendix-IV-SSF-RSF-Assignment-Matrix.pdf>. Brian Guy, Director of Operations, is the primary person responsible for representing DAIL and the SUA for emergency preparedness planning. Brian Guy reports directly to Monica White, DAIL Commissioner, and SUA Director, and serves as Monica Whites's designee for the development, revision, and implementation of DAIL-related sections of the State of Vermont Emergency Operations Plan.

### **Section 705(a) ELIGIBILITY —**

*In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307— . . .*

*(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). (Note: Paragraphs (1) of through (6) of this section are listed below)*

*In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307—*

*(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;*

Response: DAIL staff includes a designated Legal Assistance Developer per OAA guidance who works with legal assistance providers to ensure quality legal services for older Vermonters.

DAIL contracts with Vermont Legal Aid to operate the State Long Term Care Ombudsman Program and with the Area Agencies on Aging to raise public awareness and education around preventing elder abuse, neglect, and exploitation. The Ombudsman reports to DAIL quarterly; the Area Agencies on Aging report to DAIL bi-annually via their Area Plan reporting.

Vermont's APS program is the primary unit of state government responsible for investigating allegations of abuse, neglect, and exploitation of vulnerable adults under Title 33 of Vermont Statutes. APS and the State Unit on Aging both sit within DAIL, work collaboratively with community partners on Title VII programs and services, and are overseen by the DAIL Commissioner.

DAIL assures that all programs under Title VII will be operated following applicable OAA requirements.

*(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under Title VI, and other interested persons and entities regarding programs carried out under this subtitle;*

Response: APS holds at least one public hearing a year to gather input from the public on operations. In addition, the DAIL Advisory Board has an APS Committee that meets regularly,



6-9 times a year, that is open to the public, and comments from the crowd are always an agenda item. The DAIL Advisory Board also periodically seeks public input on all programs under this subtitle, including the Long-Term Care Ombudsman program and programs to prevent elder abuse, neglect, and exploitation.

*(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;*

Response: Through trained and certified Information and Assistance specialists following the No Wrong Door/ADRC model, Area Agency on Aging staff informs all clients of their rights when first receiving services and provides information to clients about how to address issues related to their rights and benefits, including warm referrals to the statewide legal assistance provider, Attorney General's consumer assistance program and the Long-Term Care Ombudsman.

*(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;*

Response: DAIL has a subrecipient grant agreement with Vermont Legal Aid (VLA) in which VLA is required to operate the Vermont Statewide Office of Long-Term Care Ombudsman. VLA submits quarterly invoices, including program, statistical and financial reports (including a schedule of actual expenditures). DAIL then reimburses VLA based on their actual spending up to a fixed amount noted in the grant agreement. Specific requirements of VLA stated in the grant agreement include but are not limited to: managing all representatives of the Office, creating a budget and work plan, preparing and submitting an annual report to the State, providing outreach and education consistent with the Vermont State Plan on Aging, etc. VLA also presents a yearly audit report reviewed by the State to provide an added level of assurance. Through these mechanisms for monitoring, DAIL confirms the commitment not to supplant any funds expended under Federal or State law in existence on the day before the date of the enactment of this subtitle to carry out each of the vulnerable elder rights protection activities described in the chapter.

*(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);*

Response: Vermont does not have a local Ombudsman under section 712(a)(5) separate from the State Long Term Care Ombudsman. Therefore, Vermont Legal Aid staffs are both the State Ombudsman and the local ombudsmen.

*(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—*

*(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for-*

*(i) public education to identify and prevent elder abuse;*

Response: APS provides training to the staff of community-based providers and other community groups to prevent and reduce the abuse, neglect, and exploitation of vulnerable adults. They review applicable laws and policies, such as reporting requirements for mandated reporters, and show how to make a report when someone suspects a vulnerable adult is at risk. In addition, APS continues to lead the Financial Abuse Specialist Team (FAST), which brings together private and public organizations collectively working to prevent financial exploitation.

*(ii) receipt of reports of elder abuse;*

Response: APS performs intake within 48 hours of receiving a report of maltreatment of a vulnerable adult. APS staff determine if the alleged victim is a vulnerable adult and if the allegations meet the statutory definitions for abuse, neglect, or exploitation. If both criteria are met, an investigator is assigned, and an investigation is conducted. If these criteria are not clear, an APS Investigator may be sent to perform a field screen to decide. APS staff make appropriate referrals to other organizations to assist the reporter and/or alleged victim, even if an intake is not referred to investigation. When an investigation is warranted, APS Investigators will interview the reporter, the alleged victim, and any other relevant witnesses, along with reviewing any available documentation. They will also provide the alleged perpetrator with an opportunity to present information. After the investigation, they will recommend substantiation to the DAILE Commissioner if the evidence indicates there was abuse, neglect, or exploitation.

*(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent;*

Response: The APS investigator will discuss appropriate protective services with the alleged victim and/or their legal representative. Except where protective services are court-ordered, the investigator works to implement protective services agreed to by the victim. Victims with decisional capacity can choose to decline all services. Services offered include but are not limited to:

- Referrals to service providers, including case management, guardianship services, mental health, and developmental services, law enforcement, and health care.
- Securing change of representative payee.
- Petitioning for removal of a court-appointed guardian.
- Notifying and filing a misuse of funds report with the Social Security Administration.
- Alerting financial institutions of misappropriation of funds.
- Assisting the client to close/changing the banking or other accounts.
- Intervening in cases of identity theft.
- Petitioning for guardianship.

- Filing for temporary restraining orders and relief from abuse orders.

*(iv) referral of complaints to law enforcement or public protective service agencies if appropriate*

Response: See the above list of possible referrals.

*(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households*

Response: If an alleged victim refuses the assistance of APS and requests that the investigation be stopped, the Investigator shall at a minimum:

- Document steps are taken to assess the alleged victim’s capacity to consent or refuse services/assistance.
- Offer protective services, referrals, and safety planning to the alleged victim, and document same.
- If the Investigator has information and/or evidence that supports the continuation of the investigation (e.g. the alleged victim’s statement, police reports, photographs), after consulting with the supervisory staff they may determine that the investigation should continue.
- The Investigator may determine that a continued investigation requires a search of the alleged perpetrator’s prior history of abusive behavior (e.g. Harmony database, the Adult Abuse Registry, the VCIC) and;
- May also include identification and interview of other potential victims.
- If the alleged incident occurred in a licensed facility or another setting (such as Choices for Care) where the alleged perpetrator may have continued access to other vulnerable adults, the Investigator will identify, contact and interview those individuals, and take protective measures as needed.

*(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—*

*(i) if all parties to such complaint consent in writing to the release of such information;*

*(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*

*(iii) upon court order.*

RESPONSE: Use of information by Adult Protective Services is guided by Vermont statute (Title 33 Chapter 69):

“Information obtained through reports and investigations, including the identity of the reporter,

shall remain confidential and shall not be released absent a court order, except as follows:

(A) The investigative report shall be disclosed only to: the Commissioner or person designated to receive such records; persons assigned by the Commissioner to investigate reports; the person reported to have abused, neglected, or exploited a vulnerable adult; the vulnerable adult or his or her representative; the Office of Professional Regulation when deemed appropriate by the Commissioner; the Secretary of Education when deemed appropriate by the Commissioner; the Commissioner for Children and Families or designee for purposes of review of expungement petitions filed under section 4916c of this title; the Commissioner of Financial Regulation when deemed appropriate by the Commissioner for an investigation related to financial exploitation; a law enforcement agency; the State's Attorney, or the Office of the Attorney General, when the Department believes there may be grounds for criminal prosecution or civil enforcement action, or in the course of a criminal or a civil investigation. When disclosing information under this subdivision, reasonable efforts shall be made to limit the information to the minimum necessary to accomplish the intended purpose of the disclosure, and no other information, including the identity of the reporter, shall be released absent a court order.”

(B) Relevant information may be disclosed to the Secretary of Human Services, or the Secretary's designee, to remediate or prevent abuse, neglect, or exploitation; to assist the Agency in its monitoring and oversight responsibilities; and in the course of a relief from abuse proceeding, guardianship proceeding, or any other court proceeding when the Commissioner deems it necessary to protect the victim, and the victim or his or her representative consents to the disclosure. When disclosing information under this subdivision, reasonable efforts shall be made to limit the information to the minimum necessary to accomplish the intended purpose of the disclosure, and no other information, including the identity of the reporter, shall be released absent a court order.”

## ATTACHMENT C: INTRASTATE FUNDING FORMULA (IFF)

The OAA requires that most funds be distributed by the SUA to the AAAs through an Intrastate Funding Formula (IFF). The IFF is the method by which Title IIIB, C, D, and E funding is allocated among the five AAAs. The total amount of OAA funding Vermont receives for allocation to the AAAs is determined by the federal government.

The Area Agencies on Aging have 18 months to adjust their budgets when demographic changes in the census cause a shift in Older Americans Act funding through the formula. State is not intending to modify or change the formula factors or weighting.

Please find below a more complete description of the formula, including guiding principles, mathematical equation, funding factors, and an implementation timeline that outlines the process.

### A. Guiding Principles:

1. **Stability:** Avoid distributing large funds associated with a small number of people. This is a challenge for Vermont's AAA service areas, which have small numbers of people in many cohorts of greatest social and economic need.
2. **Best available data:** Use the Special Tabulations (AGID) completed by the ACL of the American Community Survey (ACS) 5-year estimates. The ACS produces annual population estimates and provides population estimates based on averages of a recent 5-year period. The Special Tabulation completed by ACL provides data divided by the Planning Service Areas (PSA), the service areas of the individual AAAs. The ACS 5-year Survey is described by the U.S. Census Bureau (in *Guidance for Data Users*) as providing more precision for small populations than other data sources. As most population cohorts in Vermont are small, the Special Tabulation of the ACS 5-year Survey is utilized as best available data for the purpose of the IFF.

### B. IFF Mathematical Equation

1.  $\$TAAA = (\$S - (\$SPA + \$3OMB + \$7OMB))$
2.  $\$APASB = ((\$TAAA * .1) / AN) + ((\$TAAA * .1) / AN)$
3.  $\$CT = \$TAAA - (\$APASB * AN)$
4.  $\$A = \$APASB + ((\$CT * .15) * C1) + ((\$CT * .15) * C2) + ((\$CT * .27) * C3) + ((\$CT * .4) * C4) + ((\$CT * .01) * C5) + ((\$CT * .01) * C6) + ((\$CT * .01) * C7)$

Where:

$\$TAAA$  = Total Allocation to AAAs

$\$S$  = State Allocation (Title III + Title VII)

$\$SPA$  = State Plan Administration

$\$3OMB$  = Title IIIB funds removed for Ombudsman (\$223,614)

$\$7OMB$  = Title VII ombudsman funds

$\$APASB$  = Area Plan Administration + Service Base per AAA

$AN$  = Number of Area Agencies in State (5)

$\$CT$  = Total to run through cohort factors

$\$A$  = Area Allocation

$C1$  = Age 60-74

$C2$  = Age 75-84

C3 = Age 85+

C4 = Age 60+, Poverty

C5 = Age 60+, Limited English

C6 = Age 60+, Minority

C7 = Age 60+, Live Alone

1. Example:

FFY23:

$$\$6,377,818 = (\$7,119,261 - (\$419,398 + \$223,614 + \$98,431))$$

2. Example:

FFY23 CVCOA:

$$\$255,112 = ((\$6,377,818 * .1) / 5) + ((\$6,377,818 * .1) / 5)$$

3. Example:

FFY23 CVCOA:

$$\$5,102,258 = \$6,377,818 - (\$255,112 * 5)$$

4. Example:

FFY23 CVCOA:

$$\begin{aligned} \$1,195,689 = & \$APASB + ((\$5,102,258 * .15) * .1979) + ((\$5,102,258 * .15) * .1908) + \\ & ((\$5,102,258 * .27) * .1658) + ((\$5,102,258 * .4) * .1933) + ((\$5,102,258 * .01) * .0582) + \\ & ((\$5,102,258 * .01) * .1478) + ((\$5,102,258 * .01) * .1899) \end{aligned}$$

### C. Funding Factors:

This IFF emphasizes distribution of funds based on the numbers of people living in poverty, and the numbers of people who are age 85+.

1. **Service Base:** distribution of 10% of total Title IIIB, C, D, and E funds available for distribution, divided equally among the five AAAs (i.e. 2% per AAA).
2. **Area Plan Administration:** distribution of 10% of total funds available for distribution, divided equally among the five AAAs (i.e. 2% per AAA).
3. **Age:**
  - 15% of the *remaining* funds distributed by the proportion of people age 60-74 in each PSA.

