"Choices At Home": Connecticut's Nursing Home Diversion Modernization Project

SUMMARY/ABSTRACT: The CT Department of Social Services and its State Unit on Aging, in partnership with the Agency on Aging of South Central CT and community providers will operate "Choices at Home" with the goal of helping consumers who are at high risk of nursing home placement but not yet eligible for Medicaid to remain in their own homes. The objectives are: Provide consumers in the South Central Area with flexible service options utilizing a Cash and Counseling model with funds from the Federal Caregiver and State Respite Care Programs; Target services to individuals in the Area who are at risk of nursing home placement and spend-down to Medicaid; Develop a Single Entry Point system in the Area that provides access to long term care services and supports; and Conduct a process evaluation and design and implement a model comprehensive performance measurement program.

The expected outcomes of this project are: Consumers have a C&C option through the Caregiver and Respite programs; Consumers can receive screening, assessment, LTC options counseling, and services for at risk target group through the fully functioning SEP in the south central area; Individuals at risk of nursing home placement and spend-down to Medicaid will be effectively and efficiently identified through an assessment tool and served through existing programs; Change can be sustained beyond the grant period and incorporated into the state's overall system of LTC and rebalancing effort.

The expected products include expanded website, assessment tool, screening tool, training manuals, web-based training materials, educational video and pod casts, evaluation results, and a cadre of trained staff, consumers, and providers.

I. Current Status of Aging Network Nursing Home Diversion Efforts in the State:

A. Background: CT, like many other states, has been increasingly confronted with burgeoning Medicaid expenditures, looming demand for long-term care (LTC) services associated with demographic trends, and growing movements to enhance consumer choice and control. Following a 1996 study concluding that the state's structure for funding and overseeing LTC services needed reinforcement and coordination, the state legislature established a LTC Planning Committee comprised of 10 state agencies and the chairs and ranking members from three legislative committees to establish a statewide coordinated LTC plan for seniors. The act also created a LTC Advisory Council made up of providers, consumers and advocates to provide advice and recommendations to the Planning Committee. Since that time, the Committee has reported back to the legislature four times on the status of LTC in CT providing recommendations and action steps to address the needs of all individuals, regardless of age or disability. In 2005, the General Assembly put into law the broad philosophical statement that "individuals with LTC needs have the option to choose and receive LTC and support in the least restrictive, appropriate setting." This statement positioned the state to make changes to the laws and regulations that govern the state's LTC system to make real choices for consumers a reality. The General Assembly funded development of a LTC Services and Supports website which was completed and released to the public in September 2006. This consumer oriented website (www.ct.gov/longtermcare) provides easy access to comprehensive information on private and public LTC services and supports in the state – regardless of age or disability. During 2006 legislative session, the General Assembly authorized and funded a comprehensive statewide LTC Needs Assessment (LTCNA), the first in over twenty years. The LTCNA included a full review of CT's existing array of services and long term care system rebalancing efforts and conducted consumer surveys. A comprehensive report with its conclusions and recommendations has provided significant impetus and substance for this proposal and, in conjunction with the Committee's 2007 Plan, will help to develop the state's LTC policy over the coming years.

B. Rebalancing Progress in CT: In CT, efforts to rebalance the systems are progressing, though more slowly than in some of the leading states. Over the last 15 years, CT has made a number of important strides in improving and rebalancing LTC services and supports. The state developed a number of Medicaid home and community-based waivers including the CT Home Care Program for Elders (CHCPE) and the Personal Care Assistant (PCA) Waivers. While the state has been able to eliminate the waiting list for CHCPE, other

waiver waiting lists remain long. CT has instituted a comprehensive LTC Planning process that sets and tracks progress against ambitious goals. State policymakers and agencies developed assisted living demonstration projects, placed a moratorium on nursing home beds, as well as instituted pre-admission screening and constraints on the growth of Medicaid payments with expansion of home care through Medicaid. CT has received 8 federal grants since 2000 aimed at improving the LTC system, the majority of which are CMS systems change grants including Medicaid Infrastructure Grant (2000), Nursing Facility Transitions to Independent Living Grant (2001), Real Choices Systems Change Grant (2002), Independence Plus Waiver Initiative (2003), Quality Assurance and Improvement in HCBS (2003), Community-Integrated Personal Assistance Services and Supports (2003), Mental Health Transformation State Incentive Grant (2005), and Money Follows the Person Rebalancing Demonstration (2007). The state subsequently assumed funding for the Nursing Home Transition Program when federal funds ran out. For the first time, more CT residents are receiving LTC services in the community (51%) than in institutions (49%). Though important progress has been made, still more than two-thirds of Medicaid LTC dollars are spent on institutional care and a number of reforms to LTC organization, financing and delivery are warranted in order to achieve rebalancing goals. At this time, CT is one of 18 states that do not have a personal care option in the Medicaid state plan and one of 10 states without an Aging and Disability Resource Center (ADRC) or other mechanism to provide a "single point of entry" model of entry into the LTC support system.

II. Goal and Objectives: The long-term goal of this project is to help consumers who are at high risk of nursing home placement but not yet eligible for Medicaid to remain in their own homes and communities through the following objectives: (1) Provide consumers in the South Central Planning and Service Area (Area) with flexible service options utilizing a Cash and Counseling (C&C) model with funds from Older Americans Act Title III- E National Family Caregiver Support Program (NFCSP) and the state-funded CT Statewide Respite Care Programs (CSRCP) currently serving individuals who are not eligible for Medicaid; (2) Effectively target services to individuals in the Area who are at risk of nursing home placement and spend-down to Medicaid; and (3) Develop a Single Entry Point (SEP) system in the Area that provides access to all publicly supported LTC services and supports to individuals, including those who are at risk of nursing home placement and spend-down to Medicaid, to be used as a model for the remaining four Areas; (4) Conduct a process evaluation of the start-up, implementation, and ongoing activities of each of the project's objectives and design & implement a model comprehensive performance measurement program.

