Balancing the System:

Working Toward Real Choice for Long-Term Services and Supports in Connecticut

A Report to the General Assembly
January 2013

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APPENDIX A.

Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

CONNECTICUT GENERAL STATUTES
TITLE 17B. SOCIAL SERVICES
CHAPTER 319Y. LONG-TERM CARE

§ 17b-337. Long-term elderly care planning committee. Long-term care plan for elderly persons. Membership

(a) There shall be established a Long-Term Care Planning Committee for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. Such plan shall integrate the three components of a long-term care system including home and community-based services, supportive housing arrangements and nursing facilities. Such plan shall include: (1) A vision and mission statement for a long-term care system; (2) the current number of persons receiving services; (3) demographic data concerning such persons by service type; (4) the current aggregate cost of such system of services; (5) forecasts of future demand for services; (6) the type of services available and the amount of funds necessary to meet the demand; (7) projected costs for programs associated with such system; (8) strategies to promote the partnership for long-term care program; (9) resources necessary to accomplish goals for the future; (10) funding sources available; and (11) the number and types of providers needed to deliver services. The plan shall address how changes in one component of such long-term care system impact other components of such system.

(b) The Long-Term Care Planning Committee shall, within available appropriations, study issues relative to long-term care including, but not limited to, the case-mix system of Medicaid reimbursement, community-based service options, access to long-term care and geriatric psychiatric services. The committee shall evaluate issues relative to long-term care in light of the United States Supreme Court decision, Olmstead v. L.C., 119 S. Ct. 2176 (1999), requiring states to place persons with disabilities in community settings rather than in institutions when such placement is appropriate, the transfer to a less restrictive setting is not opposed by such persons and such placement can be reasonably accommodated.

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing and select committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Social Services appointed by the Commissioner of Social Services; (5) two members from the Department of Public Health appointed by the Commissioner of Public Health, one of whom is from the Office of Health Care Access division of the department; (6) one member from the Department of Economic and Community Development appointed by the Commissioner of Economic and Community Development; (7) one member from the Department of Mental Retardation appointed by the Commissioner of Mental Retardation; (8) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (9) one member from the Department of Transportation appointed by the Commissioner of Transportation; (10) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and (11) the executive director of the Office of Protection and Advocacy for Persons with Disabilities or the executive director's designee. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

(d) Not later than January 1, 1999, and every three years thereafter, the Long-Term Care Planning Committee shall submit a long-term care plan pursuant to subsection (a) of this section to the joint standing and select committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care, in accordance with the provisions of section 11-4a, and such plan shall serve as a guide for the actions of state agencies in developing and modifying programs that serve persons in need of long-term care.

(e) Any state agency, when developing or modifying any program that, in whole or in part, provides assistance or support to persons with long-term care needs, shall, to the maximum extent feasible, include provisions that support care-giving provided by family members and other informal caregivers and promote consumer-directed care.

§ 17b-338. Long-Term Care Advisory Council. Membership. Duties

(a) There is established a Long-Term Care Advisory Council which shall consist of the following: (1) The executive director of the Commission on Aging, or the executive director's designee; (2) the State Nursing Home Ombudsman, or the ombudsman's

designee; (3) the president of the Coalition of Presidents of Resident Councils, or the president's designee; (4) the executive director of the Legal Assistance Resource Center of Connecticut, or the executive director's designee; (5) the state president of AARP, or the president's designee; (6) one representative of a bargaining unit for health care employees, appointed by the president of the bargaining unit; (7) the president of the Connecticut Association of Not-For-Profit Providers for the Aging, or the president's designee; (8) the president of the Connecticut Association of Health Care Facilities, or the president's designee; (9) the president of the Connecticut Association of Residential Care Homes, or the president's designee; (10) the president of the Connecticut Hospital Association or the president's designee; (11) the executive director of the Connecticut Assisted Living Association or the executive director's designee; (12) the executive director of the Connecticut Association for Homecare or the executive director's designee; (13) the president of Connecticut Community Care, Inc. or the president's designee; (14) one member of the Connecticut Association of Area Agencies on Aging appointed by the agency; (15) the president of the Connecticut chapter of the Connecticut Alzheimer's Association; (16) one member of the Connecticut Association of Adult Day Centers appointed by the association; (17) the president of the Connecticut Chapter of the American College of Health Care Administrators, or the president's designee; (18) the president of the Connecticut Council for Persons with Disabilities, or the president's designee; (19) the president of the Connecticut Association of Community Action Agencies, or the president's designee; (20) a personal care attendant appointed by the speaker of the House of Representatives; (21) the president of the Family Support Council, or the president's designee; (22) a person who, in a home setting, cares for a person with a disability and is appointed by the president pro tempore of the Senate; (23) three persons with a disability appointed one each by the majority leader of the House of Representatives, the majority leader of the Senate and the minority leader of the House of Representatives; (24) a legislator who is a member of the Long-Term Care Planning Committee; and (25) one member who is a nonunion home health aide appointed by the minority leader of the Senate.

(b) The council shall advise and make recommendations to the Long-Term Care Planning Committee established under > section 17b-337.

(c) The Long-Term Care Advisory Council shall seek recommendations from persons with disabilities or persons receiving long-term care services who reflect the socio-economic diversity of the state.

APPENDIX B.

Long-Term Care Planning Committee Membership

(as of December 31, 2012)

Legislators

Senator Edith G. Prague, Co-Chair, Aging Committee
Representative Joseph C. Serra, Co-Chair, Aging Committee
Senator Kevin C. Kelly, Ranking Member, Aging Committee
Representative John H. Frey, Ranking Member, Aging Committee
Senator Theresa B. Gerratana, Co-Chair, Public Health Committee
Representative Elizabeth B. Ritter, Co-Chair, Public Health Committee
Senator Jason Welch, Ranking Member, Public Health Committee
Representative Jason Perillo, Ranking Member, Public Health Committee
Senator Anthony Musto, Co-Chair, Human Services Committee
Representative Peter A. Tercyak, Co-Chair, Human Services Committee
Senator Joe Markley, Ranking Member, Human Services Committee
Representative Lile R. Gibbons, Ranking Member, Human Services Committee

State Agencies Representatives

David Guttchen, Office of Policy and Management (Chair of Planning Committee)
Kathy Bruni, Department of Social Services
Margy Gerundo-Murkette, Department of Social Services
Jennifer Glick, Department of Mental Health and Addiction Services
Dennis King, Department of Transportation
Beth Leslie, Office of Protection and Advocacy for Persons with Disabilities
Fran Messina, Department of Economic and Community Development
Siobhan Morgan, Department of Developmental Services
Donna Ortelle, Department of Public Health
Amy Porter, Department of Rehabilitation Services
Kim Samaroo-Rodriguez, Department of Children and Families
Michael Sanders, Department of Transportation

Staff

Barbara Parks Wolf, Office of Policy and Management

Former Committee Participants

Pam Giannini, Department of Social Services

APPENDIX C.

Long-Term Care Advisory Council Membership

Organization	Representative
CT Commission on Aging	Julia Evans Starr (Co-Chair)
CT Association of Residential Care Homes	Sonja Zandri
Personal Care Attendant	Debbie Barisano
CT Association of Area Agencies on Aging	Marie Allen
CT Council for Persons with Disabilities	Gary Waterhouse
CT Association of Health Care Facilities	Matthew Barrett
CT Assisted Living Association	Christopher Carter
CT Association of Adult Day Care	Maureen Dolin
Bargaining Unit for Heath Care Employees/ 1199 AFL-CIO	Deborah Chernoff
CT Family Support Council	Moira O'Neil
Consumer	Michelle Duprey
AARP – CT	Nora Duncan
CT Association of Home Care, Inc.	Debra Hoyt
LTC Ombudsman's Office	Nancy Shaffer
Legal Assistance Resource Center	Joelen Gates
CT Community Care, Inc.	Molly Rees Gavin
CT Hospital Association	Jennifer Jackson
CRT/CT Assoc. of Community Action Agencies	Vacant
CT Alzheimer's Association	Laurie Julian
LeadingAge CT	Margaret Morelli
Family Caregiver	Susan Raimondo
CT Coalition of Presidents of Resident Councils	Veronica Martin
American College of Health Care Administrators	Richard Brown
Consumer	Sue Pedersen
Consumer	Vacant
Nonunion Home Health Aide	Vacant

Friends of the Advisory Council

Brian Capshaw, CT Coalition of Presidents of Resident Councils
Bill Eddy, CT Commission on Aging, Member
Quincy Abbot, ARC/CT
Mary-Ann Langton, CT Council on Developmental Disabilities
Claudio Gualtieri, AARP-CT
Maggie Ewald
Cathy Ludlum

APPENDIX D.

Sources of Public Comment

With the assistance of the Long-Term Care Advisory Council, a draft of the Plan recommendations was distributed widely in July and August of 2012 to diverse organizations and individuals throughout Connecticut with an interest in long-term services and supports. A draft of the full Plan and appendices was distributed for comment in October and November 2012. In total, public comments were received from 38 people and 14 organizations.

Individuals

- Brian Capshaw
- Paul Caron
- Samuel E. Deibler, Director, Town of Greenwich, Commission on Aging
- Naren Dhamodharan, NDA Consultants, LLC
- Bill Eddy
- Jeanne Franklin, Commission on Aging, CT Coalition on Aging, Southwestern CT Agency on Aging
- Pam Hoffman, SYMC/Southwestern CT Agency on Aging
- Barbara Sloan, M.Ed.
- Jan VanTassel

Organizations

- AARP: Nora Duncan, Claudio Gualtieri, Ed Dale
- Alzheimer's Association - Connecticut Chapter: Laurie Julian
- Commission on Aging: Julie Evans Starr, Deborah Mignault
- CT Association of Area Agencies on Aging: Maureen McIntyre, Marie Allen, Neysa Guerino, Joan Wessell, Christina Fishbein
- CT Association of Health Care Facilities: Matthew Barrett
- CT Association for Home Care and Hospice, Inc.: Deborah R. Hoyt, President and CEO
- CT Community Care, Inc.: Molly Reese Gavin
- Enfield Senior Center: Susan Lather
- LeadingAge Connecticut: Mag Morelli
- Long-Term Care Advisory Council Workgroup: Julie Evans Starr, Quincy Abbot, Deborah Chernoff, Bill Eddy, Joelen Gates, Claudio Gualtieri, Deb Migneault, Nancy Shaffer
- Newington Senior and Disabled Center: Dianne Stone
- Seniorlink: Matthew J. Lockwood Mullaney; Rachel Richards; and Brian McKaig
- Southwestern CT Agency on Aging: Marie Allen, Pat Knebel; Christina Crain; Mary Donnelly
- The Arc Connecticut: Quincy Abbot and Leslie Simoes, Executive Director

APPENDIX E.

LONG-TERM SERVICES AND SUPPORTS PLANNING EFFORTS

A. Long-Term Care Planning Committee History

Establishment of the Long-Term Care Planning Committee

The Long-Term Care Planning Committee (Planning Committee), created in 1998 under Pubic Act 98-239, was established for the purpose of exchanging information on long-term services and supports issues, coordinating policy development and establishing a long-term care plan. The Planning Committee is comprised of representatives from nine State agencies and the Chairs and Ranking Members of the General Assembly's Aging, Human Services, and Public Health Committees. (See Appendix A for the authorizing statute and Appendix B for a listing of Planning Committee members.)

The Planning Committee grew out of the recommendations of a December 1996 report issued by the Legislative Program Review and Investigations Committee. The study concluded that the State's structure for planning, funding and overseeing long-term services and supports needed reinforcement and coordination. The Legislative Program Review and Investigations Committee recommended the creation of an interagency committee to "exchange information on long-term care issues, ensure coordinated policy development, and establish a long-term care plan."

In addition to the Long-Term Care Planning Committee, Public Act 98-239 also established the Long-Term Care Advisory Council (Advisory Council) to advise and make recommendations to the Planning Committee. The Advisory Council members include a balance of consumers, providers and advocates representing a wide range of interests. (See Appendix C for a listing of Advisory Council members.)

Originally, the Planning Committee was required to establish a long-term care plan for the elderly that integrates the three components of a long-term services and supports system including home and community based services, supportive housing arrangements and nursing facilities. Subsequently, Public Act 01-119 broadened the Planning Committee's purview by requiring a plan for all persons in need of long-term care.

Long-Term Care Planning Committee Products

Preliminary Long-Term Care Plan – 1999

As noted above, the Planning Committee was created by statute in 1998 and held its initial meeting in August 1998. The Planning Committee's authorizing statute required the Planning Committee to produce its first Long-Term Care Plan by January 1999. Due

to the short timeframe, the Planning Committee produced a Preliminary Long-Term Care Plan that provided a description of Connecticut's long-term services and supports system in order to develop a baseline for future Plans. In addition, the Preliminary Plan was focused on long-term services and supports for elderly persons in keeping with the original statutory charge for the Planning Committee (this requirement was later changed, through Public Act 01-119, to require the Long-Term Care Plan to address all individuals who need long-term care, regardless of age or disability). The Planning Committee then began the work to develop a comprehensive Long-Term Care Plan due to the General Assembly by January 2001 (the original statute required a Long-Term Care Plan every two years – this requirement was later changed, through Public Act 01-119, to mandate a Plan be developed every three years).

Home Care Report – 2000

In 1999, the General Assembly enacted Public Act 99-279 that required the Planning Committee to develop, by February 2000, a plan that ensures the availability of home care services for elderly persons under the Connecticut Home Care Program for Elders (CHCPE) who would otherwise qualify for the program except their income exceeds the program's established income limits. The impetus for this legislation was the fact that the CHCPE had a strict income eligibility requirement that resulted in individuals with as little as one dollar above the income level being ineligible for home care services. This contrasted with the income requirements for nursing home coverage through Medicaid that allows individuals with incomes that are not sufficient to pay for their care to be eligible while contributing most of their income towards their care.