- 15% of the remaining funds distributed by the proportion of people age 75-84 in each PSA.
  - 27% of the *remaining* funds distributed by the proportion of people age 85+ in each PSA.
4. **Age and economic need:** 40% of the *remaining* funds distributed by the proportion of people age 60+ and at or below 100% of the Federal Poverty Level in each PSA.
  5. **Age and social need, defined as limited English:** 1% of the *remaining* funds distributed by the proportion of people age 60+ and with limited English proficiency in each PSA.
  6. **Age and social need, defined as minority status:** 1% of the *remaining* funds distributed by the proportion of people age 60+ and minority in each PSA.
  7. **Age and social need, defined as living alone:** 1% of the *remaining* funds distributed by the population of people age 60+ and living alone in each PSA.

### D. Implementation:

The Vermont IFF FFY 2023-2026 allocates approximately \$6,251,765 million in OAA federal funding and \$5,116,414 million from the State General Fund across Vermont for home and community-based services for a total of approximately \$11,368,179 million for FY 2023. (The funding approximations exclude the one-time, supplemental funds distributed through COVID-19 relief).

The tables below describe the process that Vermont will use to complete updates of the IFF, following the current State Plan on Aging and IFF approved by ACL. This process includes two parallel activities, integrating a delay that provides AAAs additional time to plan for changes in funding that may be caused by changes in demographics. Please note that the Resource Projections are estimates and subject to change until declared final.

**Table 1: Estimated and Final Resource Projections for next FFY: FFY23 (Est. 18 Months lead time)**

\*All dates are subject to change based on when Vermont receives Federal Awards from ACL

	Step	Target Date	Who/What
<b>Estimated Resource Projections for Next FFY</b>	1	Est March-April of prior FFY	DAIL Business Office staff receive notice of the current year, mid-year, Federal Award for Vermont (Oct-Sep).
	2	Within two weeks of Step 1	DAIL Business Office staff will use the previously produced funding formula values (table 2, below) to create a document showing estimated resource projections for the next FFY and forward this to the DDPU Director, ASD staff, and AAA staff.
	3	Within four weeks of Step 1	ASD staff will post the estimated resource projections on the DAIL website, collocated with the State Plan on Aging.

<b>Final Resource Projections for Current FFY</b>	4	Est. Aug-Sep of the current FFY	DAIL Business Office staff receives notice of the final Federal Award for Vermont used to create Final resource projections for the current FFY (Oct-Sep).
	5	Within two weeks of Step 4	DAIL Business Office staff will use the previous year’s AGID funding formula values to create a document showing estimated resource projections for the next FFY and forward this to the DDPD Director, ASD staff, and AAA staff.
	6	Within three weeks of Step 4	Within three weeks of Step 4, ASD staff will post the final resource projections on the DAIL website, collocated with the State Plan on Aging.

**Table 2: Demographic formula for the subsequent FFY (Est. 18 Months lead time):**

	Step	Target date	Who/What
<b>Demographic Formula for Subsequent FFY</b>	1	Approx. April 1	The Director of the DAIL Data Planning and Analysis Unit will consult the <a href="#">ACL website</a> to access the most recent ACL special tabulations by Vermont PSA. The Director will update the demographic tabs in the formula workbook, create an updated demographic formula with revised version date, and forward this to DAIL Business Office staff and ASD program staff.
	2	Within two weeks of Step 1	ASD staff will forward the demographic formula for the subsequent FFY to AAA staff and also post them on the DAIL website, collocated with the State Plan on Aging.

**Table 3: Funding Data by AAA and by Funding Factor:**

Table 3 displays the funding factors, the weighted percentages related to the factors, and the impact on fund distribution to the five Area Agencies on Aging for FFY18 as of 03/08/18.

	% per SPA IFF		Total	Age Well	CVCOA	NEKCOA	SWVCOA	SR SOLUTIONS	Total
Area Plan Administration	10%	<i>of total</i>	\$528,520	\$105,704	\$105,704	\$105,704	\$105,704	\$105,704	\$528,520
Service base	10%	<i>of total</i>	\$528,520	\$105,704	\$105,704	\$105,704	\$105,704	\$105,704	\$528,520
age 60-74	15%	<i>of balance</i>	\$634,226	\$212,326	\$121,870	\$72,014	\$109,132	\$118,884	\$634,226
age 75-84	15%	<i>of balance</i>	\$634,226	\$207,403	\$121,030	\$72,854	\$121,137	\$111,802	\$634,226
age 85+	27%	<i>of balance</i>	\$1,141,609	\$371,815	\$201,055	\$145,972	\$209,318	\$213,449	\$1,141,609
age 60+ poverty	40%	<i>of balance</i>	\$1,691,270	\$495,558	\$324,502	\$259,099	\$285,093	\$327,018	\$1,691,270
age 60+ limited english	1%	<i>of balance</i>	\$42,282	\$27,483	\$1,269	\$4,862	\$3,700	\$4,968	\$42,282
age 60+ minority	1%	<i>of balance</i>	\$42,282	\$19,428	\$6,360	\$4,298	\$4,932	\$7,264	\$42,282
age 60+ live alone	1%	<i>of balance</i>	\$42,282	\$13,730	\$8,278	\$5,000	\$7,340	\$7,934	\$42,282
<b>Proposed Total Title III &amp; VII</b>	<b>4,228,178</b>	<b>balance</b>	<b>\$5,285,217</b>	<b>\$1,559,151</b>	<b>\$995,772</b>	<b>\$775,507</b>	<b>\$952,060</b>	<b>\$1,002,727</b>	<b>\$5,285,217</b>



**Table 4: Funding data showing the allocation by each part of Title III**

		Age Well	CVCOA	NEKCOA	SWVCOA	SR SOLUTIONS	Total
Preventive Health (Title III-D)	1.86%	\$28,983	\$18,511	\$14,416	\$17,698	\$18,640	\$98,248
Title III-B	28.34%	\$441,801	\$282,162	\$219,748	\$269,776	\$284,133	\$1,497,620
Title III-C1	41.99%	\$654,696	\$418,131	\$325,639	\$399,776	\$421,051	\$2,219,293
Title III-C2	21.20%	\$330,518	\$211,090	\$164,397	\$201,824	\$212,564	\$1,120,393
Title III-E	6.17%	\$96,172	\$61,421	\$47,835	\$58,725	\$61,850	\$326,003
<b>Proposed Total</b>	<b>100.0%</b>	<b>\$1,559,151</b>	<b>\$995,772</b>	<b>\$775,507</b>	<b>\$952,060</b>	<b>\$1,002,727</b>	<b>\$5,285,217</b>

**Table 5: Demographic estimates by AAA (PSA).**

The data source is the AOA/AGID special tabulations by PSA, using US Census ACS estimates.

PSA	AAA	Age 60-74	Age 75-84	Age 85+	Age 60+ <100% fpl	Age 60+ limited English	Age 60+ minority	Age 60+ living alone
A	Age Well	32,005	9,665	4,050	2,955	520	1,225	11,560
B	CVCOA	18,370	5,640	2,190	1,935	24	401	6,970
C	NEVAA	10,855	3,395	1,590	1,545	92	271	4,210
D	SWVCOA	16,450	5,645	2,280	1,700	70	311	6,180
E	SR Solutions	17,920	5,210	2,325	1,950	94	458	6,680
	<b>TOTAL</b>	<b>95,600</b>	<b>29,555</b>	<b>12,435</b>	<b>10,085</b>	<b>800</b>	<b>2666</b>	<b>35,600</b>

Prior to distribution under the IFF to the AAAs, funds are deducted from the Title III funds for State Plan administration.

Prior to the distribution under the IFF to the AAAs, funds are deducted from Title IIIB for the Long-Term Ombudsman Program. Please note that the following funding is not distributed to the AAAs via IFF:

1. OAA Title III-B funds for the Long-Term Care Ombudsman Program. These funds are included in the State Long-Term Care Ombudsman grant to Vermont Legal Aid.
2. OAA Nutrition Services Incentive Program (NSIP) funds. These funds are distributed to the AAAs based on the number of Title III-C qualifying meals served by each agency during the previous federal fiscal year.

## ATTACHMENT D: VERMONT'S AGING NETWORK

The following description of Vermont's Aging Network provides essential contextual information regarding the pivotal role each component plays in addressing older Vermonter's needs and supporting their family caregivers, including the SUA's role as part of this network.

**Vermont's Department of Disabilities, Aging, and Independent Living (DAIL)** is the State Unit on Aging. It is the sole state agency responsible for administering the State Plan on Aging. DAIL comprises five divisions, each responsible for different areas of service.

**Adult Services Division (ASD):** The Adult Services Division is responsible for long-term services and supports for older Vermonters and adults with physical disabilities. ASD works with private organizations to provide a broad array of long-term services and supports, including residential support, community support, case management, family support, respite, crisis services, clinical interventions, assistance with Activities of Daily Living, guardianship services, nursing home level of care, rehabilitation services, supports to live at home, integrated health care and personal care. In addition, the ASD oversees the core programs of the Area Agencies on Aging, including those funded by the OAA; the Long-Term Care Ombudsman Program; Adult Day Services; Attendant Services; High Technology Home Care; Choices for Care (VT's 1115b HCBS waiver); Money Follows the Person, Adult Family Care, the Aging and Disabilities Resource Connection (ADRC) and the Traumatic Brain Injury Program.

**Developmental Disabilities Services Division (DDSD):** The DDSD is responsible for services to people with developmental disabilities, traumatic brain injuries, and guardianship services to adults with developmental disabilities and older Vermonters. DDSD works with private organizations to provide a broad array of long-term services and supports, including service coordination, family support, community support, employment support, guardianship services, residential support, crises services, clinical interventions, respite, and rehabilitation services. The DDSD oversees several programs and services, including Developmental Disabilities Home and Community Based Services, Flexible Family Funding, and Public Guardians.

**Division of Licensing and Protection (DLP):** The DLP enforces federal and state statutes and regulations for providers of health care (Survey and Certification) and investigates cases of alleged abuse, neglect, and exploitation of vulnerable adults (APS).

**Division for the Blind and Visually Impaired (DBVI):** The DBVI is the designated state unit to provide vocational rehabilitation and independent living services to eligible Vermonters who are blind and visually impaired. Programs and services include Transition Services, counseling and guidance, independent living services, homemaker services, assistive technology equipment, vocational training, job-seeking skills, employer assistance, and job-placement services.

**Division of Vocational Rehabilitation (VR):** The mission of VR Vermont is to help Vermonters with disabilities prepare for, obtain, and maintain meaningful employment and help employers recruit, train, and retain employees with disabilities. They also oversee DAIL's Mature Worker Initiative to encourage the hiring and retention of older worker. VOC-Rehab receives Senior Community Service Employ Program funding from the US Department of Labor. VR Vermont passes the money to the Associates for Training and Development (A4TD) to administer the program.

Community Partners Comprising our Aging Services Network:

**Vermont's five Area Agencies on Aging (AAAs):** The primary role of the five AAAs is to serve as the critical planning and development agencies within the five service areas. The AAAs are responsible for comprehensively assessing the needs of older Vermonters and family caregivers and facilitating the development of services to meet the identified needs. In addition to their planning and development function, AAAs assist many older Vermonters and family caregivers who have short-term needs or require intermittent help. Thousands of older Vermonters can retain their independence because of ongoing case management, nutrition services, and other OAA services that are not crisis-driven but are more preventive. AAAs contract with multiple providers for services such as nutrition, transportation, legal and mental health services. In recent years, emphasis has been placed on promoting the availability of evidence-based disease prevention and health promotion activities. Without such assistance, many people would eventually be at greater risk for deteriorating health and/or economic status, which can lead to a loss of independence or diminish the quality of life. In addition, many consumers of AAA services regain their independence after a stay in a hospital or nursing facility because of case management support, nutrition services, transportation, support for family caregivers, and other interventions. AAAs sponsor programs such as the Senior Companion Program and RSVP, which add a significant contingent of volunteers who enhance AAA services. Volunteers lead various healthy aging programs in communities all over Vermont, including performing in-home services, providing regular friendly visits, and assisting with food shopping. AAAs also provide regional outreach and assistance to Medicare beneficiaries about the full range of public and private health benefits through the State Health Insurance Assistance Program (SHIP) and help to prevent health care fraud through the SMP (formerly referred to as the Senior Medicare Patrol, administered by the Community of Vermont Elders). The AAAs have also been core partners in Vermont's Aging and Disability Resource Connection (ADRC). They are in the formative group of organizations forming Vermont's "No Wrong Door" ADRC model and are central players in the continuous improvement and expansion of Vermont's ADRC. They are fully engaged in delivering core ADRC services, including information referral/assistance (IR/A), options counseling, streamlining access to services, and care transitions.