III. Proposed Approach:

A. Challenges: While CT is 2nd among states in per capita LTC expenditures, nursing facilities still constitute the greatest total expenditures. This is in stark contrast to what the LTCNA shows that the vast majority of consumers want – to remain in their own homes with homecare services and supports as necessary. They want independence, choice and control when using any type of LTC services – most would like to work jointly with an agency in managing their services, and over one-quarter have a desire for self-directed care. The greatest obstacles to receiving needed community-based services, however, are finances and lack of knowledge about services. There is a critical need to educate the general population about LTC – what it is, who may need it, how much it costs, and what choices exist. Unfortunately, individuals often do not seek information about LTC until they are in a crisis situation and need immediate help. At that point it is difficult to navigate the complex system to get needed information so that supports can be secured quickly. It is also essential to create parity among age groups, across disabilities, and among programs and break down silos that exist within and among state agencies and programs. This proposal, based upon extensive research of best practices of each objective throughout the country (which, regrettably cannot be adequately acknowledged here due to space limitations), is a small step toward addressing some of the recommendations of the LTCNA, the first of which is to create a statewide SEP LTC Information and Assistance (I&A) program utilizing the existing CHOICES program (See Section C.1 for program description). Others include providing true consumer choice and self-direction to all LTC users; addressing education and information needs of the CT public; and providing support to informal caregivers.

B. Overview: "Choices at Home" – This project will operate as a partnership between the CT Department of Social Services (DSS) through its State Unit on Aging (SUA), and the Agency on Aging of South Central CT (AASCC), in collaboration with the Center for Disability Rights (CDR) of West Haven, community services providers, and LTC stakeholders. The SUA has embraced AoA's Choices for Independence initiative with its 3 strategies of streamlining access, use of flexible service models to offer more choices for high-risk individuals, and building prevention into community living. This project, limited to the Area, will complement the current progress in the state in these 3 key areas, including existing rebalancing efforts. This particular Area was selected for this project because AASCC already has the unique experience of historically offering continuum of care services. An inquiry through its Aging Resources Center or agency volunteer program is seamlessly directed to the "Bridge" where people are provided short-term/

immediate need services or interventions that would help "bridge the gap" in services through Title III-B service providers or the CSRCP for short-term/immediate need intervention, and then transitioned onto either the Medicaid or state-funded CHCPE as an application may be completed. This process ensures consumers are not lost in the cracks, and promotes an overall screen for assistance and referrals to other community supports. In "Choices At Home," project partners will be making changes to the system's infrastructure and will also leverage new and existing resources to divert people from nursing homes. Using a two-pronged approach to reach the target population, the partners will connect with existing participants in the Area's NFCSP and CSRCP as well as reach out to new consumers who are at high risk of nursing home placement and Medicaid spend-down. Using a C&C model through these 2 programs, a flexible delivery of services option will be available to consumers, supporting consumer-directed care as well as expanded services options. To ensure that all consumers are served, including the target group, LTC options counseling will be offered through the new SEP. Key supporters of these initiatives are community services providers including the CT Elder Action Network, United Way of Connecticut 2-1-1 Infoline (211), CT Commission on Aging, CT Association for Community Action (CAFCA), and the Alzheimer's Association.

C. Status Quo and Transformations:

1. Single Entry Point / ADRC system:

South Central Planning and Service Area

Status Quo	Transformation
No SEP	SEP: 1-800# at DSS
No ADRC	Fully Functioning ADRC
Informal connection: AASCC and CDR	Strong formal partners: AASCC and CDR
Little known, used LTC website	Visible, expanded features of LTC website
No marketing activities	Marketing activities for SEP and website
No additional staff for ADRC efforts	Staff with CHOICES funding at AASCC; ADRC staff at AASCC, CDR under this project
No training	Cross-training Aging & disability LTC options
Consumers receive referrals	Call-forwarding to connect directly with agencies
Limited technology	Expanded technology with Omnia and Beacon software to collect and report on consumers
No comprehensive assessment tool	Comprehensive assessment tool developed
No evaluation of existing systems	Evaluation in place
Limited feasibility of statewide ADRC	Plan for statewide ADRC feasible

Although the state does not currently have an operational ADRC, in June of this year the SUA held an initial planning meeting with stakeholders from both the Aging and Disability networks and presenters from AoA and the Lewin Group to begin the process independent of any grant opportunities. At about the same time, the legislature appropriated an additional $1 million to CHOICES, the State Health Insurance assistance Program (SHIP), in part for the additional charge of providing LTC options counseling. CHOICES (**CT**'s program for **H**ealth insurance assistance**, O**utreach, **I**nformation and referral**, C**ounseling and **E**ligibility **S**creening), is both presently and historically, the state's premier Information and Referral / Assistance (I&R/A) source for aging issues. Each of CT's 5 Area Agencies on Aging (AAAs) operate CHOICES and house staff who act as both SHIP/Senior Medicare Patrol (SMP) and Aging I&R/A resources, funded in part by OAA Title IIIB waivers in order to provide consumer directed information and assistance for their region of the state. CHOICES staff are currently in the process of receiving AIRS Certification in Aging I&R/A, making CHOICES the natural "nucleus" of an ADRC in this state.