To meet this requirement, the Planning Committee produced a report titled "Home Care for Older Adults - A Plan for Increasing Eligibility Under the Connecticut Home Care Program for Elders." that was delivered to the General Assembly in February 2000. The report concluded that the only mechanism to assure the availability of home care services under the CHCPE was to revise the income eligibility cap to mirror the income requirements utilized for nursing home care eligibility, thus allowing individuals to buy into the CHCPE.

During the 2000 legislative session, the General Assembly approved legislation that revised the income requirements for both the State-funded and Medicaid components of the CHCPE to allow individuals with incomes in excess of the income eligibility cap to become eligible for the CHCPE by buying into the program. The expanded income level was implemented for the State-funded portion of the CHCPE in October 2000. However, to implement a similar revision for the Medicaid portion of the CHCPE, federal approval was needed. The Department of Social Services (DSS) submitted a revision to their CHCPE Medicaid waiver in 2001, but the DSS proposal was not approved by the federal government.

Long-Term Care Plan - 2001

After the completion of its Preliminary Long-Term Care Plan in 1999, the next Plan from the Planning Committee was due by January 2001. Beginning in early 1999, the Planning Committee undertook an ambitious effort to solicit public input regarding what was needed for a comprehensive Long-Term Care Plan.

In March 1999, the Planning Committee, in conjunction with the Advisory Council, held a public hearing at the Legislative Office Building where over 50 individuals provided testimony regarding Connecticut's long-term services and supports system. The Planning Committee then embarked on a series of meetings with a variety of groups and organizations involved with the long-term care system. Most of the groups were members of the Advisory Council. All told, Planning Committee and Advisory Council members held 24 forums throughout 1999 and 2000. In addition, the Planning Committee and Advisory Council held five public hearings throughout the state in 2000 to garner additional feedback and input for the Long-Term Care Plan.

The input gathered through the forums and public hearings helped develop the framework for the Planning Committee's Long-Term Care Plan that was submitted to the General Assembly in January 2001.

Long-Term Care Plan – 2004

The Long-Term Care Planning Committee's third plan was issued in January 2004 in accordance with Public Act 01-119 which required the Planning Committee to issue its long-term care plan every three years instead of every two. The Advisory Council worked in partnership with the Planning Committee in four essential areas: providing data, identifying areas of need, developing priorities and recommendations, and obtaining public input.

2004 Long-Term Care Plan Status Reports

Following the release of the 2004 Long-Term Care Plan, a status update was issued annually in June of 2004, 2005 and 2006. The first section of the Status Report described progress implementing the recommendations made in the 2004 Long-Term Care Plan by State Agencies or the legislature, along with any new funds appropriated. The second section documented the implementation of the actions steps issued in Connecticut's Olmstead Plan, entitled "Choices are for Everyone", developed by the Department of Social Services in collaboration with the Long-Term Care Planning Committee and the Community Options Task Force.

Long-Term Care Website

In 2002, the General Assembly passed Public Act 02-7 (May 9 Special Session) that required the Office of Policy and Management (OPM), within existing budgetary resources and in consultation with the Select Committee on Aging, the Commission on Aging and the Long-Term Care Advisory Council, to develop a consumer-oriented

website that provides comprehensive information on long-term care options that are available in Connecticut.

In September 2006, the Connecticut Long-Term Care Services and Supports website was completed and released to the public (www.ct.gov/longtermcare). The website provides information to all individuals in need of long-term care services and supports, regardless of age or disability.

Policy Statement Formalized into Law

Public Act 05-14 codifies in law a broad philosophical statement to guide future policy and budget decisions. As a result of this legislation, the policy and planning work done through the Long-Term Care Planning Committee is required to "provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting." This statement positions Connecticut to make the necessary changes to the laws and regulations that govern the State's long-term care system to make real choices for consumers a reality.

Long-Term Care Needs Assessment

In 2006 and 2007, a needs assessment on long-term care services and supports in Connecticut was conducted by the University of Connecticut Health Center's Center on Aging. The General Assembly's Commission on Aging, in consultation with the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, contracted with the Center on Aging to conduct a comprehensive needs assessment of the unmet long-term care needs in the state and projections of the future demand for these services. This Needs Assessment was mandated by Public Act 06-188, Section 38, and funded with a $200,000 appropriation from the Connecticut General Fund and an additional $80,000 from the Connecticut Long-Term Care Ombudsman Program. Findings from the Needs Assessment informed both the 2007 and the 2010 Long-Term Care Plans, and the many of the recommendations made in the Needs Assessment have been included in the 2010 Plan. (See the Needs Assessment reports at http://www.uconn-aging.uchc.edu/res_edu/assessment.html)

Long-Term Care Plan – 2007

The Long-Term Care Planning Committee's forth plan was issued in January 2007.

2007 Long-Term Care Plan Status Reports

Following the release of the 2007 Long-Term Care Plan, a status update was issued in June of 2007 and 2008 and in October of 2009.

Long-Term Care Plan – 2010

The Long-Term Care Planning Committee's fifth plan was issued in January 2010.

2010 Long-Term Care Plan Status Reports
Following the release of the 2010 Long-Term Care Plan, a status update was issued in June of 2010, 2011 and 2012.

B. Olmstead Planning Efforts

On June 22, 1999, the United States Supreme Court decided the *Olmstead v. L.C*. case, holding that unjustified isolation, caused by unjustified placement or retention of persons with disabilities in institutions, should be regarded as discrimination based on disability, in violation of the Americans with Disabilities Act (ADA).

Federal regulation requires public entities to make "reasonable modifications" to their policies, practices, or procedures in order to avoid discrimination on the basis of disability, unless the modifications would "fundamentally alter" the nature of the service or program. As part of the Olmstead decision, four Justices stated that one of the ways the reasonable modification standard could be met is if the State had a comprehensive, effectively working plan of placing qualified persons with disabilities in less restrictive settings.

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a Community Options Task Force was created to take the lead in the development of the Plan. The men and women of this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

On March 25, 2002, the "Choices are for Everyone" Plan was completed as a collaboration between the Department of Social Services, the Long-Term Care Planning Committee and the Community Options Take Force.

A number of activities in Connecticut support the goals outlined in the "Choices are for Everyone" Plan, some of which are highlighted below.

"Choices are for Everyone" Plan -- Action Steps Update
"Choices are for Everyone" included a series of Action Steps. The Long-Term Care Planning Committee committed to the implementation of these Action Steps. Progress was reported in the annual Status Reports for the 2004 and 2007 Long-Term Care Plans.

Systems Change Grants
Since 2002, the goals of this Plan have been advanced through the work accomplished with the funding of seven *Systems Change for Community Living* grants awarded to

Connecticut by the Centers for Medicare and Medicaid Services (CMS) as part of the federal New Freedom Initiative. These grants were designed to assist states in their efforts to remove barriers to equality for individuals living with disabilities or long-term illnesses, enabling them to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements and exercise more control over the providers of the services they receive.

- Nursing Facility Transition Grant: 2001-2004
- Real Choice Systems Change Grant: 2002- 2005
- Community-integrated Personal Assistance Services and Supports (C-PASS) Grant: 2003-2006
- Independence Plus Waiver Initiative: 2003-2006
- Quality Assurance and Improvement in Home and Community-Based Services: 2003-2006
- Mental Health Transformation Grant: October 2005 – September 2010
- Medicaid Infrastructure Grant: October 2005 – September 2010

Connecticut Behavioral Health Partnership

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and DCF involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to oversee an integrated public behavioral health service system for children and families. The primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

Money Follows the Person Rebalancing Demonstration

The Money Follows the Person (MFP) Rebalancing Demonstration began operation in December 2008. The objective of the MFP Rebalancing Demonstration is to rebalance long-term service and supports from institutional care to home-based services. The program serves individuals across the age span with physical disabilities, mental illness and intellectual disabilities. Connecticut has established five rebalancing benchmarks under MFP that are aligned with the goals of the Long-Term Services and Supports Plan:

1. Transition 5,200 people from institutions to the community.
2. Increase dollars to home and community-based services.
3. Increase hospital discharges to the community rather than to institutions.
4. Increase the probability of returning to the community during the six months following nursing home admission.
5. Increase the percentage of LTSS participants living in the community compared to the institution.

APPENDIX F.

Status Report:

2010 Long-Term Care Plan for Connecticut

June 2012

Status Report

2010 LONG-TERM CARE PLAN FOR CONNECTICUT

Connecticut Long-Term Care Planning Committee

JUNE 2012

Status Report – June 2012
2010 LONG-TERM CARE PLAN FOR CONNECTICUT

Introduction

This Status Report is the third annual update on the status of the 2010 Long-Term Care Plan recommendations. It provides information on actions of the State agencies to address the Plan recommendations as well as on relevant legislation passed by the General Assembly and signed by the Governor.

Acronyms Used in this Status Report

AAA - Area Agency on Aging
ADA – Americans with Disabilities Act
ADRC – Aging and Disability Resource Centers
CMS – Center for Medicare and Medicaid Services
CT – Connecticut
CHCPE - Connecticut Home Care Program for Elders
DDS – Department of Developmental Services
DMHAS – Department of Mental Health and Addiction Services
DPH – Department of Public Health
DOT – Connecticut Department of Transportation
DSS – Department of Social Services
DECD – Department of Economic and Community Development
HUD - Department of Housing and Urban Development (HUD), Department of Economic and Community Development
MFP – Money Follows the Person
PASRR - Pre-Admission Screening Resident Review
PCA – Personal Care Assistant
SFY – State Fiscal Year
VA – Veteran's Administration

Status Report – June 2012
2010 LONG-TERM CARE PLAN FOR CONNECTICUT

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
(i) GOAL 1. Balancing the ratio of home and community-based and institutional care		
Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid home and community-based care from 53 percent in 2009 to 75 percent by 2025, requiring approximately a one percent increase in the proportion of individuals receiving Medicaid long-term care in the community every year.	The Department of Social Services (DSS) Money Follows the Person (MFP) initiative transitioned 1145 persons who had been institutionalized three months or more. As of the end of SFY 2012, six nursing facilities closed utilizing this process and one more is in process. As part of the plan to expand the MFP Rebalancing Initiative, DSS has been awarded funding to help nursing facilities diversify their existing business model by restructuring and reducing the number of skilled nursing beds. DSS hosted the first Right-sizing Retreat in November of 2011 where a set of recommended strategies were developed. Subsequent meeting were held to develop the recommendations into a strategic plan.	**Public Act 11-6**: To reflect the expansion of MFP to 2,251 individuals by the end of SFY 2013 in coordination with a "right-sizing" initiative, funding is reduced by $13,036,123 in SFY 2012 and $24,646,730 in SFY 2013. **Public Act 11-6**: Increases funding for additional mental health Medicaid home and community based waiver slots. Provide funding of $489,000 in SFY 2012 and $1,026,000 in SFY 2013 to reflect a transfer from the DSS Medicaid account. Funding will support 30 waiver slots per year to divert individuals who frequent emergency rooms and shelters from nursing homes to appropriate services. This change also results in an increase of federal funding at a 50 percent

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	The Department of Mental Health and Addiction Services (DMHAS) sits on the MFP Steering Committee. DMHAS also continues to operate two programs that address this goal: (1) the Nursing Home Diversion and Transition Program, which strives to keep clients out of nursing homes and in the community with a variety of supportive services; and (2) the Mental Health Home and Community-Based Services Waiver, which is one of three in the country. Both programs collaborate with the MFP imitative. The Nursing Home Diversion and Transition Program and the Mental Health Waiver (WISE Program) are working with Aging and Disability Resource Centers (ADRCs; aka Community Choices) who have identified individuals with mental health and/or substance abuse problems who need specific DMHAS services, or may be eligible for the Mental Health Waiver. Since July 1, 2009, the Nursing Home Diversion and Transition Program has	reimbursement rate ($244,500 in SFY2012 and $513,000 in SFY 2013), due to an increase in Medicaid waiver expenditures. **Public Act 11-242, Sections 83 & 84**: Requires DSS to develop a strategic plan, consistent with the state's long-term care plan, to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions. Providers from all three setting types must be included in the development of the plan. The bill also exempts from the general Certificate of Need moratorium on new nursing home beds those beds that are relocated to a new facility to meet a priority need identified in the strategic plan. By law, the moratorium is due to expire on June 30, 2012. **Public Act 12-118:** Extends, from June 30, 2012 until June 30, 2016, the DSS moratorium on certificate of need for new nursing home beds. The law exempts certain nursing home beds from the moratorium, including those

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	diverted approximately 315 individuals from nursing home admission and 385 nursing home residents have been transitioned back to the community. Under the Mental Health Waiver, since April 2009, 135 individuals have been enrolled with waiver support services. The DMHAS Mental Health Waiver has been renewed by the Center for Medicare and Medicaid Services (CMS) for another five years. Eligibility criteria has been stream-lined and new services were added to the waiver The DMHAS Senior Outreach Program continues to operate statewide. In this program, clinicians serve older adults (age 55+) who may have problems with substance abuse. The clinicians visit people in a variety of locations, including their own homes, Senior Centers, shelters, board and care homes; nursing homes; etc. with the goal of engaging individuals in treatment and recovery form substance abuse. The Nursing Home Diversion and Transition Program staff facilitate recovery groups (referred to as Double	used by AIDS patients. **Public Act 1291:** Requires the DSS commissioner, within available appropriations, to establish and operate a two-year, state-funded pilot program for up to 10 ventilator-dependent Medicaid recipients who live in Fairfield County and receive medical care at home. Under the pilot, the participants can hire their own licensed registered nurses (RN) and respiratory therapists directly. (Medicaid rules generally require these professionals to be hired by home health care agencies, which send them out to Medicaid recipients' homes.) **Public Act 12-104:** ▪ Reduces funding by $18.4 million to reflect ongoing cost and caseload trends in the state-funded portion of the home care program. Enrollment is currently 19% below the levels assumed in the biennial budget. ▪ Reduces funding by $1.8 million in SFY 13 to reflect delaying the implementation of the waiver until