**Elder Care Clinicians / Designated Mental Health Agencies:** The Elder Care Clinician program (ECCP) is collaborative with the Vermont Department of Mental Health, Vermont's designated mental health agencies, and Vermont's Area Agencies on Aging to provide mental health services to older Vermonters and caregivers. Eldercare services are primarily offered to homebound older Vermonters where they live. Eldercare clinicians work with older Vermonters and caregivers to address a broad range of challenges in daily living, such as depression, anxiety, stress, grief and loss, substance abuse, caregiving, and dementia.

**Adult Day Services:** Vermont's adult day service providers operate adult day centers around the state. Adult day services provide an array of services to help older Vermonters and adults with disabilities to remain as independent as possible in their own homes. Adult day services are provided in community-based, non-residential day centers, creating a safe, supportive environment where people can access both health and social services. Services include professional nursing services, respite, personal care, therapeutic activities, nutritious meals,

social opportunities, activities to foster independence, and support and education to families and caregivers.

**Senior Centers:** Senior centers serve as focal points within communities for information, referrals, and opportunities for engagement, wellness, education, and volunteering. They are dispersal sites for important information about the abuse, neglect, and exploitation of older Vermonters and knowledge to increase awareness and prevent fraud. Senior centers play an essential role in helping to prevent social isolation and provide opportunities for people of all ages to connect and contribute to their community. For example, Vermont's senior centers are where older Vermonters can obtain information about area services and resources, participate in health promotion programs, practice yoga or Tai Chi, email grandchildren, share meals and learn a new language, or learn English as a second language. Many centers also provide meal programs and receive Older American Act (OAA) funding and other support through Vermont's Area Agencies on Aging.

**Home Health Agencies:** Home health agencies (HHA) provide high-quality, medically-necessary home health and hospice care. Vermont has 12 designated home health agencies. The agencies promote the general welfare of Vermonters with health promotion and long-term care services. In addition to their acute care services, HHA programs provide person-centered care for older Vermonters and people with disabilities. HHA includes assistance with the activities of daily living and encourages independence for individuals, enabling them to live safely and comfortably at home. HHA programs and services may consist of homemaker assistance, assistance with personal care, adult day services, and case management services when home and community long-term care services are available as an alternative to nursing homes.

**Private Home Care Agencies:** Private home care agencies provide non-medical home care to support independent living and aging in place. Services range from assistance with personal care, companionship services, help with shopping and transportation, homemaking services, meal preparation, and much more. In recent years, Vermont has seen growth in the number of home care providers, with providers reporting increasing demand for their services.

**Residential Care Homes:** Vermont's residential care homes are state-licensed group living arrangements designed to meet the needs of people who cannot live independently and usually do not require the type of care provided in a nursing home. When needed, help is provided with daily activities such as eating, walking, toileting, bathing, and dressing. Residential care homes may provide the nursing home level of care to residents, known as enhanced residential care (ERC). ERC services include personal care, housekeeping, meals, activities, nursing oversight, and medication management.

**Assisted Living Facilities:** Vermont's licensed assisted living residences merge housing, health, and supportive services to promote residents' independence and aging. Within a homelike setting, assisted living residences offer a private bedroom, private bath, living space, kitchen capacity, and a lockable door. Assisted living promotes resident self-direction and active participation in decision-making while emphasizing individuality, privacy, and dignity.

**Nursing Homes:** Vermont's nursing homes are licensed facilities providing 24-hour nursing care, supervision, therapies, personal care, meals, nutrition services, activities, and social

services. Nursing facilities are an essential component of Vermont's Aging Network. They provide long-term care for individuals who require and want 24-hour nursing care and supervision and short-term rehabilitation for many Vermonters who need support after an illness or injury.

**Public Housing Authorities and Nonprofit Housing Providers:** Vermont's non-profit housing organizations and public housing authorities serve the lowest income older Vermonters, providing many homes essential to Medicaid participants to remain at home under the Choices for Care program.

**Public Transit Providers and Private Transportation Agencies:** Vermont's public transit providers, along with numerous private transportation providers, play an essential role in helping older Vermonters get to medical services, social services, senior centers, community meals programs, grocery stores, drug stores, and shopping. Key players include the Vermont Transportation Agency, which administers the Elderly and Disabled (E&D) Transportation funds in all designated regions in Vermont, and the Vermont Department for Health Access (VDHA) administers Medicaid transportation services. In addition, transportation services help older Vermonters stay connected with and participate in community events.

**Homesharing:** Vermont's home share provider helps match people who need some assistance to remain in their homes with other Vermonters seeking affordable housing. In some cases, caregiving services are also arranged. Homesharing services serve about half of the state (Chittenden, Addison, Grand Isle, Washington, Lamoille, and Orange counties). Homesharing is a promising model for alleviating housing challenges for some older Vermonters. It promotes aging in place while providing affordable housing for many.

**Supports and Services at Home (SASH):** SASH is funded in part by CMS through the All-Payer Model administered by OneCare Vermont and supported by DAILE and other State agencies. A statewide program, SASH employs person-centered support and evidence-based interventions to improve individual and population health, primarily for residents of congregate affordable housing sites. Approximately 5,000 older adults and adults with disabilities participate voluntarily in SASH setting their own goals to improve their health and well-being. SASH care coordinators and wellness nurses work in conjunction with an extensive network of partners in home health, agencies on aging, developmental and mental health, addiction services, primary care, and hospitals to support participants in achieving their goals.

**The Village Model:** The village model is summarized by the motto neighbors caring for neighbors. It is described as community-based nonprofit organizations formed through a body of caring neighbors who want to change the paradigm of aging (Village to Village Network, 2022). The characteristics of the membership-driven village model include coordination of access to affordable services, including, but not limited to, transportation, home repairs, and social and educational activities. Evidence suggests that participation in the village model positively impacts members' well-being and quality of life. Vermont has a small cohort of established villages to help inform the best approaches for educating communities around the state.

**Vermont Ombudsman Project:** The SUA contracts with Vermont Legal Aid Inc to administer the Vermont Long-term Care Ombudsman Project (VLTCOP). The project is a statewide long-term care ombudsman program that fulfills all the advocacy requirements of Title VII, Chapter 2 of the Older Americans Act. Currently, one full-time State Long Term Care Ombudsman supervises regional ombudsmen. In addition to paid staff, the project utilizes certified volunteers.

In 2005, the Vermont Legislature expanded the LTC ombudsmen's responsibilities. In addition to advocating for residents of nursing facilities, residential care homes, and assisted living residences, the legislature gave ombudsmen the authority to respond to complaints on behalf of individuals receiving home-based services through the 1115 Long Term Care Medicaid Waiver Choices for Care Program.

**Elder Law Project: (ELP)** The Elder Law Project consists of the Senior Law Project (SLP) and Medicare Advocacy Project (MAP) and focuses on the legal needs and problems of seniors. ELP provides a full range of legal services, including advice, assistance with documents, and representation. It represents seniors on legal and policy matters with the State government and the Legislature. ELP attorneys work closely with case managers to provide professional legal advice, consultation, and representation to seniors. In addition, MAP represents Medicaid beneficiaries in Medicare appeals after referral by the State of Vermont.

**Community of Vermont Elders (COVE):** COVE's mission is to promote and protect a high quality of life for Vermont's seniors through advocacy and education. It works with and for older Vermonters and the organizations that serve them to identify, interpret, and respond to critical issues that impact seniors' dignity, security, and well-being. COVE researches and educates the public and policymakers and advocates for or against adopting or revising laws, rules, regulations, or policies. COVE also sponsors SMP, funded through the Administration for Community Living to empower older Vermonters "to prevent health care fraud through outreach and education."

**AARP Vermont:** The Association for the Advancement of Retired Persons promotes the welfare of older Vermonters. AARP is a nonprofit, nonpartisan membership organization that helps people age 50 and over improve the quality of their lives. It is comprised of different legal entities. In collaboration with aging network members, the Vermont AARP has been a state leader in promoting understanding and adoption of livable communities projects like Complete Streets and Age-Friendly Communities and is an active lobbyist for senior health care issues in the Vermont state government.

**Volunteer and Community Service Programs:** In addition to the programs described above, Vermont has many volunteer and community service programs, such as RSVP, Foster Grandparents, the Senior Companion Program, Vermont Kin as Parents, and Aging in Place initiatives, to name a few. These programs provide valuable opportunities for older Vermonters and people of all ages to contribute to their community and benefit from the services offered. The range of services and benefits provided through these programs is extensive, from mentoring young children to delivering health promotion and disease prevention programs to companionship and assistance with heavy chores.

**The University of Vermont Center on Aging:** Officially established in 2008, the University of Vermont Center (UVM) Center on Aging aims to forge ongoing collaboration among faculty, students, staff, and programs within the UVM, the UVM Medical Center, and broader Vermont community to promote a sense of healthy- being and high quality of life for older adults. The Center on Aging focuses on coordinating and supporting gerontological and geriatric research at UVM, providing educational opportunities in gerontology and geriatrics, and translating research outcomes and educational activities into policy and excellent practice in medicine and human services.

**Associates for Training and Development:** Associates for Training & Development (A4TD) is the trade name of Vermont Associates for Training and Development, Inc., a private nonprofit 501(c)3 corporation founded in 1983. A4TD operates Mature Worker Training Centers in Vermont and Connecticut. Its mission is to provide training and employment services to workers

aged 55+. A4TD assigns over 400 people per year to community service positions at 501(c)3 organizations through the Senior Community Service Employment Program. On-going training and support are essential to program components. While learning job-specific skills, SCSEP participants provide needed community service to the organization and the community. The demand for this training has been overwhelming, and the project has been oversubscribed since its inception.

**Alzheimer's Association – Vermont Chapter:** The mission of the Alzheimer's Association is to eliminate Alzheimer's disease through the advancement of research, provide and enhance care and support for all affected, and reduce the risk of dementia through the promotion of brain health. The Vermont Chapter of the Alzheimer's Association provides information, education, training, advocacy, and support to individuals with Alzheimer's, families, community organizations, healthcare providers, and the community.

**Vermont Assistive Technology Program (VATP)** is Vermont's federal AT Act Program. The mission of the Vermont Assistive Technology Program is to support full access and integration for Vermonters with disabilities and aging-related needs in education, work, and their communities. The AT Act Programs help individuals of all ages find accessible solutions to overcome barriers at home, work, and in the community related to disability and aging-related needs. The VATP partners with the [Center on Disability and Community Inclusion \(CDCI\)](#) at the University of Vermont. CDCI operates three regional AT Tryout Centers and provides AT Services to Vermonters across the state.



**ATTACHMENT E: VERMONT ALZHEIMER'S PLAN**



# 2022 – 2025 Vermont Action Plan for Alzheimer’s Disease, Related Dementias & Healthy Aging



# Acknowledgements

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## Partners in the development and enactment of this plan:

- AHS Abenaki Equity Workgroup
- Alzheimer's Association, Vermont Chapter
- Alzheimer's Disease and Related Dementias Hub & Spoke Workgroup
- Bi-State Primary Care Association
- Blueprint for Health
- Chittenden County Regional Planning Commission
- The Gathering Place Adult Day Services
- Governor's Commission on Alzheimer's Disease and Related Dementias
- Green Mountain Support Services
- Rutland Regional Planning Commission
- Services and Support at Home (SASH®)
- United Way of Northwest VT
- University of Vermont College of Nursing and Health Sciences
- University of Vermont Medical Center Memory Program & Elder Care Services
- UVM Larner College of Medicine, Center on Aging
- Vermont Association of Area Agencies on Aging (V4A)
- Vermont Association of Hospitals & Health Systems (VAHHS)
- Vermont Association of Planning and Development Agencies (VAPDA)
- Vermont Center for Independent Living
- Vermont Department of Disabilities, Aging and Independent Living (DAIL)
- Vermont Department of Health Chronic Disease Prevention Programs & Offices of Local Health
- Vermont Department of Mental Health
- Windham County Senior Healthcare Collaborative

Placeholder:

Abenaki Land Acknowledgement

Our fellow Vermonters,

Alzheimer’s Disease and related dementias are public health priorities. The Department of Health (VDH) and the Department of Disabilities, Aging, and Independent Living (DAIL) are committed to creating a state where all Vermonters can experience healthy aging, which benefits individuals, families, businesses, and communities alike. With a growing, diverse set of partnerships, we are creating a state which promotes brain health and its link to physical and mental health and well-being across the lifespan. We are excited to be leading this charge through our Health Department’s Alzheimer’s Disease and Healthy Aging Program and the State Unit on Aging at DAIL as well as a network of community, clinical and non-profit partners who are central to this effort.