a. Although we are still in the initial planning phases of bringing our ADRC to fruition, we intend to use a SEP system in order to increase the access to, and ease the navigation of the myriad of services available to older adults and disabled individuals in a seamless manner to the consumer. Incorporating the use of a SEP also allows for a centralized intake and eligibility determination process that also ensures timely and consistent response to families. DSS has prior experience with a no-wrong-door client service model, the Human Service Infrastructure (HSI), created several years ago for the purpose of better using existing resources, using services efficiently, identifying client barriers, connecting clients to community resources, acts as a network of community action agencies and other service organizations, that know where to access needed services. CAFCA is a key partner in this initiative. The HSI model uses a SEP that all partners were trained to utilize once a person seeking/needing assistance could be identified, or went through any access "door." The SEP for "Choices At Home" will be a phone number to dial, toll-free in-state, similar to the 211 number successfully used in the HSI model and the 1-800 number used for CHOICES**.**

b. The ARDC will be overseen by several different offices within DSS including the SUA, Medicaid Division, and Bureau of Rehabilitation Services (BRS). (See attached ADRC Organization Chart.). These offices will collaboratively direct 2 basic hubs linked together by elements they share in common. (1) The first hub is comprised of the state's 5 AAAs, as directed by the SUA. In addition to housing Regional CHOICES Coordinators, Regional SMP Coordinators, CSRCP staff, and NFCSP staff, AAAs also provide

eligibility screening for federal, state and local programs, community forums, health fairs, educational programs, and information on: housing options, job training, adult day care, nutrition services, home maintenance, legal matters, and transportation. The ADRC will be piloted in the AASCC region during this Project and then rolled out in subsequent regions. (2) The second hub is comprised of the state's 5 Centers for Independent Living (CIL), as directed by BRS. Each CIL operates on a three-pronged approach: consumer controlled – directed, managed, and staffed to a substantial degree by qualified persons with disabilities, community based – located within the community to which the consumers reside rather than large institutions, and community responsive – designed to address the disability-related needs of a specific community by identifying services gaps and barriers that limit the independence of people in that community. CILs provide the following services: advocacy and awareness, information and resources on assistive technology and ramps, peer mentoring for youth in transition, support groups for people with Traumatic Brain Injury, nursing home transition, independent living skills training, information and referral, in-person direct services to people with disabilities, and disability sensitivity and awareness trainings for the community. The initial CIL pilot site, CDR, for both this grant and the ADRC does not mirror the AAA region exactly. The AAA South Central region will be the focus for this grant opportunity as well as the ADRC.

c. By the end of 18 months, the pilot ADRC will be fully functioning, but it should begin servicing consumers in month 13, thus allowing for time to hone skills. The Money Follows the Person (MFP) initiative, overseen by the DSS Medicaid Division, already has linked the AAAs and CILs as they work together in CT for the common goal of transitioning people out of nursing homes. Each agency will already have MFP Transition staff hired to use a SEP, a statewide toll-free phone number. The same phone number, will be utilized as the SEP for the ADRC thereby building consumer trust and respect while enhancing individual choice and informed decision-making. DSS Medicaid staff hired with MFP funding will answer the pilot SEP line and the appropriate AAA or CIL will get in touch with the consumer to perform a screening.

d. Another element of the ADRC development includes the inception of a "warm transfer," or call forwarding, telephone option between the AAA and the CIL. This option will enable either the AAA or the CIL to transfer the consumer directly to a staff member at either entity, or to other partners such as 211, in a fashion seamless to the caller. Although each AAA employs Spanish-speaking staff another telephone enhancement, funded by CHOICES will address the LTCNA finding that "despite significant growth in the Hispanic population in CT, many programs do not have the capacity to respond effectively to a person whose

first language is Spanish." With the addition of Language Line translation services both CHOICES and ADRC staff members will be able to access translation services for 170 different languages.

e. During this session, the legislature also "gave" CHOICES the additional responsibility of collaborating with other state agencies and entities in the development of consumer-oriented websites that provide information on Medicare plans and LTC options available in CT. The LTC website unveiled last year already has the ability for community service providers to update their information and the website's community resources database through a link and partnership with 211. Under the collaborative direction of DSS, the State Legislature, LTC Advisory Council, CT Commission on Aging and other ADRC stakeholders, work has already begun directly with the LTC Advisory Council to transform the state's present LTC Services and Supports website into an ADRC website based on evolving consumer need. The goal of the revamped website is to provide easy access to comprehensive information on private and public LTC services and supports in CT, including home care, community care, housing and institutional nursing home care regardless of an individual's age or disability.

f. Marketing activities for both the website and SEP phone line will take place in the AACSS region of the state and may include activities such as press releases to print and broadcast media, PSAs, development of a marketing brochure for use at AAA & CIL events as well as for MD offices, posters for partners to be placed in common community locales, bus placards in low income neighborhoods where bus use is high, articles for senior center newsletters, direct mailings to identified populations such as ConnPACE (State Pharmacy Assistance Program) recipients, or even inserts for newspapers to be delivered in targeted areas. The DSS RxXpress Bus, initially used for Medicare Rx, will be included in the marketing plan. Marketing activities in other regions of CT will begin, as appropriate, when the ADRC is rolled out in each region of the state.