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Trouble Groups, meaning the individuals have a mental illness and a substance abuse problem) in specific nursing homes. These groups are a form of the Integrated Dual-Diagnosis Treatment model and strive to promote a more successful discharge back to the community. In the Fall of 2011, DMHAS implemented the Gatekeeper Program statewide which trains non-traditional community workers (e.g., postal workers; newspaper delivery people; etc.) to identify older adults who may be at-risk in the community. Many times, these older adults might have been admitted to a nursing home, but instead, a crisis is averted and the person can age in place, at home, in the community. Since October 2011, there have been 137 referrals to the Gatekeeper Program statewide. In the Greater Hartford Area, DMHAS implemented a small Olmstead Initiative grant where two older adult (age 55+) peer support specialists are working with older adults with mental illness (or a co-occurring mental health and	SFY 14. Under the proposal individuals who might have otherwise been served under the waiver will continue to be eligible for those services traditionally available under Medicaid. ▪ Provides funding of $3,650,000 to strengthen rebalancing efforts under MFP: (1) provides grants to nursing facilities to support right-sizing ($3.0 million); (2) develops a marketing plan for direct care workers, and provide job assistance and retraining ($400,000); (3) creates an automated, web-based system to transition care from hospitals to the community ($250,000); and (4) adds independent support broker to the menu of services available under the PCA waiver. ▪ Reduces funding by $2,291,562 to reflect the closure of two residential settings at Southbury Training School (STS) and three group homes. ▪ Provides funding of $4,119,227 in the Community Residential Services account to fund

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	substance abuse disorder) who are transitioning out of nursing homes, or are at risk of institutionalization, assisting them with community integration (e.g. health and wellness, leisure activities, social roles, etc.). The Department of Developmental Services (DDS) Waiver manager is a member of the MFP Steering Committee and the Nursing Home Closure team. The DDS MFP unit was developed in 2008 and was staffed by one manager. Since January 2012 the DDS MFP unit has been able to add three additional staff funded by MFP.	placements for individuals choosing to leave STS. Funding of $3,278,227 is provided to support 34 new placements for STS residents leaving STS under the Money Follows the Person (MFP) program. Funding of $841,000 is provided for six individuals leaving STS who will be in community placements not supported by the MFP initiative. ▪ Provides funding of $1,517,366 to facilitate the discharge of approximately 25difficult-to-place hospitalized DMHAS clients into appropriate community settings.
(b) <u>GOAL 2. Balancing the ratio of public and private resources</u>		
Increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private insurance represented 7.2 percent of long-term care	Continued implementation of the CT Partnership for Long-Term Care, including outreach and educational efforts. The CT Partnership (the Office of Policy and Management in cooperation with DSS State Unit on Aging and the Area Agencies on Aging)	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
spending in 2005.	held five public forums on long-term care insurance and the importance of planning ahead between 7/1/11-6/30/12. Over 400 consumers were educated.	
STRUCTURAL		
1. Create greater integration of State level long-term care administration and functions serving both older adults and people with disabilities and their families.		**Public Act 11-44, Sections 1-69**: Creation of a new Bureau of Rehabilitative Services by removing the current Bureau of Rehabilitative Services from DSS and merging it with both the Board of Education Services for the Blind (BESB) and the Commission on the Deaf and Hearing Impaired (CDHI). **Public Act 12-1, June Special Session, Sections 28-95:** (1) Makes the Bureau of Rehabilitative Services, created by PA 11-44, a stand-alone entity rather than a bureau within DSS for administrative purposes, (2) renames it the Department of Rehabilitation Services, (3) makes the department head a commissioner instead of an executive director, and

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		(4) makes the newly named bureau a successor authority to the previously named bureau.
a. Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid, Older Americans Act and Veterans Administration (VA) funds rather than divides them.	Since 2009 two additional Aging and Disability Resource Centers (ADRCs) opened in CT. One in the Western region and one in the North Central region serving people with disabilities and people of advanced age. In October 2011, the State Unit on Aging (SUA) recognized the Southwestern Aging and Disability Resource Network (ADRN). The new designation acknowledges the progress of ADRC partners in the interest of becoming fully functioning ADRCs, but also recognizes a lack of available funding to this regional partnership necessary to meet the required criteria. In March 2012, the State Unit on Aging recognized the Eastern ADRN for their partnership and readiness efforts, while simultaneously acknowledging the lack of available resources to meet the required criteria. DMHAS continues as an active partner with the ADRCs, responding to	**Public Act 11-44, Section 145**: Postpones the establishment of the Department on Aging to July 1, 2013. **Public Act 12-104:** Provides $100,000 to establish a State Department on Aging by January 1, 2012. **Public Act 12-1, June Special Session, Section 19**: Moves the start-date for the re-established Department on Aging from July 1, 2013 to January 1, 2013. **Public Act 12-119, Section 10:** Repeals a DSS personal care assistance home-care pilot program for the elderly made unnecessary by the department's implementation of a statewide waiver.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	questions and referrals, as well as sitting on the ADRC Steering Committee. In 2009, the State Unit on Aging was awarded an Administration on Aging grant to implement a Lifespan Respite Program in CT. This three year grant seeks to coordinate resources among agencies across the lifespan and ease caregiver access to respite services for individuals of all ages and disabilities. The State Unit on Aging in cooperation with the Agency on Aging of South Central CT and the VA CT Health Care System are completing the second year of implementation of a Veteran's Directed Home and Community Based Services Program in the south central region of CT. The Veteran's Directed Home and Community Based Services Program provides veterans of all ages the opportunity to self-direct their home and community based services, manage their budgets and hire Personal Care Assistants (PCAs) of their choice. In 2011 the State Unit on Aging expanded the Veteran's Directed Home and Community Based Services	**Public Act 12-1, June Special Session, Section 14**: Requires participants of the PCA waiver, once turning 65, to be transitioned to the Connecticut Home Care Program for Elders (CHCPE) to receive these services. The state's current waiver allows individuals to either stay on the PCA waiver program or transition to the CHCPE.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Program to Fairfield County in collaboration with the Southwestern CT Area Agency on Aging and the VA CT Medical Center. Expansion statewide is expected over the next few years. DSS contracted with Mercer to conduct a study to analyze the MFP demonstration and the Elder, Katie Beckett, Personal Care Attendant and Acquired Brain Injury Home and Community-Based Services waivers, as well as the proposed HIV/AIDS waiver for 1) system efficiencies, 2) quality of care and 3) improvement in employment services. Draft recommendations were presented in October 2010 and stakeholder comments were solicited. DSS applied for and was awarded funding to demonstrate integration of funding sources, including Medicare and Medicaid, to develop an integrated care model for acute and long-term care services. DDS is a partner with DSS and other state agencies to develop a comprehensive training program for all ADRC staff. DDS Helpline and family	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	support staff participated in ADRC training.	
b. Ensure linkages between the Long-Term Care Services and Supports and ADRC Website and other websites that include specific long-term care service information.	Continuous information is sought from the Aging and Disability Resource Networks to update the Long-Term Services and Supports/ADRC Website. Linkages continue to be added to the State Unit on Aging website so consumers can access information from whatever site they happen to land on. MFP was funded to develop a web based system linking discharge planners and others to long-term supports and services. The system will be coordinated with the DSS Modernization efforts, the Administrative Services Organization, State Unit on Aging, and ADRCs.	
c. Provide for global budgeting with flexibility and authority to fund an array of long-term care services and supports, to be adjusted annually based on the projected needs of the population and for inflation.	The State Unit on Aging has been overseeing several initiatives to provide flexible budgeting for long-term care services including: • Embedded a self-directed care option into the Older Americans Act National Family Caregiver Support Program (Title III-E) and the State	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	funded CT Statewide Respite Care Program. • Implemented cost-sharing for National Family Caregiver Support Program recipients with incomes greater than 200 percent of the federal poverty level to generate revenue for Title III-E respite and supplemental services effective 10/1/2011. The implementation of the Veteran's Directed Home and Community Based Services Program in South Central CT and 2011 expansion to Southwestern CT provides veterans of all ages the opportunity to self-direct their home and community based services, manage individual budgets and hire PCAs of their choice. Veteran's Directed Home and Community Based Services participants are allowed to hire spouses. DDS implemented an individual budget system since 1998 that allows flexibility and self direction.	
d. Simplify administration through a reduction in duplication and the development of standardized	Medicaid eligibility will be streamlined by the Modernization initiative within	**Public Act 10-126:** Requires DSS, whenever it sends its annual eligibility