Alzheimer’s Disease is the fifth leading cause of death in Vermont. Among the nation, Vermont ranks 33<sup>rd</sup> for the age-adjusted death rate of Alzheimer’s Disease. By 2025, the number of Vermonters aged 65 and older diagnosed with Alzheimer’s Disease is projected to reach 17,000 – an increase of 31% since 2018. Moreover, 7% of Vermonters report subjective cognitive decline, a form of cognitive impairment and one of the earliest noticeable signs of Alzheimer’s Disease or a related dementia. Alzheimer’s Disease and other dementias impact not only the individual diagnosed, but their caregivers and families. Over 30,000 Vermonters are care partners to a family member with Alzheimer’s Disease or a related dementia, providing millions of hours of unpaid care annually. The emotional and physical burden of caregiving exacts a heavy toll.

Memory loss is not an inevitable part of aging. Earlier detection and diagnosis of dementia, reducing dementia risk, supporting brain health and the well-being of caregivers, in addition to ensuring effective management of co-morbidities for individuals living with dementia are the strategies of our public health response. Despite the ramifications of the pandemic, the forging, expansion and leveraging of partnerships to address dementias has been accomplished. We’ve made substantive progress toward our goal of increasing the capacity of primary care practices to detect, diagnose and manage dementias. These efforts will

evolve and continue to ensure that Vermonters, whether living in a city or in a more remote town, will be able to access timely, effective care in a local, familiar setting.

We are also actively collecting and sharing data, supporting primary and secondary prevention strategies, and implementing brain health related campaigns to increase awareness of how to reduce dementia risk.

Though we have achieved much, there is a long road ahead. This **Action Plan for Alzheimer’s Disease, Dementias and Healthy Aging** lights the way with goals that require a multi-sectoral response. These strategies and their associated activities align with the *National Healthy Brain Initiative Road Map* and the *National Plan to Address Alzheimer’s Disease*. Our state action plan includes priorities of our stakeholders in this work here in Vermont as well as those set forth nationally. Many Vermonters provided input during the development of this plan, and we need your help to realize its success.

We look forward to our future progress and to the realization of goals that enable Vermonters with dementia to remain at home in communities that are age- and dementia- friendly, to access effective dementia and chronic disease management in the primary care setting and through My Healthy VT, and to have family caregivers whose well-being is supported by employers, healthcare professionals, neighbors, and the community at large.

Our partnerships put us in a strategic position to support and carry out work that supports the brain health, general health, and well-being of all Vermonters. We will measure our progress annually and look forward to remaining in touch.

Sincerely,

**Mark Levine, MD**

*Commissioner, Vermont Department of Health*

**Monica White**

*Commissioner, Vermont Department of Disabilities, Aging and Independent Living*

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## About Alzheimer's Disease and Related Dementias (ADRD)

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Dementia is a progressive loss of cognitive functions such as thinking, remembering and reasoning that interferes with a person's daily life and activities.<sup>1</sup> There are several different forms of dementia, and a person's symptoms can vary depending on the type of dementia they have.

The five most common forms of dementia are dementia brought about by Alzheimer's Disease (accounting for 60-80% of cases), Frontotemporal dementia, Lewy body dementia, vascular dementia, and Parkinson's disease. Currently, there are no cures for these diseases. However, there is substantial research in progress to understand how these conditions change our brains and how those changes can be slowed or prevented.

In this document, we use the term *dementias* to refer to Alzheimer's Disease and other forms of dementia.

For more information about dementias, visit the [Alzheimer's Association](#) and the [National Institute on Aging](#), and the [National Institute of Neurological Disorders and Stroke](#).

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## National data points toward disparities in dementia rates

An estimated 6.2 million Americans aged 65 and older were living with Alzheimer's Disease in 2021. This number could grow to 13.8 million by 2060 barring the development of medical breakthroughs to prevent, slow or cure Alzheimer's Disease.<sup>2</sup> Certain populations face greater risk for dementia.

**Older Adults:** Age is the greatest risk factor for dementia. 5% of people aged 65 to 74, 14% of people aged 75 to 84, and 35% of people aged 85 and older have Alzheimer's Disease.<sup>3</sup>

**Younger Adults:** Younger-onset Alzheimer's Disease or other younger-onset dementias occur before age 65, though the prevalence is less clear. Frontotemporal Dementia is much more common in younger people with dementia than in older people. Causes of younger-onset dementias include genetics, types and frequency of brain injury, cardiovascular disease, psychiatric illness, and heavy alcohol use. Diagnosis rates among privately insured individuals ages 30 –64 years increased by 200% between 2013-2017.<sup>4</sup>

**Women:** Almost two-thirds of Americans with Alzheimer's are women. On average, women live longer than men, making it more likely for them to reach the ages of greatest risk.<sup>5</sup> There is emerging evidence that suggests there may be unique biological reasons for these differences beyond longevity alone. More in-depth investigation of any biological and environmental mechanisms that put women at greater risk than men are necessary.

**Black Americans:** Older Black Americans are about twice as likely to have Alzheimer's or other dementias as older white Americans. Systemic racism, and historical and present-day policies that have detrimental impact on the economic status, employment, and housing opportunities of Black Americans are likely contributing factors to increased chronic disease rates and a greater risk for dementia.<sup>6</sup>

**Hispanic Americans:** Older Hispanics are about 1.5 times as likely to have Alzheimer's or other dementias as older whites.<sup>2</sup> Hispanics, like African Americans, are frequently diagnosed at a later stage disease, when cognitive and physical deficits are more marked.

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5. Chêne G, et al. Gender and incidence of dementia in the Framingham Heart Study from mid-adult life. *Alzheimers Dementia* 2015;11(3):310-20.

6. Alzheimer's Association, Alzheimer's Impact Movement, March 2020, Race, Ethnicity & Alzheimer's. [https://aaic.alz.org/downloads2020/2020\\_Race\\_and\\_Ethnicity\\_Fact\\_Sheet.pdf](https://aaic.alz.org/downloads2020/2020_Race_and_Ethnicity_Fact_Sheet.pdf)

## National data points toward disparities in dementia rates, continued

**Native Americans:** Recent population-based evidence suggests that 1 in 3 Native Americans will develop dementia. Due to the historical and ongoing trauma from colonization, Native Americans have high rates of diabetes, high blood pressure, and heart disease compared with other populations.<sup>7</sup> Native Americans have the highest hospitalization rate for traumatic brain injury (TBI) in comparison to other racial and ethnic groups in the U.S. When compared with other populations, TBI death rates are greatest among Native Americans and Alaskan Natives at any age.<sup>8</sup>

**People with Down Syndrome:** Estimates suggest that 50% or more of people with Down Syndrome will develop dementia due to Alzheimer's Disease as they age. By age 40, most people with Down Syndrome have cellular changes associated with Alzheimer's Disease.<sup>9</sup>

**Prison Population:** Incarcerated individuals have a higher prevalence of hypertension, diabetes, myocardial infarction, asthma, arthritis and cervical cancer. Higher rates of chronic disease may increase risk for dementia. The risk of dementia among incarcerated individuals may be higher due to low educational attainment, higher rates of psychiatric morbidities, traumatic brain injuries and accelerated aging and its associated risk factors.<sup>10</sup>

**LGBTQIA+:** LGBTQIA+ individuals have increased risk of depression, cardiovascular disease, obesity, alcohol and tobacco use and lower rates of preventive screenings, all of which elevate the risk for Alzheimer's Disease and related dementias. Older LGBTQIA+ adults are more likely to experience social isolation and stigmatization as they age, making it difficult to find support.<sup>11</sup>

**Social Determinants of Health (SDOH)** are conditions in the environments where people live, work, learn, play worship and age. Upstream factors such as access to educational and employment opportunities affect physical health and mental health and quality of life and often contribute to wide health disparities and inequities. Our ability to age healthfully is determined, in large part, by these factors. Marginalized populations have a higher risk of chronic disease development, depression, and cognitive decline. To promote healthy aging, VDH engages in building an inclusive network of partners some of which are not traditionally viewed as health serving organizations. We continue to work toward a multi-sectoral approach to address bias, decrease stigma, raise awareness, shift societal norms and establish policies that ensure all Vermonters live in environments that support health and well-being.

7. <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=34>  
8. Rutland-Brown W, et al. (2005). Traumatic brain injury hospitalizations among American Indians/Alaska Natives. *J Head Trauma Rehabil.* 20(3),205-214.  
9. Snyder, H. M., et al. (2020). Further understanding the connection between Alzheimer's disease and Down syndrome. *Alzheimer's & Dementia Journal*, 16(7), 1065–1077. <https://doi.org/10.1002/alz.12112>

10. Maschi, T., et al. (2012). Forget me not: Dementia in prison. *The Gerontologist* 52 (4), 441-451  
11. Alzheimer's Association and SAGE: Advocacy and Services for LGBT Elders. 2019. Issues Brief: LGBT and Dementia. <https://www.alz.org/media/documents/lgbt-dementia-issues-brief.pdf>



## Our Call to Action: Dementia in Vermont

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Vermont is one of the most rapidly aging states in the United States, with 20% of residents aged 65 or older. It is the second oldest state and in the top four states with the highest percentage of adults 65 and older.<sup>12</sup>

### **The population of Vermonters 65 and older is projected to increase to an estimated 24% of the population by 2030.**

Alzheimer's Disease accounts for 80% of the dementia diagnoses in the U.S.<sup>13</sup> and is Vermont's fifth leading cause of death.<sup>14</sup> In 2020, approximately 13,000 Vermonters aged 65 and older were estimated to have Alzheimer's Disease, and projections indicate that by 2025 the number of people in Vermont with Alzheimer's Disease will increase 31% to 17,000.<sup>15</sup>

An estimated 65% of older adults with Alzheimer's or other dementias live in the community, which makes early interventions, including robust screening efforts, and earlier diagnosis, critical for population health and to enable residents to age in place.

### **Subjective cognitive decline in Vermont**

Subjective cognitive decline (SCD) is the self-reported experience of worsening or more frequent confusion or memory loss. SCD may have several causes and may be predictive of Mild Cognitive Impairment (MCI) and Alzheimer's disease or a related dementia.<sup>16</sup>

In 2020, 7% of Vermont adults 45 and older reported they experienced worsening confusion or memory loss in the last year. Of Vermonters who reported cognitive decline, 50% have discussed their confusion or memory loss with a health care professional or have had someone discuss it on their behalf.

There are disparities in the rates of SCD. For example, SCD is six times higher among adults with a disability, compared with those with no disability (19% vs. 3%, respectively). Adults whose household income was lower than <\$25K have a significantly higher rate of cognitive decline (14%), compared to adults with higher household income levels ( $\leq 8\%$ ).<sup>17</sup>

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12. Vermont Agency of Human Services Department of Disabilities Aging and Independent Living, 2018

13. [Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures](#)

14. National Center for Health Statistics, 2019

15. Alzheimer's Association, 2022 Alzheimer's Disease Facts and Figures

16. Centers for Disease Control and Prevention, [Subjective Cognitive Decline](#).

17. [Behavioral Risk Factor Surveillance System, 2016](#).

## Vermont's response to dementia as a public health priority

Over the past several decades, one of the ways Vermont has been supporting healthy aging is its response to the emerging public health crisis of dementia. Beginning in the 1990s with the creation of the Governor's Commission on ADRD, a growing network of partners are setting the stage for infrastructure building efforts and the beginnings of an orchestrated response to dementias. Collaboration between VDH and DAIL supported by funding from the CDC underpin these efforts.

### Hub & Spoke ADRD Workgroup

The Vermont Hub and Spoke ADRD Initiative, a collaboration between VDH, DAIL and health system partners begun in 2018, is an effort to increase screening, diagnosis and care for people living with dementia and their care partners by increasing capacity among primary care providers (PCP) and their teams. The workgroup began as an unfunded entity comprising individuals passionate about reducing the burden of dementia in Vermont. The Hub and Spoke ADRD workgroup includes: DAIL, UVM Medical Center Memory Program, UVM Center on Aging and School of Nursing, Vermont's Area Health Education Council (AHEC), Vermont Association of Hospitals and Health Systems, Bi-State Primary Care Association, OneCare VT (ACO), VT chapter of the Alzheimer's Association, the VT Healthcare Association, Alzheimer's Disease and Healthy Aging Program.

### Governor's Commission

The Vermont Legislature established the Governor's Commission on Alzheimer's Disease and Related Disorders in 1991. The Commission's mission is to:

- Identify key public policy issues related to dementia.
- Educate the public and private sectors regarding these matters.
- Make policy recommendations in support of developing programs and services to people with dementia, their families and caregivers.

In 2008, DAIL convened a subcommittee of the Governor's Commission on ADRD to design and develop the State Plan on Dementia. This subcommittee was charged with providing guidance and oversight for the development of a plan to help the state policymakers and stakeholders better understand how the estimated increase in people with dementia will need to be met with a corresponding increase in resources; including caregivers, specialized care units, respite services, and education.