g. Money received for the CHOICES program will also enable the hiring of additional staff members for the ADRC in order to better serve consumers by ensuring coordination of benefits, and services. These highly cross-trained and specialized ADRC staff members will primarily focus on LTC Options Counseling, and Eligibility Screening for all federal, state, local, and private programs and one will perform the function of a trainer. However, they will also be trained to conduct Needs Assessments, develop care plans when appropriate, and link consumers to specific services or critical pathways. The hired staff members will require

ample training time to learn everything from basic I&A to LTC Options Counseling, Eligibility Screening, C&C, and serving both the Aging and Disabled populations.

h. Training, Technology, Assessment & Evaluation: The DSS Office of Organizational & Skill Development (OSD) will develop, in partnership with the SUA, AASCC, and CDR, and conduct the aging/disability cross-training of both AAA and CIL staff, as well as the LTC Options Counseling training to ADRC staff. Additional staff members in both the AAA and CIL will also receive cross-training on each others' agency and scope of work & on the function of the ADRC. Additional training will need to be conducted on the implementation of a new computer resource database once it becomes available, and the software associated with these changes including Omnia and Beacon I&R. Maintaining the ADRC's mission of a SEP and to reduce fragmentation in the state's current tracking system of I&A services will require the modification of the layout structure of the Social Assistance Management System (SAMS). Finally, a review of currently used Assessment and Screening Tools for publicly supported LTC programs as well as other state and federal programs will be conducted to determine their appropriateness and room for potential improvements. A comprehensive assessment tool will be developed for the purpose of streamlining the process of identifying those most likely to benefit for programs and/or determining eligible individuals both for this specific grant opportunity as well as for use by the ADRC. A priority scale will be developed to screen and channel ADRC callers to determine if they should be linked to needed services, work with the individual and/or their caregiver to develop a plan of care, or receive LTC Options Counseling via the ADRC or to the pilot site for C&C. Both consumers and funding entities will then benefit from maximization of allocated resources and the offer of consumer directed services while still serving the people in greatest social and economic need.

2. Recruitment and Eligibility – Targeting: The method for identifying and targeting individuals in the Area who are at risk of nursing home placement and spend-down to Medicaid is extremely critical to ensure that they can remain in their homes and communities as they age. It is important to identify such persons so that they can subsequently be assessed for eligibility and need for respite and supplemental services through either of our participating C&C pilot programs, CSRCP and NFCSP. We therefore are going to use proven strategies to reach our targeted participants, a two-prong approach that has been successful in other projects: (a) First, we will identify and transition eligible participants from our existing state and federally-funded grant programs. SUA administers a number of these programs which have a wide pool of possible applicants that

can be tapped. We can also seek referrals from CT's Alzheimer's Disease Demonstration grant, "REACH" – Resources, Education, Assessment, Caregiving/Connections, Health and Hope. REACH provides support and counseling through social workers and nurses who also assess individual needs for services such as adult day care, home care, community organizations, health centers and financial assistance programs until March 2008. And secondly (b) we will identify those who are not currently enrolled in existing state-funded programs. Efforts will be focused on targeting individuals who are not currently receiving home care and are unaware of available supportive services programs. For these folks, the distribution of informative outreach materials in the Area communities is crucial. In addition to working with advocacy groups, and community service organizations, partners will increase awareness through an extensive outreach campaign consisting of various publications, brochures, flyers, public service announcements, and group presentations. Also, we will tap into intermediary Area networks that are most likely to have significant contact with targeted individuals, such as adult day care agencies, churches, health clinics and other health care providers, veteran administration organizations, and transportation providers. It is important to consider risk areas that will be assessed – functional status, health status, cognitive status, and informal supports (such as one's caregiver) – which are good indicators of risk of nursing home placement. Assessments reflect, after the fact, that 7.3% of persons in CT nursing facilities who were admitted directly from their home never had home health services first. Marketing efforts will be communicated to target audiences, participating providers and partners and will include general & program specific information. "Choices At Home" plans a multi-media approach utilizing press releases, radio, public service announcements, fact sheets, and brochures to implement an effective outreach strategy, as well as utilizing both the SUA and LTC websites. General information that will be communicated includes the following: eligibility, requirements, process for selection and enrollment, available services and options, participant responsibilities, data collection requirements, and contact information. Materials developed for outreach will be distributed regionwide, including town halls, Advocacy and Community Service Organizations, and professional offices.

3. Flexible Service Options / Cash and Counseling Model:

South Central Planning and Service Area

Status Quo	Transformation
CSRCP: No C & C option	CSRCP: C & C option
NFCSP: No C & C option for respite and supplemental services	NFCSP: C & C option for respite and supplemental services

Limited supplemental services funds	Expanded supplemental services funds to purchase items for the long term
Assessment tools: different ones used for different programs	Assessment tool uniform for CSRCP, NFCSP, ADRC, possibly other programs as well
Priority scale, not specific to at risk population	Priority scale includes at risk of nursing home placement and at risk of Medicaid spenddown