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
contracting, a unified application and assessment instrument for services and efficient application procedures.	DSS. Assessment instruments will be streamlined through the Balancing Incentive Payment Program. Since March 2012 DDS has two DSS Eligibility Specialists working at DDS Central office to facilitate the Medicaid process. Since June 2010 data sharing occurs on a weekly basis between DDS and DSS to ensure better communication and to maintain Medicaid waiver enrollment.	redetermination form to a person participating in the CT Home Care Program for Elders (CHCPE), to notify the access agency or Area Agency on Aging administering the program for that person. DSS contracts with three agencies in different areas of the state to provide coordination, assessment, and monitoring services for CHCPE: CT Community Care, Inc., (the access agency), South Central Area Agency on Aging, and Southwestern Area Agency on Aging.
e. Ensure linkages with the CHOICES Program, ADRCs, Centers for Independent Living, and providers of mental health services for all ages.	DMHAS is represented on the ADRC Steering Committee. The Nursing Home Diversion and Transition Program Nurse Clinicians and the Mental Health Waiver staff actively collaborate on community referrals. In December 2011, DMHAS facilitated a training for the South Central and Western CT ADRCs around DMHAS resources. The DMHAS Resource Guide was distributed. The three ADRC's in CT include members of CHOICES, Area Agency	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	on Aging, Centers for Independent Living and mental health providers. This will continue as more ADRCs are added. Continued efforts to share available information and resources across all programs take place regularly. ADRC program staff has received training from DMHAS on their Diversion and Transition Program for Older Adults. MFP funds mental health services and independent living centers and ADRCs.	
f. Develop systems and technology to share long-term care data. ▪ Improve technology in state systems to implement electronic records and make valuable data readily retrievable. ▪ Assist all health care providers with the implementation of electronic records and the implementation of the statewide electronic data exchange. ▪ Build data capacity and systems integration that facilitates more efficient care management for people receiving services.	MFP developed a web-based data system used by all MFP case managers including transition coordinators. The data system includes a critical incident reporting system. The system is currently under expansion. Applications for services will be stored on the server within six months.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
2. Simplify Connecticut's Medicaid structure.		
a. If the federal government revises their rules to allow it, establish a universal Medicaid home and community-based services waiver based on function, not age or diagnosis. Allow for flexibility to address a variety of specific needs.		States may now apply for a combined 1915C waiver.
b. If it is determined that a universal Medicaid waiver is not feasible, every effort should be made to ensure that eligibility criteria and level of need reporting forms are consistent across waivers.	DSS is preparing a submission for the Balancing Incentive Payment Program (BIPP). Through the BIPP, a common comprehensive level of need tool will be developed.	
c. As an alternative to a universal Medicaid home and community-based services waiver, include home and community-based services, such as personal care assistance, in the State Medicaid Plan. Include programs for adults with developmental disabilities who do not have intellectual disabilities.		
d. Make pilot programs that are proven successful a permanent feature of the Medicaid program. Require evaluation of all pilot programs after three years, including cost-effectiveness.		
e. Streamline Medicaid eligibility procedures, reduce	DSS plans to implement Modernization	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
response time to individuals and develop a web-based on-line application process for Medicaid services.	(web-based application process) to streamline Medicaid in SFY 2012 with the goal to reduce response time. MFP is demonstrating an expedited long-term care process for community placements in coordination with Modernization. Seven eligibility staff positions have been added to MFP to support this initiative.	
f. Ensure interagency accessibility to eligibility application information to streamline the application process for many state programs.	During SFY 2013, agencies will have access to the web-based Medicaid application. In addition, a web based prescreen tool will be implemented.	
g. Explore locating DSS eligibility service workers with ADRCs to reduce Medicaid eligibility determination response time.		
3. Address access and reimbursement for key Medicaid services.		
a. Explore opportunities to work with Connecticut's medical and dental schools and allied health professions to increase access to health care screening and preventive and restorative dentistry. For example, establish a Department of Developmental Services (DDS) Dental Coordinator and possible University of Connecticut dental	MFP is developing an action plan in coordination with the DSS Dental program for implementation in SFY 2012. In 2007 a Dental Coordinator was hired by DDS. The DDS Dental Coordinator	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
fellowship to address the lack of community dental care for persons with cognitive disabilities.	works directly with the Dental Coordinator at the University of Connecticut Dental Program to facilitate access to dental care for individuals with intellectual disabilities. Additionally, the DDS dental coordinator works closely with dental students, dental residents and dental hygiene students to educate them in best practices on delivering care to individuals with intellectual disabilities. DDS has contracts with RN and LPN schools of nursing that provide a clinical practicum for nursing students. These clinical experiences focus on assessment and health promotion for persons with intellectual disabilities.	
b. DSS should assess the feasibility of increasing Medicaid reimbursement rates to attract providers willing to serve individuals with disabilities. Psychiatric, dental, and podiatric services were identified in the Long-Term Care Needs Assessment as a particular problem for those receiving services through the Medicaid program. Difficulties involving access and financing persist, as well as finding medical personnel who are sensitive and respectful to the needs of people with disabilities.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
c. Reinvest the federal Medicaid match obtained through the Money Follows the Person demonstration into long-term care initiatives such as statewide ADRCs, expanded home and community-based programs, nursing facility transition and diversion programs, workforce development, support for informal caregivers, assistive technologies and prevention and wellness programs.	Federal enhanced match is currently reinvested in transition services for those not eligible for MFP services.	**Public Act 11-6**: Eliminates the establishment of a long-term care reinvestment account. These funds will continue to be treated as General Fund revenue.
d. Maximize reimbursement of state long-term care expenditures through an ongoing review process.		
e. Consider setting Medicaid rates based on objective quality measures.	MFP strategic planning initiative includes a review of rates with respect to quality across all long-term care.	
4. Further reform and coordinate the nursing facility/ institutional admission prescreening process.		
a. Expand the current State commitment to prescreen all applicants to nursing facilities age 65 and older, regardless of their payer status, to include all nursing facility applicants, regardless of age or payer source. Similar prescreening for applicants of all institutions for individuals with disabilities should be developed.	DSS, DMHAS and DDS collaborate on the Preadmission Screening Resident Review (PASRR) Program as mandated by OBRA 1987, the Nursing Home Reform Act. DDS Agreement under the Messier Settlement addresses long-term care	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	placement and the DDS Five-year Plan addresses Aging in Place.	
b. Implement a systematic, web-based, comprehensive prescreening program for persons seeking admission in a nursing facility or other institution, regardless of age or payer source. As part of this system, track length of stay in the institution.	DMHAS continues to collaborate with the DSS Alternate Care Unit around the Ascend web-based PASRR program. Monthly conference calls between the three entities continue. DMHAS Nursing Home Diversion and Transition Program nurse clinicians track and monitor the nursing home length of stay of individuals with mental illness, often facilitating the transition of individuals back to the community with supportive services.	**Public Act 12-104:** Provides funding of $300,000 to develop and implement a universal long-term care assessment tool.
c. Enhance existing educational efforts with hospitals, physicians, nursing facilities, and other institutions regarding prescreening and available community options in collaboration with providers and other entities working in the community with individuals with disabilities.	During SFY 2012, DMHAS conducted educational sessions with a variety of health care providers (e.g., nursing home administrators and directors of nursing; home care agencies; CT Hospital Association members; mental health agencies; DSS Protective Services; etc.) to educate them about PASRR and community options that	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	may be accessed through the DMHAS Nursing Home Diversion and Transition Program and the Mental Health Waiver. A Resource Guide is continually updated and distributed to participants. Additionally, Nursing Home Diversion and Transition Program staff conduct monthly meetings at specific nursing homes to review available resources and facilitate discharge planning. MFP conducts extensive training with hospital staff, nursing facility staff, physicians, and others regarding community services, screening, transition, etc. DDS is part of this group. MFP conducts extensive training with hospital staff, nursing facility staff, physicians, and other regarding community services, screening, transition, etc. The web based system will be designed specifically for hospital discharge planners. It will not only provide information about community options, but provide for electronic linkage between discharge planners and home and community service providers.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
d. Identify people who have housing to return to and preserve its availability as part of the prescreening process.	MFP created a streamlined process for hospital discharge and admission to a nursing facility that will identify and transition persons for whom there are no barriers to community living. This process is named a 'track 2 transition' and became fully operational during SFY 2012.	
INFORMATION/ ACCESS		
5. Provide true individual choice and self-direction to all users of long-term care.		
a. Expand self-directed care options under home and community-based services programs. ▪ Allow individuals and family members to choose their own care providers, including individuals from within their own informal care network, particularly family members, and allow individuals to control their own budgets. ▪ Operate programs with as much flexibility as possible, including the ability to arrange for as	The State Unit on Aging has added a permanent self-directed care option to the CT Statewide Respite Care Program and the National Family Caregiver Support Program for all five Area Agency on Aging regions, increasing accessibility to clients living in regions outside the existing piloted areas of South Central and Western CT covered in the Nursing Home Diversion grant that ended in 9/30/10. This statewide	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
many care provider hours as necessary, in whatever configuration across providers as is appropriate and preferred by the person. (See Recommendation #12) ▪ Ensure that self-directed programs are an option, not a requirement or **condition, for receiving home care services.**	option offered clients in this program the option to hire and supervise their own caregiver rather than utilizing an employee of an agency to provide services. It was implemented January 1, 2011for the CT Statewide Respite Care Program and October 1, 2011 for the National Family Caregiver Support Program. It was renamed the "Self Directed Care" option, rather than "Cash and Counseling" to better describe its scope of flexibility to clients. The implementation of the Veteran's Directed Home and Community Based Services Program in South Central CT and 2011 expansion to Southwestern CT provides veterans of all ages the opportunity to self-direct their home and community based services, manage individual budgets and hire PCAs of their choice. All Medicaid waiver programs now have self-direction (hiring staff) as an option. MFP gap analysis identified adult family care and independent support	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	broker as needed service options for persons serviced under the PCA waiver. Adult family care was also identified as a gap under the Elder waiver. Both services were approved as part of the 2012 legislative session. Service definitions will be developed and new services will be available under MFP by August 2012.	
b. Offer where feasible a self-directed care option for programs, including but not limited to the DSS National Family Caregiver Support Program (for those caring for relatives age 60 and older) and the Connecticut State Respite Care Program (for individuals with Alzheimer's disease) using the existing model being piloted under the Nursing Home Diversion Modernization Grants. Also, investigate funding options to support Fiscal Intermediary Services under these and other programs to allow individuals the flexibility to choose and hire their own personal care workers and control their budgets, similar to what are allowed under the current DDS Medicaid waivers.	The State Unit on Aging had overseen an initiative to provide flexible budgeting for long-term care services by embedding a Cash and Counseling option into the Older Americans Act National Family Caregiver Support Program (Title III-E) and the State funded CT Statewide Respite Care program. The State Unit on Aging has expanded these services statewide. This option has been made available to recipients of the CT Statewide Respite Care program and the National Family Caregiver Support Program.	
c. Implement Cash and Counseling as a tool to increase program flexibility and choice. Consider options available under Section 1915 of the federal Deficit Reduction Act to implement Cash and Counseling. Make case management available to those who wish	Case management services are provided through the National Family Caregiver Support Program and the CT Statewide Respite Care program. Each Area Agency on Aging provides case	Legislation approved permitting DSS to apply for a 1915K state plan option.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
to use it but optional for individuals who are able to manage their own care.	management services to address the specific needs of caregivers.	
d. Increase public and professional understanding of individual choice, recovery, independence and self-determination.	DSS and the Department of Public Health (DPH) collaborated on the state's first 'informed choice' conference. DPH clarified the regulations supporting informed choice and risk for licensed providers. MFP created and implemented the first informed risk agreement. The informed risk protocol was supported by the public health legislative work group as a best practice. Multiple training opportunities regarding informed risk are ongoing. DDS staff and providers participated in this process. DMHAS Older Adult Services staff have presented several times to professional and consumer groups on individual choice, recovery, etc. (e.g. DSS access agencies, CT Hospital Association, nursing facilities, National Association of State Mental Health Program Directors Older Persons Division). Additionally, DMHAS participates in the training efforts of peer support specialists enrolled in Recovery University (run by Advocacy	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Unlimited), and also conducts a 2-day training on these issues as they relate to aging and mental health State Unit on Aging and Area Agency on Aging staff have done several presentations to professional and consumer groups regarding individual choice, self-direction etc., including presenting on the Veteran's Directed Home and Community Based Services Program at venues such as the C4A Aging and Mental Health Conference and the March 2011 ADRC Statewide Meeting.	
e. Identify appropriate funding and provide training opportunities about choice, autonomy and dignity and the assistance available for transitioning from institutions to the community and the services available in the community after transition. ▪ Training should be available for people with disabilities, conservators, guardians, families, probate system staff, medical personnel, social workers, clergy, attorneys and others. Training of people with disabilities, families and professionals should include recognizing signs of abuse and neglect.	After the statewide 'informed choice' conference referenced above, regional training was hosted in September 2011 regarding informed choice and the supportive interpretation of regulation. MFP conducts extensive training for professionals. Recovery University is available to persons with mental illness who want to become certified peer recovery support specialists. Additionally, DMHAS provides training in these areas for	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Training should be updated to include recent revisions to the conservatorship statutes which promote self-determination. ▪ There should be training on Social Roles Valorization that would help human service workers better understand the value of social roles and the do's and don'ts of supporting people in the community. Social role valorization starts with the assumption that it is important for people who need long-term care to live in valued residential situations and take on valued roles in the community. This relates both to a person's individual competencies and social image in the community.	Recovery Assistants who work with mental health waiver clients. Connect-Ability Distance Learning Project provides free, accessible training for individuals who have disabilities, their families and others from the community regarding Independent Living and Employment support skills. Modules help individuals learn about employing personal assistants, preparing for emergencies, using service dogs, financial literacy, soft skills to help obtain and retain employment and assistive technology. An independent living skills overview, including a needs assessment and action plan, will be added second quarter 2012. Additional training modules will be added over the next few years to include topics such as benefits counseling, housing and more.	
6. Address education and information needs of the Connecticut public.		
a. Continue and enhance the efforts of the Connecticut Partnership for Long-Term Care (Partnership), the State's public/private alliance to help educate Connecticut residents about the importance of	The CT Partnership (the Office of Policy and Management in cooperation with DSS State Unit on Aging and the Area Agencies on Aging) held five	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
planning ahead for future long-term care needs through the purchase of high quality private long-term care insurance (LTCI). The Partnership should continue its strategy of presenting LTCI as an option that can help individuals remain in their homes or communities longer, preventing or delaying the need for nursing facility care.	public forums on long-term care insurance and the importance of planning ahead between 7/1/11-6/30/12. Over 400 consumers were educated. As of 12/31/11, over 55,000 CT residents owned Partnership for Long-Term Care insurance policies. The Partnership has saved CT's Medicaid program an estimated $13.4 million to date.	
b. Coordinate efforts of the Connecticut Partnership for Long-Term Care with the long-term care support options counseling efforts of the ADRCs.	The five Area Agencies on Aging continue to take on a larger role with the CT Partnership for Long-Term Care in the form of information and referral and coordination of the public forums as part of their CHOICES and ADRC program activities. Additional ADRC staff as well as select CHOICES staff and counselors attended the CT Partnership for Long-Term Care agent trainings in order to receive detailed training on long-term care costs in CT, the need to plan ahead for long-term care and the CT Partnership for Long-Term Care.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
c. Develop targeted information campaigns about long-term care services and supports in collaboration with high-visibility, convenient community partners, such as hospital discharge planning offices, community and senior centers, Area Agencies on Aging (AAAs), ADRCs, public libraries, mental health agencies, advocacy groups, physicians, clergy and teachers. These campaigns should integrate existing Internet resources such as the Long-Term Care Website. Additional training and resources should be provided to those who are the most frequent sources of long-term care information and advice, such as social workers and heath care providers, as well as Probate Court officials and conservators.	MFP currently conducts targeted outreach and plans to develop web-based tools over the next 12 months. In addition to MFP having a dedicated staff person with responsibility for statewide training, MFP partnered with UConn Center on Aging to assist with the development of materials and web-based training modules during SFY 2012. The new web-based information system will also advance this activity. DMHAS developed a video which highlights two waiver clients and the services they now receive in the community. The video, along with other information about the mental health waiver, can be accessed at www.ct.gov/dmhas and hit links for waiver services. DMHAS also developed a "Think Waiver" flyer that is on the DMHAS website and also distributed statewide. ADRCs have developed new program marketing materials and utilized a Long-Term Support Options Counseling brochure at outreach and marketing events.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
d. Initiate a campaign of cultural change around long-term care, especially targeting health care professionals (physicians, nurses, social workers, occupational therapists, physical therapists, etc.). These professions often influence consumer choices.	MFP has initiated a campaign of cultural change. This activity was highlighted as part of the Right-sizing recommendations. Mintz and Hoke are partnering to develop a campaign scheduled for implementation in the fall of SFY 2013. DMHAS Older Adult Services staff has spoken about culture change throughout departmental meetings. Older Adult Services staff were instrumental in revising the department's Nursing Home Placement Policy which emphasizes a culture change in long-term care for persons with a mental illness.	
7. Develop and implement a statewide system of Aging and Disability Resource Centers for providing information, referral, assistance and long-term care support options.		**Public Act 12-119, Section 1:** Directs DSS to develop and administer a statewide Community Choices (ADRC) program.
a. Use the existing model from the DSS State Unit on Aging, through leveraging of available funding sources including the federal Administration on Aging, to enhance ADRC services in south central and western Connecticut.	As of 2012, three ADRCs exist in CT and meet the fully functioning criteria set forth in June 2010 by the Administration on Aging. These ADRCs are located in the South Central, Western, and North Central regions of the state. In October 2011, the State	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Unit on Aging recognized the Southwestern Aging and Disability Resource Network (ADRN). The new designation acknowledges the progress of Aging and Disability partners in the interest of becoming fully functioning ADRCs, but also recognizes a lack of available funding to this regional partnership necessary to meet the aforementioned criteria. In March 2012, the State Unit on Aging recognized the Eastern ADRN for their partnership and readiness efforts, while simultaneously acknowledging the lack of available resources to meet the required criteria. Therefore, the statewide system structure is in place pending available funding. Four federal grants were awarded to DSS under the Affordable Care Act as of October 1, 2010. CT was one of only four states to receive all four ADRC funding opportunities. 1. The formula funded opportunity, Medicare Improvement for Patients and Providers Act, made funding available to Area Agencies on Aging, State Health Insurance	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Programs, and ADRCs through states for outreach/ assistance on additional programs for low-income Medicare beneficiaries including preventative benefits. $442,003 2. The competitive funding opportunity, ADRC Options Counseling Grant, strengthens options counseling in existing ADRCs. $500,000 3. The competitive funding opportunity, ADRC Evidence-Based Care Transition Grant, strengthens CT's existing care transition intervention model in the North Central ADRC with the Hospital of Central CT. The purpose of the funds is to prevent unnecessary hospital readmissions. $193,418 for one year and potential for funding in 2nd year. 4. The competitive funding opportunity, ADRC Nursing Home Transition and Diversion Programs Grant, provides supplemental administrative funds through MFP to strengthen the capacity of existing	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	ADRCs. The purpose of the funds is to assist with the implementation of the Nursing Home Minimum Date Set version 3.0, Section Q. $448,500	
b. Implement new ADRCs in the remaining three areas of the state: eastern, southwestern, and north central. Base further development of the model upon evaluation of the existing ADRCs and tracking of their quality and efficiency.	In May 2010, a third ADRC was established in the North Central region. A statewide ADRC Five Year Plan was submitted to the Administration on Aging in April 2011 and includes expansion plans for the eastern and southwestern regions of the state. In October 2011, the State Unit on Aging recognized the Southwestern Aging and Disability Resource Network (ADRN). The new designation acknowledges the progress of Aging and Disability partners in the interest of becoming fully functioning ADRCs, but also recognizes a lack of available funding to this regional partnership necessary to meet the aforementioned criteria. In March 2012, the State Unit on Aging recognized the Eastern ADRN for their partnership and readiness efforts, while simultaneously acknowledging the lack of available	**Public Act 12-119, Section 1**: Directs DSS to develop and administer a statewide Community Choices (ADRC) program.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	resources to meet the required criteria. Therefore, the statewide system structure is in place pending available funding.	
c. Build on the existing model with Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) as the core regional partners providing comprehensive information and assistance and explore other disability and mental health models and regional partners to maximize the variety and creativity of approaches. Continue to integrate disability specific agencies in the ADRC network, including mental health agencies and advocacy organizations.	The North Central ADRC, established in May 2010, is a collaboration among the State Unit on Aging, North Central Area Agency on Aging, Independence Unlimited, and CT Community Care, Inc. Continued collaboration exists at both the regional ADRC level and the state level through the Statewide ADRC Committee.	
d. Train ADRC staff, utilize a comprehensive resource database, create management information system (MIS) database tracking, and enhance the Long-Term Care Website to include interactive features.	ADRC staff receives ongoing training. Recent 2012 training includes an overview of the Long-Term Services and Supports website. ADRC staff will have access to the comprehensive resource database developed under the MFP imitative.	
e. Build on the connection with the CHOICES program, the widely recognized information and assistance program operating out of the AAAs.	The CHOICES program and ADRCs are working very closely together.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
WORKFORCE		
8. Address the long-term care workforce shortage.		
a. Enhance public perception of long-term care jobs and professionalize paraprofessional positions.	MFP workforce development workgroup developed a strategic plan to support expansion of 9,000 additional long-term care workers by 2016. $300,000 per year is available to fund the plan. DDS also participates. As part of Right-sizing, an additional $400,000 was appropriated by Public Act 12-104 to assist with workforce development. Mintz and Hoke are partners leading this effort.	**Public Act 12-33**: Allows certain personal care attendants (PCAs) to collectively bargain with the state through an employee organization (i.e. a union) over reimbursement rates, benefits, payment procedures, contract grievance arbitration, training, professional development, and other requirements and opportunities. The bill creates a PCA Workforce Council to study and plan for improving PCA quality, stability, and availability. It also (1) requires DSS and the council to compile and maintain lists of covered child care providers and PCAs lists, respectively; and (2) provides liability protection for the state under certain circumstances. **Public Act 12-104**: As part of Right-sizing, an additional $400,000 was appropriated to assist with workforce development. DSS and the public