## Building Our Largest Dementia Infrastructure (BOLD)

In 2020, Vermont was one of 17 state or county health departments, territories or tribal governments that received funding from the Centers for Disease Control and Prevention (CDC) to establish working groups, leverage existing partnerships and expand data collection to address Alzheimer's Disease and Related Dementias as a public health priority.<sup>18</sup> The four pillars of the 3-year grant are:

1. Increase early detection
2. Promote risk reduction
3. Support caregivers
4. Reduce avoidable hospitalizations

The Vermont Department of Health's Alzheimer's Disease and Healthy Aging Program will reapply for the next round of CDC funding from the BOLD Initiative in 2023, which will launch later that fall. The intent is to continue the multi-pronged efforts and, through the new round of funding, to implement this Action Plan, assess our progress and update the course, as appropriate, throughout its term. A new state Action Plan on Alzheimer's Disease and Healthy Aging will be released in 2025.

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18. Centers for Disease Control and Prevention, 2022, "Alzheimer's Disease and Healthy Aging: BOLD Infrastructure for Alzheimer's Act," <https://www.cdc.gov/aging/bold/index.html>



## About the Action Plan

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This document, the Vermont Action Plan on Alzheimer's Disease, Related Dementias and Healthy Aging, updated by the Vermont Department of Health is a principal deliverable of the BOLD Infrastructure for Alzheimer's Act cooperative agreement.

This Action Plan is intended to serve as a guide, in concert with other important work, to improve the quality of life of all Vermonters. In 2018, DAHL and VDH released [a brief action plan](#) to advance activity and support of Alzheimer's and healthy aging in Vermont using the Healthy Brain Initiative Roadmap published by the CDC. This new Action Plan builds upon previous work and will be a companion document to the State Plan on Aging. The State Plan on Aging offers a framework for the ongoing operations of programs funded through the Older Americans Act. The plan will go into effect October 1, 2022.

### Development of the Action Plan

Throughout 2021 and 2022, VDH's Alzheimer's Disease and Healthy Aging Program and its evaluation contractor, [Professional Data Analysts](#) (PDA), met with stakeholder groups working on Alzheimer's and Healthy Aging in Vermont. PDA facilitated a process to gain perspectives from each group to develop a framework for ensuring multi-sectoral representation from diverse partners.

To date, 41 individuals representing 39 different agencies or programs have contributed to the action plan through workshops, draft reviews, and other meetings.

In the Winter of 2022, the program started meeting with the AHS Abenaki Equity Workgroup to gain the cultural perspective of the Abenaki and Wobenacki people about aging and dementia care.



## Complementary plans in Vermont

Vermont has several state plans that serve different purposes but are being crafted to offer complementary strategies for addressing dementia as a public health priority and aging well in the state. Collectively, these plans will ensure a comprehensive advance toward our mutual goal: **Enable all Vermonters to age with dignity, respect and independence in the healthiest manner possible.**

Each plan has a unique scope and focus. The emphasis of this Action Plan is reduction of dementia risk, earlier detection of dementias, recognition and support of family caregivers and promotion of body and brain health.

Complementary plans in Vermont include:

- VT State Plan on Aging
- VT Action Plan on Aging Well
- VT State Health Improvement Plan

## VT State Plan on Aging

This is a federally mandated 4-year plan outlined in the Older Americans Act<sup>19</sup> which requires a needs assessment to ascertain demographic information about Vermont residents, particularly older Vermonters, family caregivers, information about existing services used by older Vermonters, family caregivers, characteristics of unserved and underserved individuals and populations, and identification of gaps in services, including a review of variations in community needs and resources.

[Vermont's State Plan on Aging](#) outlines the roles and responsibilities of the State and the area agencies on aging in administering and carrying out the Older Americans Act. The plan provides goals and objectives related to assisting older residents, their families, and caregivers with an emphasis on following the principles of the Older Americans Act.

## VT Action Plan on Aging Well (VAPAW)

Development of a [10-year plan](#) is underway through collaboration between the Department of Health, the Secretary of Administration, and the Department of Disabilities, Aging and Independent Living. This plan is mandated by the [Older Vermonters Act \(Act 156\)](#), which puts forth principles and a system of services, supports and protections for older Vermonters in 8 focus areas:

1. Self-determination
2. Safety and protection
3. Coordinated/efficient system of services
4. Financial security
5. Optimal health and wellness
6. Social connection and engagement
7. Healthy community design
8. Family/caregiver support

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19. Administration for Community Living, 07/08/2021, "Older Americans Act," <https://acl.gov/about-acl/authorizing-statutes/older-americans-act>

## VT State Health Improvement Plan

Vermont's State Health Improvement Plan (SHIP) is based on a health equity model, Race Forward, and guides the state's work in addressing inequities. The BOLD Program supports addressing social determinants of health as called out in the SHIP, especially those impacting older Vermonters such as transportation, social support, caregiving, employment, and food access.

Social determinants of health (SDOH) are conditions in the environments where people live, work, learn, play, worship and age. These conditions affect physical health, mental health and quality of life. Our ability to age healthfully is determined, in large part, by these environmental factors. SDOH contribute to disparities that lead to health inequity. Populations that do not have access to safe, reliable housing, social inclusion, educational opportunity, food security and other determinants have a higher incidence of poor physical and mental health.<sup>20</sup>



Consequently, to promote an agenda for healthy aging, the VDH must engage a host of partners, many of which are not traditionally viewed as health-serving organizations. This multi-sectoral approach is necessary to raise awareness, shift societal norms, and establish policies that ensure all Vermonters live in environments that support health and well-being.

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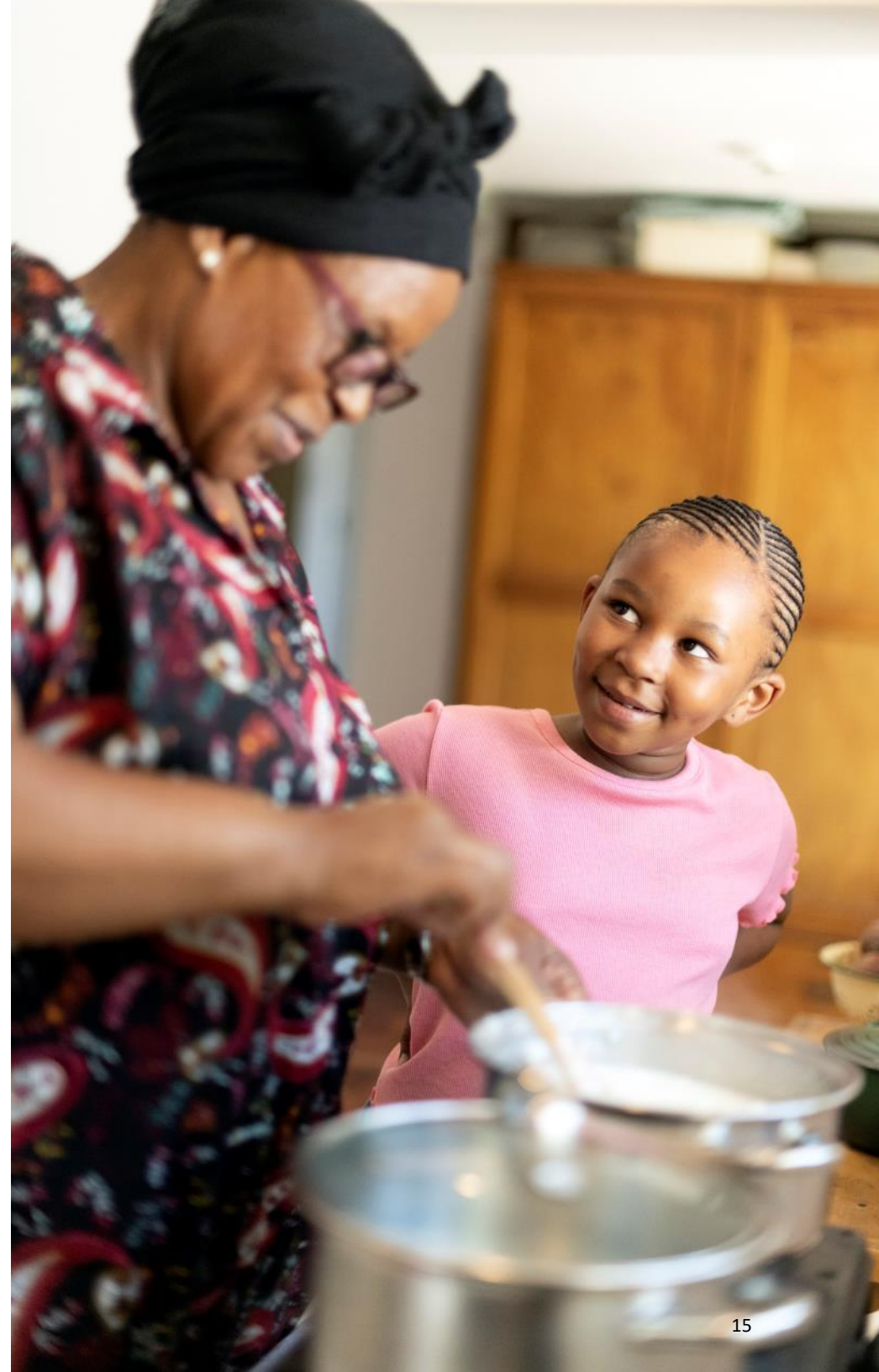
20. Centers for Disease Control and Prevention, 2022, "Social Determinants of Health: Know What Affects Health," <https://www.cdc.gov/socialdeterminants/index.htm>

## Alignment with national efforts

Vermont's Action Plan is also aligned with national priorities to focus the collective response of public health, healthcare systems, advocacy organizations and other partners to achieve meaningful, effective impact. That alignment includes goals and strategies supported by the latest scientific evidence available. As the science of prevention and treatment of dementias advances Vermont's plan will be adjusted accordingly. Vermont strives to address dementia, support healthy aging, and to be prepared for applying for additional funds to increase its capacity, ensure a sustained effort and to become an age-friendly state.

National efforts include:

- The Healthy Brain Initiative HBI
- The National Alzheimer's Project Act (NAPA)
- RAISE (Recognize, Assist, Include, Support & Engage)





## The Healthy Brain Initiative (HBI)

HBI is a resource created by the CDC and the national Alzheimer’s Association to improve understanding of brain health as a public health practice. This [resource](#) outlines how state and local public health agencies and their partners can promote brain and cognitive health, address cognitive impairment for people living in the community, and help meet the needs of caregivers. A series of 25 proposed actions are aligned with the essential domains of public health and categorized accordingly. Those domains are:

- Monitor and Evaluate
- Educate and Empower the Nation
- Develop Policies **and** Mobilize Partnerships
- Ensure a Competent Workforce

Actions within each of these four domains are guided by three core principles to ensure health equity, collaboration across multiple sectors, and to leverage resources for sustained effect.<sup>21</sup>

## The National Alzheimer’s Project Act (NAPA)

On January 4, 2011, the National Alzheimer's Project Act (NAPA) (Public Law 111-375) was signed into law. The Act requires the Secretary of HHS, in collaboration with the Advisory Council, to create and maintain a [National Plan](#) to overcome dementias.<sup>22</sup> The goals that form the foundation of the National Plan are:

1. Prevent and effectively treat Alzheimer's Disease and related dementias by 2025.
2. Enhance care quality and efficiency.
3. Expand supports for people with Alzheimer's Disease and related dementias and their families.
4. Enhance public awareness and engagement.
5. Track progress and drive improvement.

In 2021 the National Plan was updated for the ninth time. In this revision, a sixth goal was added:

6. Accelerate action to promote healthy aging and reduce risk factors for Alzheimer’s Disease and related dementias.

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21. Centers for Disease Control and Prevention, 2022, “Healthy Brain Initiative,” <https://www.cdc.gov/aging/healthybrain/index.htm>

22. Office of the Assistant Secretary for Planning and Evaluation, National Plan to Address Alzheimer’s Disease, 2022, <https://aspe.hhs.gov/collaborations-committees-advisory-groups/napa/napa-documents>

## **RAISE (Recognize, Assist, Include, Support & Engage)**

The RAISE Family Caregivers Act of 2017 (Public Law 115-119) called for the establishment of the Family Caregiving Advisory Council to advise and provide recommendations, including identified best practices, to the Secretary of the HHS on recognizing and supporting family caregivers. The Alzheimer's and Healthy Aging Program has nominated a Vermonter to be appointed to the Council.