a. CT Statewide Respite Care Program (CSRCP) is a state-funded program operating since 1999 that was designed to provide respite services to caregivers of individuals with Alzheimer's disease and related dementias. It has a well-established record of providing case management, counseling, referrals and direct services to individuals with Alzheimer's disease through a strong partnership among the 5 AAAs, the Alzheimer's Association, and DSS. The individuals must have a Physician's diagnosis of Alzheimer's disease or a related dementia and have an income of $30,000 or less and assets of $80,000 or less a year to access the program. The program offers up to $3,500 each year for respite services to families to relieve caregiver stress. The services are largely traditional and have included: Adult Day Care, Companions, Homemakers, Assisted Living, Nursing Home Respite. The legislature approved an additional $1 million for SFY'08, increasing funding to $2.3 million, thus creating the possibility of expanding service options to caregivers. The program uses a case management model in which clients are assessed and a care plan is developed that best meets their needs. Of the 145 participants served in SFY '06, more than half of the clients in this program recertify their eligibility and continue receiving services over a period of time after their first year. It should be feasible to implement a more consumer directed approach to service delivery, basing care plans upon established successes in individual clients' cases. They have already received comprehensive assessments and have worked closely with the program's care managers. Experience with the PCA Waiver indicates that self-directed care is greatly streamlined by only servicing clients who have already been the recipients of traditional services through a case management model. We will, therefore, (1) target the consumer-directed model of care with the CSRCP clients who have recertified services first. We will further (2) target those clients who do not have access to available services through traditional means in their community (Ex. adult day care). Due to the shortage of agency staff that has been widely reported, we will further (3) target key services of non-licensed, non-agency affiliated caregivers, particularly those already employed by a family, through a consumer directed approach. Expanding the pool of available staff extends options to families not currently able to access services. The program's current Assessment Tool will be utilized until a revised universal version becomes available, as well as the Screening Tool and Prioritization Scale to be used by the ADRC.

b. OAA Title III-E – National Family Caregiver Support Program (NFCSP) provides federal funding to states to enable them to provide multifaceted systems of support services for family caregivers. With an annual budget of over $2 million, the program has a well-established record of providing these services from approved community service providers to assist caregivers in gaining access to services, providing counseling services and caregiver training, and in making decisions related to their caregiving roles. NFCSP provides services to caregivers including family members caring for relatives aged 60+ and grandparent or older relative caregivers (55+) caring for children 18 years of age or under. The AASCC should have adequate potential project participants through NFCSP as evidenced by service figures from FFY 2006: 923 individuals for one-on-one assistance, 775 for counseling, support groups, and training; 110 for respite services; and 303 for supplemental services. Experience has shown that caregivers participating in this program tend to be more autonomous in their roles and, therefore will find the self-directed model will offer enhanced opportunities to best tailor services. The project will focus on respite & supplemental services. See Section 2a CSRCP for use of Assessment & Screening Tools, Prioritization Scale and targeting method.

c. Cash & Counseling Model - CT currently has a myriad of federal grants supporting community based LTC as well as 5 Medicaid waivers. These home and community-based services programs offer a variety of services and other supports to those who wish to live in the community for as long as possible. Some CT waiver programs have active consumer and family involvement as part of their design and operation. CHCPE, for example, serves individuals aged 65+. The PCA and Acquired Brain Injury (ABI) Waivers serve adults aged 65+, and the Department of Mental Retardation (DMR) Waiver has no age limit. The PCA, ABI and DMR Waivers are all structured on person-centered models that allow for the development of flexible service plans. Each of these waivers involves the individual as the employer who is responsible for hiring, firing, paying providers, and managing their individual budgets. The option of using a fiscal intermediary (FI) is provided as a resource under the PCA and ABI Waivers, while those participating in the DMR Waivers must use a fiscal intermediary with the option of requesting the services of a Support Broker to provide case management with additional supports.

(1). **Area Pilot Program** C&C will be added as an option for service delivery under both NFCSP (Respite and Supplemental Services) and CSRCP. It is expected that 75 consumers in the at risk target group will be served through the C&C model in the last 9 months of the grant: 25 through the CSRCP, 25 through NFCSP Respite and 25 through NFCSP Supplemental Services. C&C Features of CSRCP and NFCSP Respite and

Supplemental Services include (a) Offered to all program participants; (b) Targeted to individuals who meet the functional criteria of being at risk for nursing home placement and the financial criteria of being at risk for Medicaid spenddown; (c) Service plan will be developed to complement the informal caregiving and individual resources already in place; (d) Allows individuals to choose the level of control and flexibility they would like to exercise over their support services; (e) The individual and family caregiver, along with their planning and support team, identify the needs, preferences, and outcomes for the service plan; (f) The use of individualized budgets will allow individuals identified through the prioritization process a funding range based on their assessed level of need. (g) The Individual Budget will be developed by choosing the type, amount and duration of services and supports that will be provided to each consumer; (h) All service plans will be reviewed as consumer needs change; (i) Financial management and counseling services will be provided to assist individuals in choosing whether or not they hire their own staff, use an approved vendor for services, or choose a combination of vendor-delivered and self-directed service options; (j) Individuals who choose to self-direct their service options will utilize the services of a FI to work with them in managing the Individual Budget and the responsibilities of being an employer, such as hiring, training, supervising, paying, and if necessary, firing; (k) The FI will also perform background checks for all workers, have them sign a waiver form for liability purposes, and provide some quality assurance measures; (l) Individuals receiving services through CSRCP and NFCSP always have the option of receiving services through a more traditional case management model if C&C does not seem appropriate for them.

(2) C & C Workgroup: SUA and AASCC will convene a workgroup, which will include consumers, to develop the framework for the C&C model. The workgroup will be involved in several steps including: (a) Examine existing state and federal regulations that govern the NFCSP and the CSRCP to assess the need for regulation and/or policy and procedural changes; (b) Evaluate existing assessment and screening tools currently being used for both programs as well as those of the CHCPE and the Medicaid Waiver programs to adapt a comprehensive assessment tool for the C&C program, in coordination with ADRC assessment tool; (c) Review and modify the current priority scale for services to ensure that individuals at risk of nursing home placement as well as those at risk of Medicaid spenddown are served through the CSRCP and NFCSP; (d) Develop an array of expanded service options, including non-traditional service options for those consumers who may require respite and supplemental services not available through the traditional case management model; (e) Develop an outreach and marketing strategy; (f) Establish FI eligibility criteria.