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		relations firm Mintz and Hoke are partners leading this effort.
b. Promote flexibility of workplace employment policies and practices. Flexibility is important not only for older workers who may need to work longer than planned, but also for caregivers.		
c. Develop career paths allowing for increases in responsibility, status and wages.	DMHAS created a position of Recovery Assistant to work with mental health waiver clients. This new position emphasizes knowledge about mental illness, person-centered care planning, and principles of recovery. The position combines the tasks of a PCA, homemaker, companion, and respite worker. Recovery Assistants are employed by private agencies authorized to provide services to mental health waiver clients. Currently, 525 people have completed Recovery Assistant training. The approval of nurse delegation in the state and the subsequent development of a newly certificated medication administration designation offer home health aides the option of increasing responsibility, status and potentially wages.	**Public Act 12-1, June Special Session, Section 11:** Permits a registered nurse to delegate the administration of medications that are not injected into patients to homemaker-home health aides who obtain certification for medication administration. **Public Act 12-1, June Special Session, Section 12:** Provides that nothing in the Nurse Practice Act can be construed to prohibit a PCA employed by a registered homemaker-companion agency from administering medications to a competent adult who directs his or her own care and makes his or her own decisions pertaining to assessment, planning, and evaluation.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
d. Create loan forgiveness programs for students graduating into professions where there is a shortage of workers, requiring employment within long-term care settings that have the greatest need.		
e. Develop, coordinate and expand education and training programs targeted to areas of workforce shortages. ▪ Attract students into the field with scholarships and grants. Education and training curricula should be considered beginning in high school. ▪ Provide re-training for individuals who lose their job in such sectors as manufacturing and institutional care for new careers in long-term care, especially home and community-based care. ▪ Expand efforts at collaboration among the Connecticut Department of Labor, the Workforce Investment Boards and the Older Workers program to address the needs of workers who have lost their jobs and need to be retrained in order to support themselves. ▪ Promote distance learning as an option for workforce shortage areas.	American Recovery and Reinvestment Act of 2009 dollars provided to expand efforts of the Older Workers program in CT allowed for the retraining and education of older workers in new skills to obtain employment. American Recovery and Reinvestment Act of 2009 dollars provided to expand efforts of the Older Workers program in CT allowed for the retraining and education of older workers in new skills to obtain employment. MFP is actively partnering with the Department of Labor regarding training and retraining especially as it relates to staff at closing nursing facilities.	**Public Act 10-3, Section 29:** By January 1, 2011, the education commissioner and the vocational-technical school system superintendent must establish and administer licensed practical nurse programs at six vocational-technical schools. The school locations must be distributed on an equitable geographic basis throughout the state. The requirement applies unless the education commissioner notifies the Education Committee by November 1, 2010 that he will not establish the programs and the reasons why. If the appropriation for the programs is too little to cover their costs, the bill allows program tuition to be increased to cover the shortfall. **Public Act 10-8:** Specifically authorizes the CT State University System (CSUS) to award doctoral degrees in nursing education. It

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Provide opportunities for college students seeking internships or community service. College students are often interested in a year of community service after college, but before entering the work world.		expands the CSUS's degree-granting authority, which currently includes doctoral degrees in education; master's degrees and other graduate study in education; and liberal arts and career programs at the bachelors, masters, and sixth year level.
f. Inventory existing direct care workforce initiatives to identify duplication and gaps.	MFP workforce development workgroup led a mapping initiative funded by the federal Centers for Medicare and Medicaid to identify duplication and gaps. In May 2012 MFP was awarded additional technical assistance regarding this initiative.	
g. Review the current licensing certification statutes for formal caregivers to be sure that appropriate skills, training and roles are required as the system of formal caregiving evolves.		
h. Engage Workforce Investment Boards to develop approaches to increase the size of the formal long-term care workforce, including training, education and incentives. The wage gaps, including benefits, between public and private frontline workers and across those workers who care for different populations should be addressed. Transportation issues must also be addressed.	The MFP workforce development workgroup has developed a partnership with the Workforce Incentive Boards.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
i. Allow individuals to choose their own care-providers and increase flexibility in Connecticut's self-direction model to increase availability of workers and help to address the workforce shortage. (See Recommendation #5)	Participants in all Medicaid waivers now have the option to choose their own staff. The State Unit on Aging has implemented two self-directed care models that allow individuals to select the caregiver of their choice: 1) A self directed care option through the Older Americans Act National Family Caregiver Support Program (Title III-E) and CT Statewide Respite Care Program and 2) the Veteran's Directed Home and Community Based Services option in the south central region of the state.	
j. Expand the use of the non-traditional workforce, such as personal care assistants (PCAs) and personal care managers, to help address the increased number of individuals desiring home and community-based care. To make the positions competitive and a viable career, these types of jobs must provide the necessary worker benefits and supports, including health insurance. Low cost opportunities for health insurance for PCAs should also be explored.	Several times a year, DMHAS offers two-day trainings for recovery assistants (RAs) who work with Mental Health Waiver clients. Thus far, over 300 RAs have been trained. Generally, RAs are employed by community home care agencies. Recovery University trains consumers of mental health services to be certified peer recovery support specialists, a job classification acknowledged by the State of CT. DDS and DMHAS collaborated for a	**Public Act 12-33**: Allows certain personal care attendants to collectively bargain with the state.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Nursing home closure to assist two individuals to live together and the DDS provider attended the RA training.	
k. Support the creation and availability of PCA registries such as *www.rewardingwork.com* .		
l. Recruit bilingual multicultural individuals to long-term care positions.		
9. Provide support to informal caregivers.	The MFP workforce workgroup is researching national best practices and will propose an initiative to provide additional support to Medicaid eligible participants by June 2012. UConn Center on Aging is conducting research regarding burden and stress of informal caregivers that will provide the baseline benchmark for MFP interventions.	
a. Provide support for informal caregivers and family members in a variety of coordinated forms, such as information and training, respite services, tax benefits and incentives, payment to informal caregivers, transportation alternatives, physical, occupational and speech therapy alternatives, and mental health and disability supports such as peer	The State Unit on Aging has been overseeing an initiative to provide flexible budgeting for long-term care services by embedding a cash and counseling option into Older Americans Act National Family Caregiver Support Program and the State funded CT	**Public Act 10-179: Section 1:** Increase appropriation for Alzheimer's Respite Program from $2,294,338 to $2,794,338 in SFY 2011. **June Special Session, Public Act 10-**