The [report](#) includes 26 recommendations that were developed in response to a broad range of information-gathering efforts conducted between 2019 and 2021.<sup>23</sup> The council used the findings from these efforts to develop the recommendations and present to Congress in September 2021:

1. Increase awareness of family caregiving.
2. Integrate the caregiver into processes and systems from which they have been traditionally excluded.
3. Expand access to services and supports to assist family caregivers.
4. Ensure financial and workplace protections for caregivers.
5. Perform more consistent research and data collection to assist in the development and dissemination of systemic policies and interventions that can help family caregivers in meaningful ways.

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23. Administration for Community Living, 2022, "RAISE Family Caregiver's Act Initial Report to Congress," <https://acl.gov/RAISE/report>



## Monitoring and evaluation of the Action Plan

By nature, The Action Plan for Alzheimer's Disease and Healthy Aging is a collaborative effort. The Governor's Commission in collaboration with the Hub & Spoke ADRD workgroup, DAIL and VDH will facilitate annual checks on the progress of the plan as well as any necessary shifts in course that better address our goals. *This plan is a vital document.* Vermont continues to build stronger, more diverse partnerships to address the burden of Alzheimer's Disease and related dementias, which may lend multiple dimensions to the tactics used to accomplish our strategies and reach our goals.

Throughout its development, stakeholders expressed a desire to ensure that the action plan would include measures to track progress and outcomes. To achieve this, VDH and the BOLD project team will collect and share progress updates related to this plan annually using population-level indicators that quantitatively describe the population of Vermonters impacted by Alzheimer's and related dementias as well as performance outcomes that describe the work being done and its alignment to the goals in this plan.

Acknowledging that measurement strategies and the public health context are evolving, the indicators and measures included here may shift over time to better reflect progress in Vermont.

### Population-level indicators

The following indicators along with several others will be included in a publicly available scorecard, published by VDH and planned for release in 2023.

- Increase Medicare Annual Wellness visits by 5% from 2022 to 2025.
- Decrease preventable dementia-related hospitalization by 5% by 2025 focusing on the top three causes of hospitalizations among individuals with a primary diagnosis of dementia.
- Establish a baseline and work to decrease the percentage of those identifying as caregivers who experience social isolation.
- Establish a baseline and work to increase the number of caregivers who get the social and emotional support they need.
- Reduce risk of dementia among at least 2 of the identified 12 modifiable risk behaviors by 5% by 2025.

## Action Plan Goals

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The following are the priority goal areas addressed in the action plan. These goal areas reflect the current needs, gaps, and improvement areas identified by national organizations including the Healthy Brain Initiative, the National Alzheimer's Project Act and the RAISE Family Caregivers Act. Vermont stakeholders affirm that these priority areas are vital to the multisystem response necessary to effectively address the impact and reduce the risk of dementias.

- 1 Improve healthcare quality to achieve greater health equity for Vermonters with dementia and their families
- 2 Support all Vermonters with dementia and their families
- 3 Enhance public awareness and engagement
- 4 Improve data to track progress
- 5 Accelerate action to promote healthy aging and reduce risk factors for dementias

### Definition of terms

**Goal:** Goals are high-level priority areas. The goals in this plan are based on the Health Brain Initiative (HBI) and the National Alzheimer's Project Act (NAPA)

**Action:** Actions describe how partners in Vermont will achieve these goals. Actions in the plan have been selected and prioritized through stakeholder input.

**Strategy:** Strategies are specific things that partners in Vermont will do to support the actions and goals in the plan.

**Performance Outcomes:** Performance outcomes are measurable objectives aligned with specific actions and strategies. These outcomes and others will be monitored and included in regular updates related to this plan.

# Goal 1: Improve healthcare quality to achieve greater health equity for Vermonters with dementia and their caregivers

## Actions:

- 1) Strengthen the competencies of all who deliver healthcare and other care services through interprofessional training and other strategies to ensure trauma-informed, dementia-capable care.
- 2) Continue to assess and build a dementia-capable and culturally competent workforce to support people with dementia and their caregivers.
- 3) Educate public health and human services professionals on sources of reliable information about brain health and ways to optimize service delivery for individuals with dementia.
- 4) Improve care for populations disproportionately affected by Alzheimer's Disease and related dementias, and for populations facing care challenges.



## G1. Action 1. Strengthen the competencies of all who deliver healthcare and other care services through interprofessional training and other strategies to ensure trauma-informed, dementia-capable care.

### Strategies:

- Continue infrastructure building to increase provider capacity to screen, diagnose and coordinate treatment and care for their patients with dementias and support care partners.
- Collaborate with The UVM Center on Aging to educate providers on dementia detection, care and management of individuals including populations at higher risk through presentations at annual Gerontology Conference and other education events.
- Hub & Spoke ADRD workgroup will continue to develop, promote, implement and monitor dementia education initiatives such as Project ECHO, VT Health Learn and consultation supports.
- Coordinate with DAIL and Department of Mental Health to train first responders, nurses and allied health professionals to deliver dementia-capable, trauma-informed care.
- Explore the UCLA ADC Model and work with health systems to establish two sites in VT within three years.
- Recognize, engage and include family caregivers as essential members and partners in the care team of the person receiving support.
- Utilize an evidence-based curricula such as *Best Friends, Mouth Care without a Battle* and others to educate community health workers, long term care staff and senior housing staff to improve dementia competency and compassionate service delivery.
- Explore development and systematization of training delivery to Vermont's direct care workforce.
- Leverage the Age-Friendly Health System framework to support attainment of dementia capable practices and reduce provider bias.
- Curate and promote education for practitioners to increase knowledge of neurodivergent conditions, how to differentially diagnose MCI or dementia, and how to develop assessment-informed plans for post-diagnostic care.

### Performance Outcomes by 2025:

- ✓ 75 % of Vermont's primary care clinics will have participated in 1 or more dementia trainings (such as Project ECHO or VT Health Learn).
- ✓ Establish a baseline on use of ICD-10 coding for dementia diagnosis and management by Primary Care Teams and begin work to increase this.
- ✓ Hub & Spoke ADRD will coordinate 2 Project ECHO series on Dementia Diagnosis, Care and Management or another relevant topics.
- ✓ UVM will host 2 Grand Rounds Sessions on dementia care topics including reimbursement for healthcare primary care teams.
- ✓ VDH will include Vermonters with lived dementia/dementia caregiver experience and create two briefs showcasing personal accounts.
- ✓ VDH and the Alzheimer's Association will promote and coordinate trainings for EMS first responders in 4 counties by 2025.
- ✓ VDH will conduct two health communications campaigns for providers featuring the role of the family caregiver as part of the care team.
- ✓ UVM Center on Aging and VDH will recruit content expert on dementia detection and management in neurodiverse individuals to address the Gerontology Conference and/or present a Grand Rounds for primary care teams in partnership with healthcare associations.
- ✓ Work with SASH® to coordinate and promote 2 training series on dementia for the VT Community Health Worker Network.

## **G1. Action 2. Continue to assess and build a dementia-capable and culturally competent healthcare workforce to support people with dementia and their caregivers.**

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### **Strategies:**

- Work with the Governor's Commission on ADRD on policies that support workforce development and retention at all stages of care.
- Strategize for coordinated testimony to the legislature.
- Partners, including the Hub & Spoke ADRD workgroup will use the results of the workforce assessment to drive programmatic decision making.
- Governor's Commission on ADRD will submit a report to the legislature with recommendations to achieve dementia-capable workforce and improve provider response.
- Consult the Agency for Healthcare Research and Quality (USDHHS), American Hospital Association and other sources to identify an assessment that focuses on the cultural, diversity competence of the patient-provider interaction and the system of care surrounding that interaction.

### **Performance Outcomes by 2025:**

- ✓ Governor's Commission report will be submitted to the legislature by January 15, 2024.
- ✓ VDH and partners will monitor and report out annually on outcomes related to building a dementia-capable and culturally competent healthcare workforce.

## **G1. Action 3. Educate public health and human services professionals on sources of reliable information about brain health and ways to optimize service delivery for individuals with dementias.**

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### **Strategies:**

- Annually convene stakeholders on their needs and ideas for education opportunities for the public health and human services workforce to increase dementia friendly environments and service care delivery.
- Promote resources and trainings that address dementia caregiving, risk reduction and early detection offered by CDC Centers of Excellence, Us Against Alzheimer's and other entities.
- Disseminate the latest scientific evidence on supporting brain health.
- Perform an assessment to evaluate the adequacy of existing services, identify service gaps and propose strategies to expand the existing workforce to address the projected increase in dementias.
- Work with Alzheimer's Association, the AHS Director of Trauma Prevention and Resilience Development, Chronic Disease Prevention professional or other relevant content area experts to coordinate, promote and deliver annual training series for public health and human services workforce.

### **Performance Outcomes by 2025:**

- ✓ VDH in collaboration with the Alzheimer's Association will deliver an annual training series for the public health and human services workforce.
- ✓ Annually, create a minimum of 2 new modules on brain health, dementia detection, management and care, and healthy aging to be added to VT Health Learn.
- ✓ VDH and partners will annually monitor outcomes (increase in dementia-capable knowledge and skills) among public health workforce.

## G1. Action 4. Improve care for populations disproportionately affected by dementia, and for populations facing care challenges.

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### Strategies:

- Promote culturally accessible and appropriate messaging to trusted community providers, e.g., Support and Services at Home (SASH®), emergency services, Area Agencies on Aging, USCRI-VT, Vermont Chronic Care Initiative & Blueprint for Health's Community Health Teams.
- Work with partners to develop and disseminate communications on the symptoms of dementias and the importance of seeing a physician for timely diagnosis.
- Work with VDH Health Equity Team and partners to offer trainings to address cultural, racial and dementia biases in medical practices and health systems and other entities.
- Explore dementia screening tools appropriate for neurodiverse individuals and coordinate training and guidance for primary care teams.
- Field the BRFSS Subjective Cognitive Decline Module biannually to collect data and inform state-level policy and community-level action.
- Collaborate with the Disabilities Council to engage neurodiverse individuals and individuals who have experienced Traumatic Brain Injury (TBI) to address concerns related to dementia or other topics.
- Work with AAAs to develop innovative ways to increase services to older Vermonters from groups disproportionately affected by dementias.
- Coordinate with partners to address structural inequities and barriers to healthy aging in the State Health Improvement Plan (2024).
- Identify, promote and deliver trainings to reduce cultural biases in healthcare settings, state agencies, and communities.
- Work with an Abenaki cultural liaison to promote culturally appropriate trainings for healthcare providers, social service providers and the public health workforce around working with the Abenaki community.
- In collaboration with the Health Equity Team, work to promote policies that change the course of structural inequities in Vermont.
- Establish a working relationship with the VT Department of Corrections to promote health aging and management of inmates with declining cognitive abilities.

### Performance Outcomes by 2025:

- ✓ VDH will work with the Health Equity Team and other community partners to identify and/or develop and monitor implementation outcomes:
  - ✓ Promote and implement two or more linguistically and culturally relevant messaging campaigns to address stigma and increase talking with provider about memory concerns.
  - ✓ Promote and implement two or more resources to improve cultural literacy among primary care teams.
  - ✓ VDH Health Equity team and the Hub & Spoke ADRD Workgroup will curate and promote trainings to address racial, cultural and ageist biases in healthcare settings.