(3) Fiscal Intermediaries (FIs) will be used for C&C services. AASCC, with DSS and workgroup input, will develop eligibility criteria and an application for the FIs that provide services under this program. DMR, PCA and ABI waiver programs have extensive experience with FI agencies in the state; therefore, the AASCC is in a prime position to incorporate the use of this service into the C&C pilot program. The AASCC will enter into provider agreements with eligible FIs which will include clearly defined terms for supports, services, payment mechanisms, and accounting requirements.

(4) Outreach activities will be aimed at existing program participants & new consumers, targeting persons who are at risk for nursing home placement and Medicaid spenddown & their families. AASCC will develop and administer a client survey in the target group to identify current program participants who may be interested in C&C services. Other outreach activities will generically target those not eligible for the Medicaid funded portion of CHCPE who are between the ages of 60–64, those individuals receiving assistance through the state-funded portion of CHCPE who are at risk for Medicaid spenddown, and other elders not eligible for Medicaid assistance and at risk for institutionalization. The outreach strategy includes visiting caregiver support groups in the south central region, appearances in cable access programs, submission of article for use in senior center newsletter, submission of articles to town weekly newspapers, including 2 Hispanic papers, and connecting with hospital discharge planners. The marketing activities will include: newspaper inserts delivered to homes in targeted areas; marketing brochure for distribution to DRC and health care providers in the Area; and marketing items with the C&C logo to be given to caregivers at Senior Expos.

(5) Training will be aimed at staff, consumers, and caregivers/providers: (a) Training for staff on the C&C model will be developed by DSS and AASCC staff in conjunction with OSD; (b) Training for consumers will include a video and pod casts. With expertise and assistance from OSD, the SUA plans to create a video presentation using New Mexico's Mi Via: Choosing Self-Direction video as a model, to educate consumers on the C&C model with assistance from OSD. Information about traditional & non-traditional types of respite and supplemental services such as assistive technologies, and home modifications that consumers can access through the pilot program will be presented in pod cast format, audio broadcasting on the Internet; and (c) Training for caregivers/providers which also be developed with assistance from OSD, through web-based trainings modeled after the Iowa Respite and Crisis Care Coalition (IRCCC) partnership with Essential Learning, an organization that provides a web-based Learning Management System, to offer easily accessible trainings online for providers that care for disabled individuals in their homes.

D. Evaluation: The evaluation component of this project will include two major features. The first feature will be a *process evaluation*, and the second feature will be the development and implementation of an outcome-oriented *performance measurement program*.

1. Process Evaluation: During the 18 month project period, a process evaluation will be implemented for each of the 3 project objectives. (a) An evaluation framework based on the Lewin Group's national assessment of ADRCs, encompassing 5 domains will be used to evaluate the start-up process for each objective. The framework includes the following domains: operations, coalition building, policy and regulatory issues, clinical aspects, and baseline (i.e., existing system characteristics). (b) Next, the process evaluation for implementation and ongoing activities related to each objective will be conducted as described below: (1) *Flexible service options:* The process evaluation will involve establishing a uniform reporting system, using SAMS and Omnia software (described in IT section F below), that will allow the capture of the following data elements at the consumer level: total number of consumers offered the C&C model; total number accepting and refusing the C&C option; reasons for refusing the C&C option; among those accepting, for what specific purposes did they choose to use C&C funds (distinguishing human assistance from low and high technology assistive devices and home improvements); and, among those accepting, how did their human support system expand compared to its composition before starting to use the C&C option. All of these data will be reported on a quarterly basis. At a broader level, this process evaluation also will chart the degree to which the final model of establishing a FI to broker the C&C funds compares with the model envisioned at the start of the project, as explained in this application. (2) *Targeting services***:** Consumers in the Area currently enrolled in the NFCSP & CSRCP may or may not fall into the targeted population for this project. The process evaluation for the objective will include a description of the screening and assessment process designed to determine which consumers in the geographic area enrolled in the 2 state respite programs are at risk of nursing home placement and spend-down to Medicaid. Additionally, the process evaluation will monitor and report all the types of outreach activities developed to expand the consumer base in the target population in the Area, as well as the response to each outreach strategy. (3) *Single Entry Point***:** The process evaluation will involve establishing a uniform reporting system (see Section F) to capture information on each person who accesses the SEP system, via telephone or on-line. At a minimum, this reporting system will include demographic data, reasons for contacting, and sources of referral to this SEP.

The ways in which screening procedures are established to determine if consumers contacting this system are in 1 of the 2 target groups also will be charted in the process evaluation.