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
support, mobile crisis information, psychoeducation, disability education, wellness and recovery planning, and counseling. Assessment and periodic reassessments of the capabilities and needs of family caregivers should also be provided, especially when there may be specific caregiving challenges such as caring for individuals with dementia and Alzheimer's disease.	Statewide Respite Care program. This option has been made available to recipients of the Statewide Respite Care program effective 1/1/2011 and the National Family Caregiver Support Program effective 10/1/2011. The Veteran's Directed Home and Community Based Services Program can serve to provide respite services to caregivers of veterans regardless of age. Additionally the VA launched a caregiver web site and toll-free number for support.	**2: Section 1:** Reduces the DSS appropriation for Alzheimer Respite Care by $500,000 in SFY 2011.
b. Increase availability of and access to respite and adult day programs statewide without age and specified disability restrictions. Inventory existing programs and coordinate easier access to respite services by individuals of all ages and disabilities. For example, replicate the Alzheimer's Respite Care program to provide respite services for any caregiver of individuals with disabilities of all ages. Such expanded respite care services would need to be flexible enough to accommodate any unique caregiving challenges for individuals with specific disabilities, such as Alzheimer's disease.	The Lifespan Respite Grant, received by the State Unit on Aging, seeks to inventory existing respite services to individuals across the lifespan, as well as to establish best practices for future development of innovative respite options for caregivers of individuals of all ages and disabilities.	
c. Explore the potential for supporting overnight respite care in settings other than institutions, such		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
as evening or overnight adult day care. This should include consideration of licensing and Medicaid reimbursement issues.		
d. Build on and expand current efforts supported under the National Family Caregiver Support Program, enhancing the basic information, training and respite services that are already provided.		
e. Support partnerships across State agencies to share information on age and disease specific programming for caregivers and develop coordinated sources for caregivers to obtain information on available respite services, utilizing ADRCs.		
f. Expand and support caregiver respite service options through the availability of flexible respite services, including respite services provided in an individual's or caregiver's home. (See Recommendation # 5)	The Veteran's Directed Home and Community Based Services Program provides respite to overburdened caregivers in many forms including the provision of a PCA of the family's choice (this can even be a spouse).	
g. Explore informal peer support training as a means to meeting needs without increasing the cost associated with licensed or other professional personnel.	Coordination with the Chronic Disease Self-Management Program and the National Family Caregiver Support Program is taking place in order to provide training to caregivers and consumers on how to manage chronic	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	health conditions and lessen the adverse effects of caregiver stress and anxiety. ADRC staff have become trained CDSMP lay leaders to facilitate additional community based trainings in connection with Care Transition work.	
QUALITY		
10. Promote efforts to enhance quality of life in various settings.		
a. Include a structure and process to ensure quality oversight throughout the system.	The MFP quality management system will be implemented during SFY 2013.	
b. Develop improved quality measures for persons with long-term care needs in the community under person-centered, self-directed programs. Such measures must reflect the individuals' own preferences and desires and allow reasonable risks while still avoiding unreasonable risks. The individual's right to "Dignity of Risk" should be honored. An individual must be able to give "informed consent" to undertaking a risk that might otherwise be considered a compromise of quality of care.	The University of CT concluded research on outcomes of the DMHAS Mental Health Waiver Program, finding high rates of satisfaction among clients receiving long-term care services in the community. The DMHAS Olmstead Initiative is currently tracking outcomes related to community integration of clients transitioned out of nursing home settings. MFP operates under a continuous	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	quality improvement process.	
c. Increase the quality of care in the various long-term care settings by including educational programs, identification of mechanisms that encourage longevity of employment, team building concepts and education of the public regarding the continuum of care. Include education about evidenced-based programs such as fall prevention, Gatekeeper Program, Healthy IDEAS (Identify Depression, Empowering Activities for Seniors), and Chronic Disease Self- Management.	DMHAS Older Adult Services staff provide on-going education statewide regarding the newly implemented Gatekeeper Program. Nursing Home Diversion and Transition Program staff received training in the DSS-sponsored Live Well Program, as well as a similar program developed by the Lilly Pharmaceutical Company. Staff is exploring ways to implement this type of programming in nursing facility settings to prepare clients for transitioning to the community. DMHAS has also implemented Double Trouble programs in certain nursing facilities to educate clients about recovery from mental illness and substance abuse. And the DMHAS Olmstead Initiative peers work with older adult clients around factors related to community integration.	
d. Incorporate the needs of older adults and persons with disabilities in all state emergency planning.	DDS public and private congregate day and residential service sites have emergency response plans that include identified sites for relocation in the event of an emergency.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DDS has identified personnel who participate in the State Emergency Operations Center should the governor activate the Center in the event of an emergency. DDS, on a monthly basis, sends to the Connecticut Department of Emergency Management and Homeland Security (DEMHS) data about the number, location, and contact information regarding congregate day and residential service sites located in each of the 169 towns in Connecticut. This information in turn is sent by DEMHS to each of the towns' Emergency Management Directors to be used in their emergency planning and response efforts. DDS personnel, in conjunction with other people representing an array of citizens with disabilities, has trained over 2,100 first responders in the 41 town Capital Region regarding the functional needs of people with disabilities in emergency circumstances such as needs during evacuation, shelter, and relocation situations. DDS participates on a quarterly basis	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	with local, state and federal officials from Emergency Planning Zone towns in and around the Millstone Nuclear Power Plant to design, exercise and evaluate emergency planning and response protocols in the event of a radiological incident at the Millstone Nuclear power Plant. DDS regularly and actively participates in State and federally sponsored emergency management drills. DDS personnel are members of the Statewide Mass Care Emergency Support Function, ESF 6, group tasked with, among other things the review and revision as necessary of the Mass Care template of the Local Emergency Operations Plan that standardizes comprehensive statewide and regional approaches for support services and temporary shelters for all Connecticut citizens, including people with disabilities, during disasters and public health emergencies. Connect-Ability's Distance Learning Initiative provides free, accessible training for individuals who have	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	disabilities, their families and others from the community. The Emergency Preparedness modules helps individuals with disabilities and their family develop and coordinate a plan and an emergency preparedness kit.	
e. Employ a state disability coordinator who can organize and coordinate emergency preparedness trainings with people with disabilities for fire responders, emergency medical technicians (EMT), police and community teams.		
f. Support the purchase and maintenance of assistive technology. More emphasis should also be placed on the use of robotics in the home to assist with activities of daily living. Expenditures for assistive technology can be minor when compared to the extended cost of human services for personal assistance. This technology can allow an individual to maintain or regain independence and reduce their reliance on paid services.	Assistive technology devices are an available service through the National Family Caregiver Support Program as a supplemental service item. Veterans on the Veteran's Directed Home and Community Based Services Program may use their flexible service budgets to purchase assistive technology devices when not covered under traditional VA programs and funding sources. This program also allows veterans to save and plan for more costly purchases through a planned savings component of the program. The Bureau of Rehabilitative Services	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	(BRS) also administers the CT Tech Act Project, which helps to increase access to assistive technology devices through a variety of services, information and referral, and the provision of an alternative financial loan program for the purchase of assistive technology. Assistive technology is a primary focus of the MFP demonstration. ADRC staff received training in 2011 on the CT Tech Act Project and available technology devices for purposes of providing information and resources to consumers. Connect-Ability's Distance Learning Initiative provides free, accessible training for individuals who have disabilities, their families and others from the community. Modules help individuals learn about assistive technology options. The DMHAS Mental Health Waiver and also the DMHAS Acquired Brain Injury Program include home modifications and assistive technology in its range of services.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
g. Utilize federal and state health promotion resources through adoption of Evidence-Based Programs.	State Unit on Aging has successfully obtained grants from Centers for Medicare and Medicaid Services (CMS) and Administration on Aging Chronic Disease Self Management Programs in partnership with DPH. These are evidenced-based programs that have been rolled out across the state. The State Unit on Aging has received a grant continuation for the 2007 Evidence-Based Program Grant to introduce the Tai Chi: Movement for Better Balance evidence-based program in the Western and South Central Regions. The State Unit on Aging was awarded a $400,000 American Recovery and Reinvestment Act of 2009 Chronic Disease Self-Management Program grant from the Administration on Aging to systematically embed the Chronic Disease Self-management Program statewide in supportive partnership with Medicaid, ADRCs and the Area Agencies on Aging. This grant ended on 3/31/2012 with 920 participants and 684 course completers reached	The Yale CT Collaboration for Fall Prevention (CCFP) received an allocation from the state legislature to continue the Statewide Fall Prevention Project to provide training for clinicians and other target groups in the community with strategies for fall risk assessment and intervention.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	statewide. To date the Chronic Disease Self-Management Program has reached sustainability through continuation of Area Agency on Aging regional coordinators. Coordinators are funded through Administration on Aging Title IIID Disease Prevention and Health Promotion funds and funds from the Center for Disease Control through the DPH. DMHAS Older Adult Services implemented a statewide Gatekeeper Program and has participated in training for the Live Well Program which emphasizes chronic disease self-management.	
h. Establish a working Fall Prevention partnership between the DSS Aging Services Division and the DPH to expand current DPH fall prevention projects (i.e. home safety assessments, fall prevention seminars, medication safety programs, and fall prevention exercise classes) to serve new populations and geographic areas. Conduct social marketing, distribute public education materials, and utilize the media. Coordinate these activities with other existing Fall Prevention programs in the state. While fall prevention efforts are primarily focused on older adults, fall prevention programs should be	The CT Collaboration for Fall Prevention through Yale has been expanding their fall prevention assessment, training and outreach initiative statewide utilizing state funds through the State Unit on Aging. The State Unit on Aging received a grant continuation for the 2007 Evidence-Based Program Federal Grant to introduce the Tai Chi: Movement for Better Balance evidence-based program	Fall Prevention Program received additional funding in SFY 2010 and 2011 from the insurance fund in the amount of $950,000 for the two years.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
available to individuals of all ages.	in the Western and South Central Regions. This Tai Chi intervention focuses on fall prevention and is a partnership between the State Unit on Aging and DPH. This Tai Chi project started in 2010 and will continue into 2012. Through the CT Collaboration, evidence-based fall prevention programs will continue to meet the needs of CT's older adults. Assessment, training and outreach initiatives continue as well as a statewide coordinated effort to continue Tai Chi: Moving for Better Balance. DDS has implemented a fall risk screening and assessment protocol for individuals in community residences and programs. Information is collected and plans developed to minimize fall risk as appropriate.	
i. In addition to family guardians and conservators, investigate establishing a public guardian/ conservator in Connecticut and require that all guardian/conservators be trained (www.guardianship.org).		
j. Address the isolation and segregation of older adults	Data is collected on all MFP	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
and people with disabilities by emphasizing connection to natural supports and community as well as social and recreational opportunities. This should include strategies to link individuals with informal, non-paid networks. Support for transportation options to aid and encourage participation is also important.	participants to identify persons who have transitioned from a nursing facility to the community and feel isolated. Interventions to address isolation are implemented if needed. The DMHAS Olmstead Initiative utilizes older adult peers to work with older adults with psychiatric disabilities who are transitioning from nursing homes, helping them to identify key interests related to community integration (i.e., libraries; senior centers; hobbies; etc.).	
11. Address the scope and quality of institutional care.		
a. Develop a plan to modernize the physical plants of existing nursing facilities when feasible and appropriate. Modernized and high quality skilled nursing facilities are needed as an available option for consumers of long-term care.		
b. Explore the concept of the small nursing home and compare to the current nursing facility model in terms of reducing acute care hospital admissions, complications and declines in health and function and assessing overall costs.		**Public Act 11-6**: Reduced funding by $750,000 in SFY 2013 to reflect capping any further development of small house nursing home beds at 280.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
c. As nursing facilities and other institutions close, or occupancy levels are reduced, Connecticut should continually conduct a needs analysis to: 1) determine if any of the beds are needed elsewhere in the system; and 2) de-license, reclassify, or hold in abeyance the remaining beds. Distinctions should be made between beds serving long-term care needs and beds serving post-acute rehabilitation needs. Data and analysis is needed to guide both providers and policy makers. As this occurs, there is an opportunity to redirect the appropriate level of resources to enhance home and community-based services and supports.	DSS is developing a right-sizing plan scheduled for implementation in SFY 2013. The plan will guide future workforce development, community housing, nursing facility closure or down-sizing – or addition of beds if merited, at a community level. Funded by MFP, Mercer Consulting is assessing the projecting demand for long-term services and supports on a semiannual basis.	
PROGRAM AND SERVICES		
12. Provide a broader range of community-based choices for long-term care supports, foster flexibility in home care delivery, and promote independence, aging in place and other community solutions.		**Special Act 12-6:** Establishes a task force to study how the State can encourage "aging in place" that must include an examination of (1) infrastructure and transportation improvements, (2) zoning changes to facilitate home care, (3) enhanced nutrition programs and delivery options, (4) improved fraud and abuse protections, (5) expansion of home medical care options, (6) tax

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		incentives, and (7) incentives for private insurance. No later than January 1, 2013, the task force must submit a report on its findings and recommendations to the General Assembly and the task force will terminate on the date that it submits such report or January 1, 2013, whichever is later. **Public Act 12-104:** Reduce funding by $500,000 to reflect the addition of adult family living services to the Connecticut Home Care Program for Elders and the Personal Care Assistance waiver. This allows individuals who provide adult family living (adult foster care) services to receive a stipend based on the person's activities of daily living and cognitive needs. This would not be available to family members who have already been providing this service.
a. Develop increased flexibility in Connecticut's highly professionalized model of home care delivery without sacrificing quality of care and health and safety concerns. In the current model, both agencies and individual providers are sometimes subject to	Independent Support Broker was added to the PCA waiver and to MFP during the 2012 legislative session. This year the Veteran's Directed Home	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
extensive and inflexible licensing requirements and regulations. ▪ Reduce restrictions on who can provide home and community-based services to foster personal choice and independence, flexibility, aging in place, and the needs of caregivers. States such as Oregon and Washington can serve as useful models. ▪ Study, and implement where appropriate, scope of practice issues, such as delegation of specific tasks in specific settings, and use of lower cost alternatives (e.g. homemaker vs. home health care) while not compromising the quality of care. ▪ Review the current scope of practice definitions for the nursing professions, and develop options for refinement in order to promote flexibility. ▪ Consider allowing under Medicaid waivers and public funding an independent provider model in which providers are not required to work for an agency, a model that is more cost-effective and flexible. DDS currently employs such a model.	and Community Based Services Program expanded the role of PCA to allow for spouses to serve as paid PCAs.	
b. Provide incentives to existing, experienced providers to transition or expand their services to provide more community-based options.	MFP Right-sizing initiative is funded to provide options for institutional providers to diversify their business	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	model to provide community long-term care services.	
c. Break down the barriers to community integration, such as the "not in my backyard" syndrome.	MFP engages in one-on-one outreach as each person transitions to the community.	
d. Expand the Veterans directed home and community-based program being developed and piloted in the south central region of the state through the DSS State Unit on Aging, Area Agency of South Central Connecticut and the Veterans Administration Connecticut Health Care System, West Haven Office. Enhance partnerships between the aging and disability networks and the Veterans Administration to better serve veterans of all ages and disabilities.	The State Unit on Aging in cooperation with the Agency on Aging of South Central CT and the VA CT Health Care System concluded the first year of implementation of the Veteran's Directed Home and Community Based Services Program in the south central region of CT serving the maximum allowable number of veterans (46). In SFY 2011, in partnership with the Southwestern CT Area Agency on Aging, the program expanded into Fairfield County and has served 15 veterans. The expectation is that the model will be implemented statewide in the future.	
e. Enhance the availability of and access to community mental health services to support individuals at home. This includes improving access to Local Mental Health Authorities in addition to advocating for investment in the creation of a comprehensive system of community mental health services.	On an ongoing basis, DMHAS Older Adult Services provides education to Local Mental Health Authorities and other community providers on older adults with mental health and/or substance abuse problems. A Resource	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Through collaboration with the Local Mental Health Authorities and other service providers, expand the capacity of the DMHAS Older Adult Services to educate the system about the aging process and develop services that meet the behavioral health needs of older adults, particularly services that provide interventions in homes and communities to promote aging in place over institutionalization.	Guide has been developed outlining ways to access mental health resources. DMHAS implemented a statewide Gatekeeper Program to help identify older adults at-risk in the community. Every year a two-day training is held for providers around the topic of aging and mental health. Nursing Home Diversion and Transition Program nurse clinicians and Mental Health Waiver staff collaborate with the ADRCs to help link people to community mental health services. For the past five to six years, DMHAS has acted as a consultant to the conference planning committee of the CT Association of Area Agencies on Aging, assisting with incorporating topics and speakers on mental health issues into the annual conference.	
f. Expand the number of slots, funding and case management in the various community-based State-funded and Medicaid waiver programs, including the Connecticut Home Care Program for Elders, Connecticut Home Care Program for People with Disabilities, Personal Care Assistance, Acquired Brain Injury, Katie Beckett, Mental Health Waiver, the DDS Comprehensive Supports Waiver and the DDS Individual and Family Support Waiver. Some of these programs have a waiting list and this	MFP increases capacity, funding and, if necessary, slots for each MFP participant after 365 days. The Acquired Brain Injury Waiver was renewed by CMS for January 1, 2012, adding 25 additional slots for persons transitioning from MFP to the Acquired Brain Injury Waiver.	**Public Act 12-104:** Increases funding for Traumatic Brain Injury (TBI) Community Services Placements by providing funding of $1.5 million to reflect six additional placements.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
impedes the ability of persons with disabilities from transitioning into or remaining in the community.	As of April 1, 2012, the DMHAS Mental Health Medicaid Waiver was renewed by CMS for another five years, with an increase from 216 client slots to 553 client slots. In April 2011 DDS was approved to operate a third waiver EDS-Employment and Supports Waiver. On April 30, 2012 DDS applied for an Autism Waiver pending CMS approval.	
g. Continue to advocate for changes to federal Medicaid law that will facilitate an expansion of home and community-based options. In the past, Connecticut submitted a proposal to the federal Centers for Medicare and Medicaid Services (CMS) to expand the medically needy income formula allowing individuals with incomes in excess of 300 percent of Supplemental Security Income to be eligible under the Medicaid portion of the Connecticut Home Care Program for Elders (CHCPE). This proposal would have allowed individuals the same access to home and community-based care as they have for nursing facility care. Unfortunately, Connecticut's proposal was rejected by CMS. Connecticut should resubmit this proposal and continue its efforts in this regard. If successful in its effort to expand the income		

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requirements under the CHCPE rules, Connecticut should also examine the feasibility of utilizing similar income requirements under its other Medicaid home and community-based services waiver programs, resulting in equal access to home and community-based care and nursing facility care for individuals of all ages and disabilities.		
h. Current Medicaid law prohibits the reimbursement of room and board charges for those living in the community, including in assisted living communities. Connecticut should continue its efforts to remove this prohibition or expand other State and federal programs such as Section 8 housing vouchers, allowing more aggressive development of community living options.		
i. Enhance rates and grants to home and community-based service providers in order to develop and maintain an adequate network of services.		
j. Allow reimbursement for adult day care for residents of subsidized assisted living facilities.		
k. Enhance interagency efforts to offer community-based service options to dually diagnosed individuals.	MFP has transitioned several persons who share an apartment where services are coordinated between waiver operating agencies.	