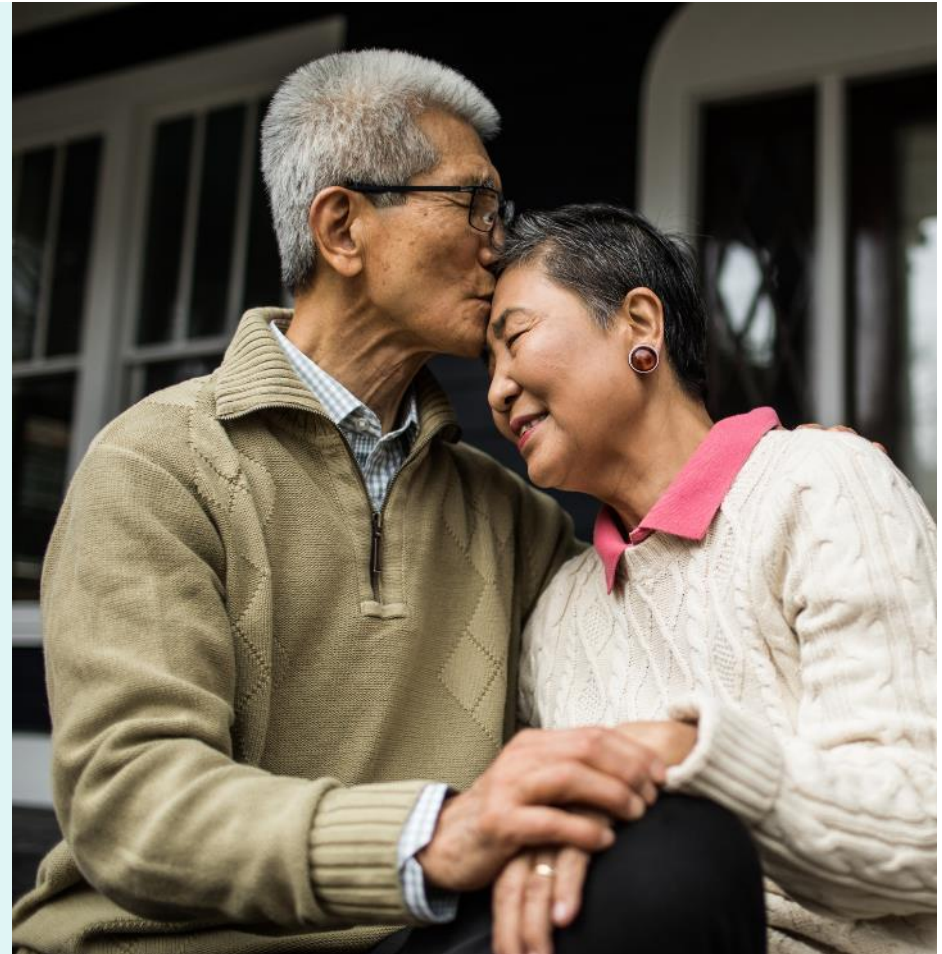


## Goal 2: Support all Vermonters with dementia and their families

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### Actions:

- 1) Educate healthcare professionals to be mindful of the health risks for caregivers and make referrals to supportive programs and services.
- 2) Strengthen knowledge about, and greater use of annual wellness visits, care planning, and related tools for people in all stages of dementia.
- 3) Provide culturally relevant information and tools to assist all Vermonters with dementia and their care partners to anticipate, avert, and respond to challenges that typically arise during the course of dementia.
- 4) Ensure that health promotion and chronic disease interventions include messaging for healthcare providers that underscores the essential role of caregivers and the importance of maintaining their health and well-being.



## G2. Action 1. Educate healthcare professionals to be mindful of the health risks for caregivers, and to make referrals to supportive programs and services.

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### Strategies:

- Promote caregiver resources and supports to the public and through referral mechanisms to healthcare providers.
- Use Smart Phrase developed by the Hub and Spoke workgroup which includes mini-cog assessment and community resources to perform early diagnosis and support individual and their care partner's health.
- Annually assess evidence-based programs for increasing wellness of dementia caregivers and implement as feasible.
- Field the BRFSS Caregiver Module biannually to assess and disseminate data to inform state-level policy and community-level action.
- Disseminate communications to primary care physicians and their teams that ensures identification of family caregivers for their patients experiencing cognitive decline.
- Support primary care providers to identify family caregivers and prompt health and wellness management for caregivers.

### Performance Outcomes by 2025:

- ✓ Work with the UVMDC Dementia Family Caregiver Center to promote and track caregiver education, resources and support.
- ✓ Work with OneCare, Bi-State Primary Care Association and other partners annually to coordinate communications to ensure caregivers are recognized by primary care provider teams diagnosing and treating individuals with dementia.

## G2. Action 2. Strengthen knowledge about, and greater use of the Annual Wellness Visit, care planning, and related tools for people in all stages of dementia.

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### Strategies:

- Collaborate to promote advance directives, advance care planning and estate planning in addition to resources available through Vermont's Money Follows the Person programming.
- Include the UVMDC Dementia Family Caregiver Center in media campaigns addressing caregiver health and well-being.
- Promote the utilization of the Medicare Annual Wellness Visit (AWV) and its benefits to Primary Care Teams.
- Promote and link family caregivers to TCARES assessment, conducted by Area Agencies on Aging, to determine appropriate supports and reduce stress.
- Promote a "No Wrong Door" approach to caregiver resources that includes 211, the Senior Helpline and Alzheimer's Association Helpline in addition to DAIR's and the Alzheimer's and Healthy Aging resources.

### Performance Outcomes by 2025:

- ✓ Increase calls and information requests to Area Agencies on Aging by 10%.
- ✓ Establish a baseline for AWV and begin efforts toward increasing it in partnership with OneCare VT.

## G2. Action 3. Provide culturally relevant information and tools to help people with dementia and caregivers anticipate, avert, and respond to challenges that typically arise during the course of dementia.

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### Strategies:

- Develop health communications that address dementia care to help people with dementia and their caregivers navigate the course of dementia.
- Work with Area Agencies on Aging (AAA) and other partners to disseminate materials.
- Address the stigma of diagnosis through a public education and primary care campaign.
- Educate providers and family caregivers on need for timely referral to hospice care.
- Educate Vermonters and providers about advance directives and how to file them.
- Develop communications that raise awareness about the broad application of palliative care as a component of dementia management.
- Promote use of ICD-10 codes for prevention that support healthy aging and management of dementia.
- Coordinate and promote a core set of services and resources for medical professionals, caregivers, Vermonters with dementia and their families.
- Initiate a relationship with local or national library associations to explore resources for caregivers in Vermont.
- Utilize appropriate modes of communication to reach communities at greatest risk, including ensuring that communications are translated into relevant languages.

### Performance Outcomes by 2025:

- ✓ VDH will conduct semi-annual promotions of the Alzheimer's Association's Living with Alzheimer's series for people living with dementia and their caregivers during Alzheimer's Awareness Month (November) and Brain Health Awareness Month (June).
- ✓ VDH will create or promote 4 public communication campaigns designed to inform individuals living with dementia and their caregivers about what to anticipate and how to navigate the course of dementia.
- ✓ Annually, monitor use of preventive services ICD-10 codes.

## G2. Action 4. Ensure that health promotion and chronic disease interventions include messaging for healthcare providers that underscores the essential role of caregivers and the importance of maintaining their health and well-being.

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### Strategies:

- Through Hub and Spoke ADRD and the UVM Center on Caregivers, disseminate training and resources on the integral role of caregivers as members of the care team.
- Increase and promote the use of respite care across the state.
- Promote evidence-based programs for caregivers to support their emotional and physical health and provide dementia care strategies.

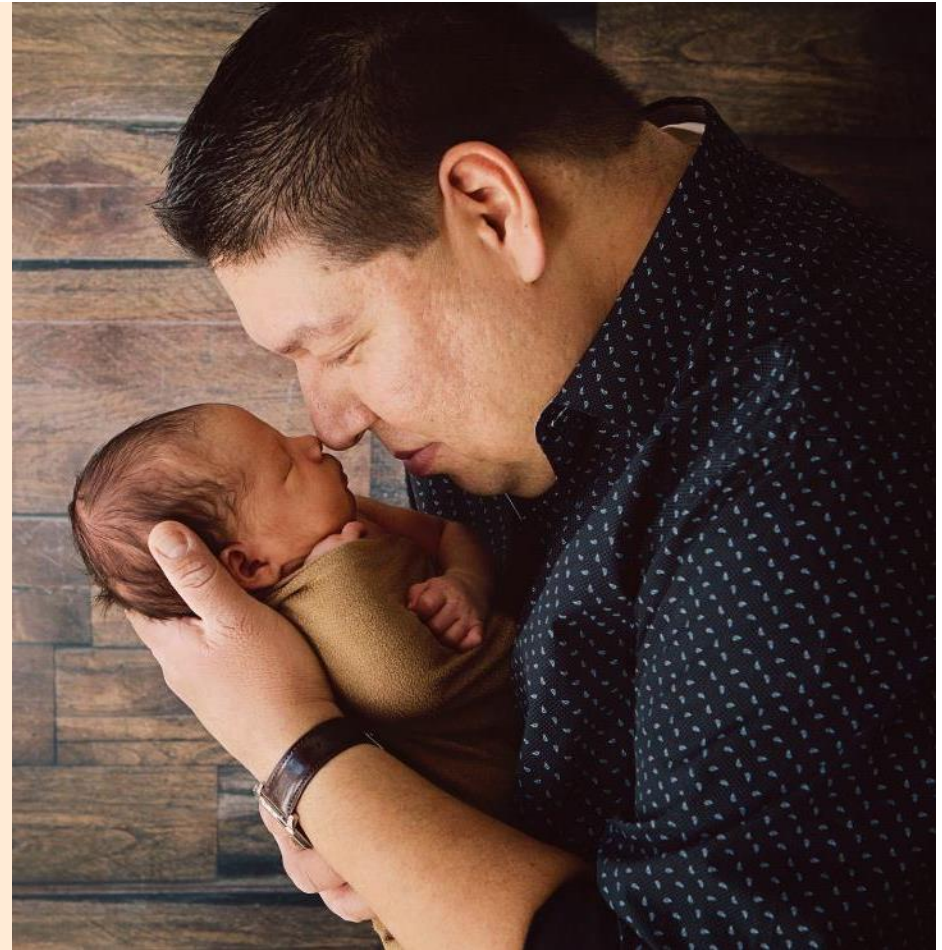
### Performance Outcomes by 2025:

- ✓ VDH chronic disease programs and Alzheimer's and Healthy Aging program will partner with the Caregiver Support and Education Center at UVMHC on two provider resources, including respite care, that underscore the need to maintain caregiver health and well-being.
- ✓ VDH will work with UVMHC and health partners to promote the use of dementia SMARTPHRASE to prompt referrals to caregiver supports.
- ✓ Annually promote National Alliance for Caregiving & Administration for Community Living campaigns & trainings during Family Caregiver's Month.

## Goal 3: Enhance public awareness and engagement

### Actions:

- 1) Increase messaging and education about dementia, the vital role of caregivers, and the importance of maintaining caregivers' health and well-being.
- 2) Coordinate efforts to educate the public about the link between body and brain health and cognitive changes that should be discussed with a health professional, and benefits of early detection and diagnosis.



### G3. Action 1. Increase messaging and education about dementia, the vital role of caregivers, and the importance of maintaining caregivers' health and well-being.

#### Strategies:

- ❑ Develop or use existing messaging that emphasizes the important role of caregivers in supporting people with dementia.
- ❑ Raise awareness about ageism and how it affects individuals with dementia at work, in their community and in the healthcare setting.
- ❑ Promote Dementia- and Age-Friendly communities to support family care partners and individuals with dementia in their own communities.
- ❑ VDH and DAIL will develop and disseminate educational materials on dementia for patients, families, caregivers and providers.



#### Performance Outcomes by 2025:

- ✓ ADRD partners will deliver two presentations/trainings annually to employers on strategies to support employees who are caregivers.
- ✓ VDH will disseminate annual PSAs on statewide media to increase awareness of the demands on dementia care partners and available resources.
- ✓ VDH, UVMCC Center on Caregiving and V4A will conduct two communication campaigns that address the importance of stress management, chronic disease management and self-care for family caregivers.

### **G3. Action 2. Educate the public about the link between body and brain health and cognitive aging, changes that should be discussed with a health professional, and the benefits of early detection and diagnosis.**

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#### **Strategies:**

- Conduct annual public education campaigns about brain health and dementia risk reduction lifestyle modifications.
- Educate the public about normal versus concerning cognitive changes and the benefits of early detection and diagnosis of dementias.
- Promote annual public education campaigns to encourage individuals to address cognition and brain health with their healthcare provider.
- Incorporate reframing aging into VDH communications and presentations with a focus on ways to support brain health as we age.
- Conduct a media campaign to improve oral health literacy across the lifespan, the importance of oral health in older adults and relevant evidence-based strategies for different stages of dementia.
- Establish contact with VT Interfaith Action to systematize engagement with faith-based care networks.
- Coordinate with Municipal Planners to foster Age-Friendly, Dementia-Friendly and Healthy Community Design efforts.
- Build relationship and communication channels with Vermont Coalition for the Uninsured and COTS to reach unhoused, uninsured Vermonters

#### **Performance Outcomes by 2025:**

- ✓ VDH will conduct annual media campaigns to increase dementia risk reduction awareness and destigmatize conversations with healthcare providers about cognitive health.
- ✓ VDH will conduct two campaigns that distinguish normal cognitive changes in aging from those that are warning signs of dementia.

## Goal 4. Improve data to track progress

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### **Actions:**

- 1) Use data gleaned through available surveillance strategies and other sources to inform the public health messaging, programs and policy responses to cognitive health, impairment, and caregiving.
- 2) Implement the Behavioral Risk Factor Surveillance System (BRFSS) optional module for Cognitive Decline and the BRFSS optional module for Caregiving in alternate years.





## G4. Action 1. Use data gleaned through available surveillance strategies and other sources to inform the public health messaging, programs and policy response to cognitive health, impairment, and caregiving.