2. Performance Measurement Program: A comprehensive performance measurement program will be designed and implemented during the 18-month project as part of the evaluation component, focusing on desired outcomes of the Project. Performance indicators will include consumer-oriented measures specifically for the flexible service option & measures related to system-level nursing home diversion goals of delaying or avoiding aggregate nursing home admission and spend down to Medicaid through more careful targeting, and through the development of the SEP. (a) *Consumer-oriented measures* will be designed to be captured at 6 month intervals, and both single point in time results and changes over 6 month periods in samples with 2 measurement points will be reported using report shells based on models developed by the C&C program. A comparison group to the C&C consumer group will be established, to include consumers in the target population enrolled in the 2 state respite programs who remain or choose to enroll in the traditional care management service model for these respite programs in CT. The consumer measures will draw on existing quality assurance measures collected by CT in HCBS programs, for example in 1915c Medicaid waivers. Through the department's MFP Demonstration Program, quality assurance measures for various HCBS programs are being reviewed for consistency and integration across programs. In addition to collecting quality assurance information parallel to that collected for participants in other CT HCBS programs, the following consumer-oriented measures will be collected: (1) Satisfaction with overall arrangements for care (based on CT's existing Nursing Facility Transition Program and MFP consumer satisfaction evaluation); (2) Satisfaction with paid caregivers (based on items from Report Shell 8 of the C&C program performance indicators); (3) Quality of life (based on the National MFP Demonstration Evalution QOL measures which are currently under development by Mathematica Policy Research, Inc.). (4) Unmet need and access to care (based on items from Report Shell 9 of the C&C program performance indicators); (5) Family (unpaid) caregiver health and well-being (based on measures of primary family caregiver burden—brief Zarit scale); depressive symptoms (based on the CES-D scale); and health-related QOL (based on the SF-12 scale). (b) *System-level measures* will be reported using report shells based on models developed by the C&C program. During the 18-month project period, the evaluation team will work with other grant partners to determine how each of these measures will be calculated for reporting purposes, and these methodologies will be included in the project final report: (1) Numbers of consumers diverted from nursing home care; (2)

How long target group members remain in the community; (3) Numbers of consumers diverted from spending down to Medicaid; and (4) How long target group members avoid Medicaid.

E. Information Technology: For purposes of this project, SUA will be utilizing or adapting its current Synergy systems. (1) *Flexible service options:* SAMS is a comprehensive consumer and case management system. This system is web-based and used statewide to monitor consumer and service delivery of programs. It will be used to track the demographics of consumers, both in the at-risk population & general population, and the services they receive. It will trace whether consumers received assistance with a traditional model or with the C&C model. SAMS and Omnia (described below) will be used to produce consumer and service delivery profiles for each model and identify consumers who are diverted from nursing home care. (2) *Targeting services:* An assessment form will be developed that will measure consumers' risks for Medicaid spend-down and nursing home placement. Omnia software will be purchased so that this assessment form can be designed and integrated with SAMS. It will also enable us to extract and manipulate data from this assessment to determine the number of consumers who were diverted from nursing home care. Since Omnia integrates with SAMS it provides the capability for cross comparison of assessment data with consumers' service delivery information. (3) *SEP:* To maintain the ADRC's mission of a SEP and to reduce fragmentation in the state's current tracking system of I&A services, a new software system, Beacon, will be purchased that can be designed and integrated with SAMS. Beacon is fully incorporated with the AIRS taxonomy and has the ability to track call activity, topics discussed, resources to which referrals are made & prompts to conduct follow up service. It will also have the capability to integrate case management with I&A services, which will provide an opportunity for meaningful outcome-based measurements. Users will be able to create and maintain resource databases within the system to provide current information on existing LTC services. The assignment of keywords will enable searches on resource directories, which can be used to identify and access appropriate LTC resources to help divert consumers from nursing home placement. *Beacon Web* allows the resource directory in Beacon to be posted on a website where consumers can search the same resource directory as the call center professionals. Synergy currently has 4 clients who use *Beacon Web* in their ADRCs. Since the SUA and AAAs currently utilize 211 community resources database on the Infoline website, it will be of value to coordinate, not duplicate, the Beacon features with the resource database presently available.

IV. Project Outcomes and Sustainability: (a) The expected <u>outcomes</u> of this project are: (1) Consumers have expanded options for delivery of services through the NFCSP and CSRCP, with a C&C model available;

(2) Consumers can receive screening, assessment, LTC options counseling, and services for at risk target group through the fully functioning SEP in the south central area; (3) Individuals at risk of nursing home placement and spend-down to Medicaid will be effectively and efficiently identified through an assessment tool and served through existing programs; (4) Change can be sustained beyond the grant period and incorporated into the state's overall system of LTC and rebalancing effort.

(b) This proposal is replete with evidence throughout supporting the sustainability of this project. The vast majority of the grant will be used to "build" the infrastructure and test and evaluate the components, rather than for operating a program. Although the $100,000 budgets for "pilot" supplemental services paid under this project will not be recurring after the grant ends, the items purchased with these funds, such as ramps, assistive technology, will be usable beyond the grant period, thereby continuing to keep people out of nursing homes. The legislature's commitment for the future is reflected in the follow-thru shown to implement the LTC Committee's recommendations for action through statute and funding allocations, including the recent CHOICES and Alzheimer's Respite funding. New strategies to reach out to consumers in the target group and comprehensive assessment tool to identify, assess, serve, and track consumers who are diverted from nursing homes will be used on an ongoing basis. The C&C model developed in the Area can continue to operate in that area since the project was implemented purposefully with funds from the existing NFCSP and CSRCP that are historically available each year. It is anticipated that funds to cover the FI fees can be covered by SUA Title III admin and CSRCP admin funds. The assessment tool created to identify, serve, and track at risk consumers can continue to be used after the grant period ends. The training modules for staff and the video, pod casts, and web-learning tools will continue to be used after the project ends, training an ever expanding group of staff, consumers, and providers. With favorable outcomes, maintenance of support of AAA/CIL partnerships and the proven success of this pilot, the expansion can continue region by region throughout the state. The LTC website will be more visible and continue to expand. The SEP phone line can continue to operate in tandem with MFP at DSS and "warm lines" can continue to operate as they serve as a model for other partnership endeavors. It is expected that after the 18 months, that the aging and disability network in the Area will be able to divert people from nursing homes using the new system that has been set up to deliver services in a flexible manner, with the C&C option and the ADRC, and target those efforts to those most at risk of nursing home placement and spend-down to Medicaid.