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l. Explore Aging in Place models of community living, such as the Beacon Hill Village in Massachusetts (www.beaconhillvillage.org), that are designed to enable people to stay in their neighborhoods as they age, by organizing and delivering programs and services that allow them to lead safe, healthy productive lives in their own homes.	Funding for the Community Renewal Team's Grandfamilies Housing Development, Generations, was provided through the Department of Housing and Urban Development (HUD), Department of Economic and Community Development (DECD), the City of Hartford and DSS Aging Services Division. Services for seniors and/or grandparents raising their grandchildren have been established allowing for comprehensive on-site support services in a community setting.	
13. Increase availability of readily accessible, affordable and inclusive transportation.		
a. Increase the availability and affordability of transportation options available to aging individuals and those with disabilities that provide transport not only for medically-related purposes, but also employment, social and recreational activities through utilization of models such as the Independent Transportation Network (ITN - http://itnamerica.org), expansion of the Municipal Matching Grant program funded through the Connecticut Department of Transportation (CT DOT), and volunteer programs such as Interfaith Caregivers and RSVP.	Funding for the Municipal Grant Program run by DOT was reduced by 25 percent in SFY 2012, decreasing from $4 million in grants to $3 million. Connect-Ability, in partnership with DOT and RideShare, developed the Getting On Board accessible transportation guide for the Eastern, North Central, Northwestern, South Central and Southwestern regions of the state. Guides are available through	**Public Act 11-6**: Eliminates funding of Non-ADA Dial-A-Ride Program ($576,361). This funding is used by the transit districts to support programs in their areas that are not covered by ADA Para-transit service areas or service days, and for people who are not qualified for ADA para-transit services. **Public Act 12-104:** The Americans with Disabilities Act (ADA) Para-

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	transit districts, state agencies, libraries, schools, para-transit providers, hospitals, colleges, Chambers of Commerce and other organizations. A web-based Trip Planner has been developed in partnership with CTTRANSIT and DOT. Trip information is available for the Hartford, New Britain, New Haven and Stamford bus routes at www.cttransit.com/tripplanner. The state's first wheelchair accessible cab became available in October 2009, jointly developed by the City of New Haven's Department of Persons with Disabilities and MetroTaxi, the state's largest full-service taxi company. Connect-Ability continues to support increased access to affordable and available transportation. Metro Taxi in New Haven and Yellow Cab in Hartford requested a total of 140 permits for accessible taxis from DOT. The taxis were purchased with funds from the Department of Energy and uses compressed natural gas. Several individuals with disabilities attended the	Transit Program provides transportation services for disabled persons in all areas with local fixed route bus services. ADA fares increased 4% on 1/1/12 and are scheduled to increase another 4% on 1/1/13. ADA fares have not increased since January 2005. This Act reduces the subsidy by $59,150 due to the 4% fare increase on 1/1/12 and eliminates the 4% fare increase scheduled for 1/1/13. However, sufficient funding is provided in the account to suspend the 4% fare increase planned to take effect 1/1/13.

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	hearing and supported the taxi companies' request. At the annual legislative breakfast, DOT Commissioner gave an update on transportation funding and a shift in direction from a highway focus to a 50/50 highway and transit focus. The monthly transit commuter benefit extension did not pass Congress before the December 31, 2011 deadline and therefore the $230 transit benefit has decreased to $125 per month per person while the parking benefit is indexed up to $240 per month. A workshop entitled The Ever Changing ADA: Understanding Recent Regulations and Court Rulings was held recently at Greater Hartford Transit District. Panelists included representatives from the federal, state and local governments. DOT is seeking proposals for the Federal Transit Administration Program, New Freedom Program. This program is for new public transportation services or alternatives that go above	

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	and beyond the requirements of the ADA. Requests for up to two years of funding will be considered. Projects must be derived from the Locally-Coordinated Public Transit Human Services Transportation Plan (Coordinated Plan). Funds are apportioned to urbanized areas and non-urban areas by formula. The total fund available is $2,135,423.	
b. Encourage municipalities to work together to form regional plans that meet local and regional needs.	The Independent Transportat5ion Network (ITN) model expanded to include program in Westport.	
c. Consider the formation of a broadly representative task force, led by a state-wide liaison from CT DOT, to fully investigate alternative approaches and resource needs to improve transportation options. Coordinate with the Medicaid Infrastructure Grant (Connect-Ability) team which has identified transportation as a priority area.	Connect-Ability will continue partnership with DOT, transit agencies, transit planners and the Community Association for Community Transportation to address the needs assessment of the Locally-Coordinated Public Transit Human Services Transportation Plan (Coordinated Plan) to reduce barriers to employment.	
d. Give priority to the availability of public transportation resources whenever new housing resources are being developed for individuals with disabilities or the general public.	DECD encourages its housing developers to undertake responsible development strategies for state and federally funded projects. These strategies include the development of	

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	mixed-use properties located in regional or rural community centers where there is access to public transportation, and an existing ADA compliant infrastructure within walking distance to shopping, education, recreational and municipal and social services.	
e. Provide transportation options beyond the limitations of the existing Medicaid medical transportation contracts to participants of Medicaid home and community-based services waiver programs. A recurring problem is the lack of same day transportation to unanticipated medical appointments. Another obstacle is that social service provider organizations willing to provide transportation to their customers receive no specific reimbursement for this expense.		
f. Persons with disabilities who want to access public transportation may not be able to get to and from the public transportation lines. Explore solutions to this barrier to transportation, such as reconfiguring vans funded under the federal Capital Assistance Program for Elderly Persons and Persons with Disabilities (Section 5310C) into a feeder-system so these vans can take people with disabilities to and from public transportation lines. Also address the need for para-transit services in rural areas due to the limited availability of public transportation.		

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g. Provide adequate funding for the Dial-a-Ride Program (municipal match for demand-responsive transportation).		
h. Enhance sidewalks, cross-signals, crosswalks, and curb cuts to ensure pedestrian access.		
14. Preserve and expand affordable and accessible housing for older adults and individuals with disabilities.		**Public Act 12-104:** Expand Congregate Housing Program by providing $202,500 for rental assistance to low income tenants and supportive services at 50 units of new congregate housing (to be built with $12.5 million in capital funding in SFY 13). The supportive services include: one main meal per day, housekeeping services, a twenty four hour emergency service, a resident services coordinator, emergency transportation services, and a wellness program.
a. Promote universal design and "Visit-ability" in new building projects and with architects and housing developers. Require Visit-ability standards as part of tax credits to builders for affordable housing.	State Unit on Aging student intern worked with Independence Unlimited to lend administrative support to work on Public Act 10-56.	**Public Act 10-56**: Authorizes DECD, in consultation with the CT Housing Finance Authority (CHFA), to establish a program that encourages CT developers to build residential

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	In accordance with Public Act 10-56: DECD established an informational webpage on its Internet website that provides links to available visitable housing resources at www.ct.gov/ecd/cwp/view.asp?a=1098&q=466356&ecdNav=|. In its 2010 design standards the CT Housing Finance Authority (CHFA) added that all newly constructed ground floor residential spaces shall be designed as visitable for guests.	homes that are easy for people with disabilities to visit (commonly known as visitable housing). The bill also exempts developers from a requirement to obtain a State Building Code variance or exemption to construct visitable homes. And, it authorizes municipal legislative bodies to adopt ordinances giving these developers a property tax abatement. Within available appropriations, the bill requires DECD to establish an informational webpage in a conspicuous place on its Internet website that provides links to available visitable housing resources.
b. Increase outreach to landlords and homeowners about resources and financing to make their units and homes accessible.	MFP has leased over 400 units over the past two years; over 100 homes were modified.	
c. Provide funding for home modifications that would either allow individuals to remain in their own homes or return to their own home following institutionalization.	MFP funds modifications on homes allowing the individual to transition from an institution to the community. DECD partners with MFP. During the 2012 legislative session, an additional $1 million in funding for modifications costing in excess of $10,000 was approved.	**Public Act 12-189, Section 30:** Amends section 28 of Public Act 11-57 by adding that not more than $1 million must be used for grants-in-aid for accessibility modifications for persons transitioning from institutions to homes under the MFP program. DECD has approved an additional

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	Some funding for home modifications is available to consumers through the National Family Caregiver Support Program as Supplemental Services enabling individuals to remain in their own homes, avoiding costly nursing facility placement. DECD has awarded the Corporation For Independent Living $1.5 million to continue funding its program for code compliance and accessibility modifications for homeowners throughout CT. The DDS Medicaid waivers allow for home modification.	$500,000 in Housing Trust Fund program funds for Centers for Independent Living to continue the Money Follows the Person Transition program which provides grants for accessibility modifications to both homeownership and rental units for those persons leaving long-term care institutions.
d. Encourage all State agencies, cities, and towns to update their ADA Transition Plans to ensure that necessary accessibility modifications are made when rehabilitating or updating public facilities, including public housing, or their programs, policies, and services.	DECD encourages cities and town to update their ADA Transition Plans by including it in its annual competitive Community Development Block Grant Small Cities Application. Towns are awarded bonus points if Transition Plans are submitted with the application and are updated every three years.	
e. Preserve and expand the stock of affordable housing and link residents with existing community-based services. Explore a range of different housing	DECD continuously provides gap financing to fund a broad range of affordable housing options including	**Public Act 10-179: Section 1:** Adds $1 million for Next Steps Supportive Housing in SFY 2011.

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options to maximize the number of units available with supports, including Supportive Housing, with an emphasis on truly integrated community housing. Make alternative low income housing and rental assistance available for older adults and people with disabilities. Models of community living used by DDS, generally no larger than one to four people per single dwelling, should serve as a model of true community integration.	HUD Section 202 and 811 projects and supportive housing options. MFP partners on grant applications submitted to HUD. To date, five assisted living units were created as a result of the partnership. MFP also partners with developers. To date, three new accessible two bedroom apartments were built. DMHAS continues to expand supportive housing options across all populations that receive DMHAS services, including those that are homeless. Specifically DMHAS manages over 1000 units of Shelter Plus Care, a HUD rent subsidy program for homeless individuals with a mental health or substance abuse disorder. In addition, DMHAS is part of an interagency collaborative that provides an additional 1100 units of permanent supportive housing. DMHAS also has created innovative supportive housing models to individuals cycling between the homeless shelter system and the criminal just system as well as a program that provides supportive housing to those individuals discharging	**Public Act 10-3, Section 4:** Transfers $380,000 for the DECD HomeCT program to the General Fund. **Public Act 10-179: Section 14:** Carries forward to SFY 2011 the unspent balance as of June 30, 2010 of funds appropriated to DECD for Home CT. This program provides grants to towns that choose to zone land for developing housing mainly where transit facilities, infrastructure and complementary uses already exist or have been planned. **Public Act 11-6**: Expands supportive housing by providing DSS half-year funding of $775,850 in SFY 2013 to cover Rental Assistance program (RAP) certification for 150 units. The proposed capital budget for the upcoming biennium includes $30 million in SFY 2012 for supportive housing under DECD. The current administration intends to provide $50 M in SFY 2012 and SFY 2013 ($100 M total) for the development of affordable housing.

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	from an inpatient psychiatric setting. In February, 2012, DECD issued a Notice of Funding Availability under the Competitive Housing Assistance for Multi-family Housing Properties (CHAMP) initiative for approximately $25 million to invest in the creation, preservation, and/or stabilization of affordable and/or workforce multifamily rental housing throughout CT with a goal of creating and/or preserving approximately 250 units of affordable and/or workforce rental housing. Approximately 30 applications for funding were received. In January 2012, DECD issued a Notice of Funding Availability under the State Housing Rehabilitation and Preservation Program (SHRP Initiative) for $10 million for the preservation of existing state financed public housing. Funds will be used to upgrade, modernize, enlarge and in some cases make additional units accessible units within the projects. Through the Supportive Housing Demonstration Program Initiative, $ 8.6 million has been committed to four	This will add more accessible housing to the stock because in accordance with the state building code, all newly constructed or substantially rehabilitated buildings with an elevator must be fully accessible housing; without an elevator 100 percent of the ground floor units must be 100 percent accessible. In addition, 2 percent of all units must be designed for the hearing or vision impaired. All other rehabilitation must be made accessible to the maximum extent feasible. The current administration has requested and anticipates providing the following for Supportive Housing: • $30M in bond financing for development of 150 units • $1.5M in general fund dollars for rental assistance for 150 units • $1.1M in general fund dollars for service subsidies for 150 units **Public Act 12-104:** Provides funding of $750,000 for 300 additional Rental Assistance Program vouchers. Funding is provided for the following: 1) 150 vouchers and $375,000 for

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	existing supportive housing projects to undertake rehabilitation and recapitalize operating budgets and reserve accounts for repairs and maintenance in order to stabilize and insure continued operations for the future. A total of approximately $15 million will be used for nine projects under this initiative. Through the Supportive Housing Initiative, $30 million was awarded to six projects on April 1, 2012 for the development of 179 new, permanent, supportive housing units. In addition, $2.6 million in service subsidies and rental assistance was made to the initiative. DECD will be funding $15 million of new rental housing projects that are determined to be "shovel ready" by the end of SFY 2012.	traditional RAPs, and 2) 150 vouchers and $375,000 for scattered site supportive housing. Funding is provided starting April 1, 2013.
f. Increase the utilization of housing vouchers in communities throughout Connecticut so additional vouchers may be requested from HUD.	DMHAS has continued to manage HUD programs with a long waitlist and works with HUD annually on applying for new housing resources through the McKinney-Vento Act. DMHAS also works with various Housing Authorities to ensure that DMHAS clients are able to access Section 8 vouchers.	