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### Strategies:

- Analyze available BRFSS and hospitalization data to capture dementia-related health inequities and survey caregivers and long-term care providers.
- Create accessible infographics to share Vermont specific cognitive health, impairment, and caregiving statistics.
- Disseminate data products through all relevant partner networks electronically or in a mode appropriate to the intended audience.
- Continue efforts to build a healthy aging and equity surveillance system in VT.
- Use the findings to inform planning and implementation of additional strategies.
- Examine data sources including CAPHS, VCURES, electronic health record and claims data to establish baseline dementia rates for racial and ethnic populations at risk.

### Performance Outcomes by 2025:

- ✓ VDH and DAIL will create a dementias and Healthy Aging page on [healthvermont.gov](http://healthvermont.gov).
- ✓ The Governor's Commission on ADRD and partners will disseminate data from BRFSS and other data sources to inform public policy.

## G4. Action 2. Implement the Behavioral Risk Factor Surveillance System (BRFSS) optional module for Cognitive Decline and the BRFSS optional module for Caregiving in alternate years.

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### Strategies:

- Leverage partnerships, including with the National Alzheimer's Association, to procure funding for BRFSS modules relevant to dementia and healthy aging.
- Assess how to amend to BRFSS and other state survey questions to add to Vermont's body of knowledge about dementia caregivers and those living with the disease.
- Provide the BRFSS Coordinator with feedback on the draft module questions being proposed by the CDC for the upcoming survey year.
- Engage diverse family caregivers in data gathering that documents their experiences, translates evidence into best practices.
- Coordinate with partners to accumulate, interpret and disseminate data from community health promotion programs.

### Performance Outcomes by 2025:

- ✓ VDH will work with Area Agencies on Aging case managers and caregiver supports to create two lived experience briefs.
- ✓ VDH will create and use the Alzheimer's Disease and Brain Health dashboard to support monitoring of the Action Plan.
- ✓ VDH will meet with the BRFSS Coordinator twice annually and participate module selection process.

## Goal 5: Accelerate action to promote healthy aging and reduce risk factors for dementias

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Adopting healthy behaviors, which have been shown to prevent cancer, diabetes and cardiovascular disease, may also reduce risk or slow progression of cognitive decline and possibly dementia. Public health has strengths and capacities to advance awareness about the relationship between brain health and physical health by linking dementia and cognitive decline risk messaging to health promotion activities that address common risk factors. This goal highlights the benefit of prevention and management of existing chronic disease and improving social determinants that underpin risk. All these risk factors can be addressed at multiple levels including individual, family, community, region and state by the Vermont Department of Health and the array of community partnerships.

Public health actions to promote healthy aging and reduce risk factors for dementias are presented here in twelve domains: education, hypertension, hearing loss, smoking, obesity, depression, physical inactivity, diabetes, social isolation, unhealthy alcohol use, traumatic brain injury, and sleep. The association between oral health and brain health and potential public health actions are being addressed by the Alzheimer's Disease and Healthy Aging Program and the Office of Oral Health at VDH.

Achieving this goal requires a broad range of agencies and stakeholders to collaborate. VDH and other dementia partners may not be accountable for all these measures but will strive to support these outcomes and the community partners best suited to achieve them.

For more information, you can access the resource [Modifiable risk factors for Alzheimer's Disease](#).



### Overarching strategies:

- Reduce prevalence of chronic disease among Vermonters.
- Reduce preventable hospitalizations in older adults with dementia.
- Promote the importance of effective chronic disease management to protect brain health.

## Risk 1. Lack of education

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### Strategies

- Support access to affordable and high-quality early, k-12 and post-secondary education for all Vermonters.
- Support, promote and link Vermonters to adult-learning initiatives and learning throughout the lifespan.
- Promote 10 Ways to Love Your Brain which includes building and maintaining cognitive reserve.

### Performance Outcomes by 2025:

- ✓ Increase by 2% students awarded a high school diploma 4 years after starting 9th grade by 2025 (Vermont Social Determinants of Health Scorecard)
- ✓ Promote annually "10 Ways to Love Your Brain" and other resources that encourage maintenance/development of cognitive reserve.

## Risk 2. Hypertension

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### Strategies:

- Meet quarterly with the [Vermont Department of Health Cardiovascular Health Program](#) to work on strategies to increase awareness and action toward lowering hypertension.
- Meet biannually with the [University of Vermont Center for Cardiovascular and Brain Health](#) to work on one or more collaborative actions to lower hypertension and cholesterol among Vermonters.
- Use the Million Hearts Campaign strategies to address hypertension for improving brain health among Vermonters.
- Run a minimum of two Brain Health and Hypertension Campaigns by 2025.

### Performance Outcomes by 2025:

- ✓ Decrease the percentage of Vermonters reporting having hypertension from 25% in 2020 to 22%.
- ✓ Increase the percentage of Vermonters who have worked with a healthcare professional to create a self-management plan to help lower or control their blood pressure from 60% in 2020 to 65% .

## Risk 3. Hearing loss

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### Strategies:

- Plan public awareness campaigns promoting hearing aid usage with the Governor's Commission on ADRD.
- Collaborate with Hub and Spoke ADRD Workgroup partners to increase awareness of primary care providers in assessing patients for hearing loss and care (baseline of 22% of those who had seen a provider, Older Vermonter Survey 2020)

### Performance Outcomes by 2025:

- ✓ Promote Project Work Safe as a means of increasing use of hearing protection in workplaces.
- ✓ Complete 2 public awareness campaigns promoting insurance coverage for hearing aids to reduce the percentage of Vermonters with uncorrected hearing loss.

## Risk 4. Smoking

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For more information on tobacco cessation efforts in Vermont, see the [Vermont Tobacco Control State Plan](#).

### Strategies:

- Conduct a minimum of 2 brain health and quit smoking campaigns by 2025.
- Engage a minimum of 3 times a year with the AHS Abenaki Equity Workgroup to learn and employ strategies including tailored messaging involving the voices of the Vermont Abenaki to address commercial tobacco use among Vermont Native Americans.
- Deploy provider engagement tactics on a quarterly basis at the Vermont Department of Health, Vermont Department of Mental Health and the Department of Vermont Health Access to increase screening and advising to quit tobacco use.

### Performance Outcomes by 2025:

- ✓ Decrease the percentage of adult Vermonters reporting past 30-day use of cigarettes from 14% in 2020 to 12%.
- ✓ Increase the percentage of Vermont adults attempting to quit in the last year from 53% in 2020 to 58%.
- ✓ Reduce smoking prevalence among Vermont Native Americans from 41% in 2019 to 36%.

## Risk 5. Obesity

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### Strategies:

- Conduct integrated messaging campaigns to promote physical activity guidelines (leisure-time activity) appropriate for all age groups.
- Conduct integrated messaging campaigns to promote nutrition as a means of maintaining a healthy weight and protecting brain health.
- Decrease number of Vermonters reporting stress or chronic stress.

### Performance Outcomes by 2025:

- ✓ Decrease by 2% the percentage of high school students who are obese from 13% to 11%.
- ✓ Decrease % of Vermont adults who are obese from 27% in 2020 to 24%.

## Risk 6. Depression

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### Strategies:

- Conduct a minimum of two message campaigns on the role of mental health, exercise, diet and stress management and brain health by 2024.
- Through the Hub and Spoke ADRD Initiative educate primary care providers to increase depression and mental health screenings for older adults.
- Annually include information in the Alzheimer's and Healthy Aging Newsletter on ways to reduce stigma around depression and dementia.
- Collaborate with DAIL, the Department of Mental Health, and AAAs on providing social and emotional supports.

### Performance Outcomes by 2025:

- ✓ Decrease the percentage of Vermonters reporting depressive disorder from 23% in 2020 to 20% in 2025.
- ✓ Complete two Grand Rounds or similar educational forums to educate Primary Care Teams about depression screenings in older adults.

## Risk 7. Physical inactivity

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### Strategies:

- Annually promote the free physical activity benefits available through You First Program for eligible Vermonters
- Annually promote and monitor participation in Area Agencies on Aging physical exercise programs.

### Performance Outcomes by 2025:

- ✓ Decrease the percentage of Vermont adults who do not get the recommended physical activity level from 39% in 2019 to 35% in 2025.
- ✓ Increase the overall participation in exercise programs at Area Agencies on Aging by 5%.
- ✓ Conduct at least two digital campaigns to promote physical activity and brain health by 2025.

## Risk 8. Diabetes

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### Strategies:

- Annually promote nutrition coaching available through most insurers.
- Explore the feasibility of tracking nutrition prescription programs and sharing these results with promotion to increase accessibility and use.

### Performance Outcomes by 2025:

- ✓ Reduce the percentage of Vermont adults 45 and older who report having diabetes from 12% in 2019 to 10% in 2025.
- ✓ Reduce prevalence of diabetes and subjective cognitive decline from 17% in 2019 to 15% in 2025.
- ✓ Increase the annual registration number for the Diabetes Prevention and Management sessions available through My Healthy Vermont by 10% from 2024 compared to 2022.

## Risk 9. Social isolation

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### Strategies:

- The Alzheimer's and Healthy Aging Program will work with the Area Agencies on Aging, the Climate and Health Program and the Governor's Commission on ADRD to connect Older Vermonters with affordable and accessible transportation to increase access to local resources, community events and social networks.
- The Alzheimer's Disease and Healthy Aging Program will promote community-based cultural and educational programs, Adult Day services and respite grants for caregiver wellness.
- The Alzheimer's and Healthy Aging Program will promote age-friendly communities and efforts associated with healthy community design through the Offices of Local Health two times a year.

### Performance Outcomes by 2025:

- ✓ Establish baseline data for social isolation among all adults and adults experiencing subjective cognitive decline using 2022 BRFSS data.
- ✓ Reduce the percentage of Vermonters who rarely get social and emotional support they need from 9% in 2018 to 7% in 2025.

## Risk 10. Unhealthy alcohol use

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### Strategies:

- Work with substance use partners to increase messaging on the benefits of reducing underage drinking in Vermont to protect brain health.
- Work with substance use partners to increase messaging on the benefits of reducing adult binge drinking for improving brain health.
- Promote Vermont Health Link for Vermonters to access nonjudgmental support and referrals to treatment, recovery and other substance use services.

### Performance Outcomes by 2025:

- ✓ Reduce the prevalence of adults who binge drink/misuse alcohol from 18% in 2019 to 16% in 2025.
- ✓ Increase awareness of alcohol interactive prescription medications among Vermonters aged 65 and older.

## Risk 11. Traumatic brain injury

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### Strategies:

- Apply for and obtain funding for Vermont to implement a robust falls prevention program by 2023.
- Annually include in Alzheimer's and Healthy Aging presentations and communications the benefit of strength training and physical activity for falls prevention over the lifetime.
- The Alzheimer's and Healthy Aging program will work with the Department of Highway Safety on promotion of seatbelt use to protect brain health.
- Promote substance use prevention among youth and adults as fall-prevention strategies among Vermonters.

### Performance Outcomes by 2025:

- ✓ Reduce from 33% (2018) to 30% (2025) the number of adults 45 and older who have fallen in the last 12 months.
- ✓ VDH will incorporate fall prevention workshops into My Healthy VT by 2024.

## Risk 12. Sleep

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### Strategies:

- Conduct a minimum of two risk reduction campaigns for dementias that address insufficient sleep and the link to chronic disease by 2025.
- Increase public awareness on the importance of sleep for brain health and promote recommendations for assisting with improving sleep quality and quantity.

### Performance Outcomes by 2025:

- ✓ VDH will share sleep related metrics from a minimum of two risk reduction campaigns.
- ✓ Increase the number of adults who get enough sleep.



## Evaluation

Evaluation is fundamental to the success of this Action Plan. The Alzheimer's Disease and Healthy Aging Program in collaboration with the Governor's Commission on ADRD, Hub and Spoke ADRD workgroup, the Alzheimer's Disease and Healthy Aging workgroup, and our evaluation contractor will report progress annually. The annual evaluation report will be posted on [healthvermont.gov](https://healthvermont.gov) and on the [Governor's Commission on ADRD](#) webpage.

## Conclusion

This Action Plan will guide Vermont's response to the public health priority of Alzheimer's Disease and Related Dementias. Over the next three years, through new and established initiatives involving health systems, public health, community-based organizations, academic institutions, advocates and social service agencies, we will advance our efforts to better serve those living with dementia and their families. Our intent is to remain nimble in order respond to emergent priorities and a rapidly changing landscape. We encourage Vermonters and their community leaders to work together to promote health across the lifespan. We strive for diverse representation in our work to promote healthy aging, earlier detection of dementia, dementia risk reduction, effective chronic disease management and robust support of care partners. Consequently, we invite interested parties to join us!

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