V. Project Management: Project Leader: Margaret Gerundo-Murkette, MSW (.20 FTE), SUA Program Manager, will serve as the Project Leader for this initiative; provide oversight and management to ensure that the roles and responsibilities of the project partners are fulfilled; responsible for the overall coordination of the project and the primary contact for the Administration on Aging; prepare reports, coordinate attendance at conference calls and other project related business. **DSS Project Staff**: Jennifer Throwe, MSW (.15 FTE), CHOICES Coordinator, will manage the development & implementation of the SEP/ADRC; Cynthia Grant (.15 FTE), CSRCP Coordinator, and Roberta Gould (.15 FTE), NFCSP Coordinator, will manage the development & implementation of the C&C model through the CSRCP and NFCSP; Additional Field Representative (.15 FTE) to assist with coordination of grant efforts. **AASCC Project Staff**: Beverly Kidder, DSW, Aging Resource Center Director, and Betsy Wieland, LCSW, Respite Care Manager Supervisor, will serve as the lead project staff for the Area. Ms. Kidder will oversee agency's tasks for the ADRC while Ms. Wieland will oversee them for C&C for both the CSRCP and NFCSP. **CDR Project Staff**: Marc Gallucci, Esq, Executive Director, will serve as lead project staff for CDR, overseeing the development of the ADRC at CDR. **OSD Training Staff**: Darleen Klase, Director, will oversee the development & administration of training thru her staff for the C&C and SEP/ADRC initiatives; **Data Collection, Reporting, and Evaluation Staff**: Robin Tofil, MS, SUA Research Associate, will oversee the data collection & reporting, including the purchase of software for these initiatives. Richard Fortinsky, Ph.D. and Julie Robison, Ph.D., Co-Principal Investigators from UConn Center on Aging, will be responsible for the evaluation components of this project. Please refer to the Work Plan for specific tasks for which each staff person is responsible.

VI. Organizational Capability: The mission of the CT Department of Social Services (DSS), the lead agency which houses the SUA, is to serve families and individuals, including the elderly and those with disabilities, who need assistance in maintaining or achieving their full potential for self-direction and self-reliance and independent living. DSS is responsible for the administration of the Medicaid program, CHCPE, ConnPACE, & over 90 legislatively authorized programs. DSS has an annual budget of approximately $3 billion (one-third of the state budget) and manages over 700 contracts. By statute it is responsible for administering a number of programs under federal legislation including the Rehabilitation Act, the Older Americans Act (OAA), and the Social Security Act. DSS has been instrumental in furthering CT's rebalancing goals through the work accomplished with the funding of seven Systems Change for Community Living grants. The Aging Services Division functions as the State Unit on Aging (SUA) under the OAA.

Responsible for planning, developing, and administering a comprehensive and integrated service delivery system for elderly persons in CT, the Division manages a budget of over $26 million and oversees 54 contracts that implement all federal OAA programming and State funded programs for the elderly. As the SUA, it oversees the 5 regional AAAs, thus insuring coordination and integration of programs across the state. Among these programs are health and nutrition, legal services, NFCSP, CSRCP, CHOICES**,** and volunteer programs. The Agency on Aging of South Central CT (AASCC), organized and operated under the auspices of the federal Older Americans Act, is one of CT's 5 regional planning, funding and direct service non-profit organizations. AASCC directly serves over 12,000 individuals through its own departments, formally partners with over 100 home and community-based service providers, coordinates service delivery through the local Interagency Council on Aging, and annually grants approximately $2.9 million in federal and state funds to 21 agencies that serve older adults. In addition to services described on pages 6-7, its service array includes the following: (1) regional management of CT's home and community-based Medicaid waiver and several caregiver respite support programs; (2) regional sponsorship of programs including the Retired and Senior Volunteer Program (RSVP) and Senior Companion Program (SCP); and (3) Opportunities for Older Adults, a program that serves individuals with intellectual disabilities. The Center for Disability Rights (CDR) is one of 5 CT Centers for Independent Living (CILs), is located in South Central CT and funded in part by the Department of Education, Rehabilitation Services Administration, Independent Living Branch (See page 7 for specifics). University of CT Center on Aging faculty will be responsible for the development and direction of the evaluation component of this project. Established in 1986, the Center supports robust nationally recognized research programs. Faculty includes accomplished geriatricians and gerontologists whose individual research skills include clinical, translational, basic or health outcomes/population research. In fact, staff has directed the evaluation activities of two AoA-sponsored projects on evidence-based practice in CT; served as principal investigators for a number of CT's Systems Change Grants from CMS including the MFP Demonstration Project; and conducted the CT LTC Needs Assessment. The Office of Organizational and Skill Development (OSD), which provides an expansive grouping of Training, Organizational Development (OD) and Media and Production Services to DSS, will provide the Training Component of the Project. By providing services under a partnership with the UConn School of Social Work, OSD benefits from access to the resources of the University to enhance services to DSS.

VII. Work Plan, Letters of Commitment, & Organizational Charts: See Attached Exhibits.