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g. Over the next biennium, support the efforts of DECD regarding the *CTHousingSearch.org* website to identify accessible units and increase their utilization. Ensure that all State agencies that construct or rehabilitate housing or provide rental assistance, report the accessible units to the website.	This program continues to be funded.	
h. Ensure that persons with disabilities and older adults are accessing foreclosure assistance programs when needed including special assistance if forced to move.	The CT Supreme Court has ruled that there can be no reasonable accommodations made on foreclosures because the statutes do not apply to lending institutions. However, the CT Fair Housing Center through funding from the state of CT (general funds-DECD), assists with part of the cost of a foreclosure attorney, works with housing counselors, and represents people in foreclosure. The CT Fair Housing Center recommends the aged or disabled to request what are known as "long law days." That is the time span until transfer of ownership takes place. This gives occupants the longest time possible to find a replacement dwelling and is particularly helpful if the dwelling must have accessibility features or requires modifications.	
i. Expand affordable assisted living options. Strategies	Within the past year, MFP partnered on	**Public Act 09-5 Sept. Special**

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could include making assisted living available to individuals under the age of 55 and combining HUD and other housing programs to cover housing costs for those whose assisted living services are covered by Medicaid. Direct systematic attention toward expanding available slots in pilot programs for assisted living and other supportive community-based residence settings, and making these programs permanent. Remove obstacles in state laws that prevent full maximization of federal funds under the Assisted Living Conversion Program.	four applications to HUD.	**Session**: Eliminates the limit of four projects under the Assisted Living Conversion Program. **Public Act 12-104:** Transfers funding of $680,000 from Medicaid to the Connecticut Home Care Program to support the expansion of the Private Pay Assisted Living Pilot from 75 to 125 individuals. **Public Act 12-1, June Special Session, Sections 9 & 10:** Increases, from 75 to 125, the total number of people who can participate in two private assisted living pilot programs.
j. Establish a Resident Services Coordinator in every State-funded Elderly Housing facility. Currently, there is one Resident Services Coordinator in every three facilities. Training is also needed to equip Resident Service Coordinators to serve both older adults and people with disabilities.		**Public Act 10-179: Section 1:** Eliminates funding for Residential Service Coordinators in SFY 2011. However, this funding remains in place. It was switched to General. Fund line item entitled "Elderly Rental Registry and Counseling." The proposed funding level for the Resident Service Coordinator Program is $1,021,000 for SFY 2012. The level is essentially the same as the previous year; therefore, no new service

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		coordinator positions can be funded.
k. Create incentives for underutilized institutions to convert their facilities to adult day care services, assisted living, residential care homes, independent living communities, or other community housing options in order to offer settings that reflect the more home-like features that people generally prefer.	The MFP right-sizing initiative includes funding for this activity.	
l. Develop new housing alternatives for persons with persistent mental illness who do not need nursing facility level of care. Consider Supportive Housing as one strategy to pursue.	CT has a strong Interagency Committee on Supportive Housing, made up of eight State agencies with the expressed goal of creating additional units of supportive housing statewide.	See comments on supportive housing.
m. Raise public awareness about reverse mortgage options.		
15. Support programs that divert or transition individuals from nursing facilities or other institutions.		
a. Support current nursing facility diversion and transition programs, such as Money Follows the Person (MFP), the home and community-based Medicaid waiver programs, the Pre-Admission Screening Resident Review (PASRR), Aging and Disability Resource Centers (ADRCs), cash and	As of June 2012. MFP has 21 central office staff and 75 fully dedicated field staff to support the transition of 1,000 people per year from institutions to the community.	

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counseling options under existing respite programs, and the DMHAS Nursing Home Diversion and Transition Program.	The DMHAS Nursing Home Diversion and Transition Program is comprised of seven nurse clinicians (three of who are cross-trained in the Mental Health Waiver Program) and two bi-lingual case managers. Additional staff will join the team in the next few months. At the same time, additional staff has joined the Mental Health Waiver Program. Both programs interface with PASRR, MFP, and ADRCs. The North Central ADRC began piloting a Care Transition Intervention Initiative with the Hospital of Central CT in July 2010 for the purpose of reducing unnecessary hospital readmissions. The South Central ADRC began a Care Transition Intervention Initiative with Mid-State Medical Center in March 2012 for the purpose of reducing unnecessary hospital readmissions and improving outcomes for patients. The Western ADRC began a Care Transition Intervention with Charlotte Hungerford Hospital in April 2012 for the same purpose.	

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	DDS has moved 25 people out of institutional settings under MFP since 2009.	
b. Identify individuals at risk of institutionalization, including people determined to be ineligible for Medicaid, and develop a long-term care service system that is able to sustain community living and significantly delay or avoid institutionalization. ▪ Establish and fund ADRCs statewide. (See Recommendation #7) ▪ Refer identified individuals who are at risk of spend-down to Medicaid and at risk of institutionalization to the ADRC for comprehensive long-term care needs assessments so that a home and community-based services plan can be developed. ▪ Emphasize diversion at the point of hospital admission and discharge. Information on the availability of community services and Medicaid home and community-based waivers should be provided to discharge nurses and updated periodically. ▪ For people residing in institutions, provide additional transition discussions after three	An Assessment and Priority Tool is utilized for short-term respite programs administered through the Aging Agencies on Aging to identify applicants with the greatest social an economic need as well as those at risk of spend-down to Medicaid and at the highest risk for institutionalization. Protocol for ADRC referrals have also been established to link consumers to community-based services as appropriate. DMHAS Nursing Home Diversion and Transition Program Nurse Clinicians focus on diverting clients from nursing facilities admission, as well as track and monitor nursing facility admissions that do occur. They collaborate with MFP Transition Coordinators and the facility social services department around discharge planning as appropriate. The Olmstead Initiative also facilitates nursing facility transitions by helping clients identify community integration	

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months, six months and annually thereafter. Discharge planning should be an active part of every person's plan of care. ▪ Support and expand the DMHAS Nursing Home Diversion and Transition program to avoid continued institutionalization of individuals with mental illness at the point of hospital discharge. ▪ Expand the number of Medicaid eligibility service workers stationed at ADRCs, hospitals, community health centers and local mental health authorities to expedite the Medicaid eligibility screening process. ▪ Simplify the Medicaid application process and develop a web-based on-line application system, making both a paper-based and computer based application process equally available. Also, develop and implement an expedited eligibility process for state programs that support services in the community such as the Connecticut Home Care Program for Elders (CHCPE) and other Medicaid home and community-based services waiver programs. (See Recommendation #2) ▪ Support and promote the availability and development of adequate housing such as Supportive Housing, services and in-home respite in efforts to divert people from initial	factors of interest. In SFY 2012, an expedited eligibility process will be implemented supporting community discharges; seven dedicated eligibility staff will be located at DSS central office coordinating with hospital and nursing home staff. An additional seven positions are funded in the community to support persons applying for Medicaid with collection of necessary documentation. DSS continues to fund a transition program for anyone not eligible for MFP demonstration services. Discharge planners will have access to a new web-based resource database. The Medicare Data Set Section Q requires that all individuals in nursing facilities are asked quarterly if they would like to return home. Facilities are required to submit names to MFP within 10 days.	

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institutionalization.		
16. Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.	MFP is coordinating with BRS to ensure work is integrated into all transition planning.	
a. Increase expectations and opportunities for people with disabilities in achieving career potential. Educate the public and professionals about career potential for persons with disabilities.	Connect-Ability continues to implement its comprehensive marketing campaign, designed to increase expectations and develop opportunities for partnership between people with disabilities and business. Connect-Ability has unveiled a new Distance Learning Initiative. This online platform was developed to provide individuals with disabilities, educators, employers, family members, providers and others free online training on a variety of topics. Participants can register and review courses by visiting the "e-Learning" tab of Connect-Ability.com. Also under the Connect-Ability umbrella, the Employment Practices Improvement Collaborative (EPIC) has been promoting collaborative approaches to employment for persons	**Special Act 12-9:** Requires the Office of Workforce Competitiveness, in collaboration with the Department of Education and the Board of Regents for Higher Education, to study model programs concerning the pre-employment training and employment of young adults with autism spectrum disorder and other developmental disabilities. The Office of Workforce Competitiveness must report on the study to the General Assembly no later than January 1, 2013.

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	with addictions and/or psychiatric disorders throughout the broader workforce development system. To date EPIC has developed and hosted various workshops including; Evidence-based Supported Employment, the Employment Rights of People with Disabilities and systems collaboration. EPIC has trained service providers who work with the criminal justice system regarding the pardons process and the establishment of an ongoing team of "Pardon Experts" to support people who have a criminal justice background. EPIC has developed an individualized, printable re-entry guide in conjunction with 2-1-1 InfoLine. EPIC has also provided employability training and post training support for recovery support peers. Beginning in mid-April 2012, EPIC will offer free online classes for job seekers with visible or hidden disabilities who encounter barriers to employment, and the people who support them. Available on the "e-Learning" tab of Connect-Ability.com, EPIC designed each of the courses to deliver interactive, engaging and relevant learning experiences for	

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	people newly engaged with the world of work, and those who need support to re-enter the workforce or stay on the job. Current course offerings include Employability Training and Soft Skills. Each course includes modules and simulations/interactive vignettes that teach a range of skills and support information offered for job seekers and employment facilitators. For facilitators, materials include downloadable teacher's guides and information about Evidence-based Supported Employment, Motivational Interviewing and Supporting Job Seekers through Stages of Change. This online tool also includes simulations to help job seekers and Employment Facilitators practice employment-related skills. Specific courses are also offered for people who may have a criminal past, are currently in recovery or have a checkered work history. The Employment Training courses will continue to be added to the Connect-Ability website resources from January to April 2012. The Collaborative has a highly trained staff pulled from various agencies, including the DMHAS, BRS and the Department of Labor (DOL).	

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	ADRCs regularly provide Employment Options Counseling, which includes one-on-one discussions of career potential for persons with disabilities and can result in appropriate referrals to Connect-Ability.	
b. Improve the transition process for young adults moving from school to post-secondary education or employment.	Connect-Ability and its partner agencies have focused on the transition process for young adults. The partners have created a transition toolkit with resources for many key stakeholders. BRS has been partnering with the State Education Resource Center to implement a statewide Transition Initiative, using the expertise of the Regional Education Service Centers. The initiative provides information to school systems, students and families about employment resources, including services available through the adult service system. Connect-Ability has developed a searchable online database of community rehabilitation providers. This searchable database is available on the Connect-Ability website and allows	**Public Act 12-104:** Provide Funding for Additional High School Graduate Placements ($470,011) to support an additional 48 graduates in day programs, employment and behavioral supports that were not budgeted.

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	all stakeholders to search for providers by location, services and youth or adult categories. DDS made significant infrastructure changes to support the employment of persons with disabilities in CT. There were multiple conferences, staff additions and collaborations between state agencies and private provider partners. These changes resulted in 40 new jobs for consumers served by DDS. To collect baseline data on employment attitudes and activities, DDS completed surveys with case managers, families and individuals, providers and resource managers. Extensive resource material has been established on the DDS Employment website. <u>A sample of additional achievements by DDS in the last two years:</u> 1) DDS management staff participated in a variety of Department of Education/ BRS inter-agency employment-related committees. 2) BRS/DDS staff partner on employer-related projects. 3) Self Advocate Coordinators have training materials available and have ongoing	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	defined activities to do with regional employment/day service providers. 4) DDS is involved in ongoing statewide advocacy and trainings activities related to transportation issues.	
c. Increase the recruitment, employment and retention of individuals with disabilities and older adults into Connecticut businesses.	Connect-Ability continues to staff the technical assistance center in a way that maximizes opportunities for relationship building with businesses. Connect-Ability also continues to partner with the Business Leadership Network, a coalition formed to provide peer to peer support for businesses looking to diversify their work environment by including people with disabilities in their diversity efforts. The Bureau of Rehabilitative Services is in its third year of implementing its Employment Division, staffed by a Director of Employer Development and nine Employment Consultants. ADRCs worked with the Bureau of Rehabilitative Services on the Medicaid Infrastructure Grant so that ADRC staff can educate and connect persons with disabilities to employment.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Connect-Ability also continues to fund the Business Leadership Network, a coalition formed to provide peer to peer support for businesses looking to diversify their work environment by including people with disabilities in their diversity efforts. On October 19, 2011, Connect-Ability partnered with The CT Business Leadership Network (CT BLN) and CT businesses to host a series of statewide Disability Mentoring Day activities. The event was an opportunity for companies and individuals throughout the U.S. to participate in National Disability Employment Awareness Month.	
d. Increase access to transportation to and from work for individuals with disabilities and older adults. (See Recommendation #13)	Connect-Ability will continue collaborative efforts with Department of Transportation and the Kennedy Center to standardize the statewide standardized ADA para-transit application for people with disabilities.	
e. Create a statewide technical assistance center for job seekers with disabilities and employers.	Connect-Ability has created a comprehensive website and a toll-free line, staffed with individuals who can help job seekers, businesses, advocates, and other stakeholders find the	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	appropriate resources related to employment.	
f. State government, as the largest employer in Connecticut should adopt older worker friendly initiatives that provide flexibility for workers, while ensuring that their work is completed on time and with high quality. Options include: voluntary schedule reductions, flexible work hours, phased-in retirement programs and telecommuting options.	Connect-Ability has developed a Model Employer toolkit that provides information for businesses and state government entities about diversifying their workforce.	

APPENDIX G.

State Long-Term Services and Supports Programs and Expenditures

SFY 2011 – 2012

I. **Overview of State Agencies Providing Long-Term Services and Supports**

II. **State Long-Term Services and Supports Programs in Connecticut – SFY 2012**

III. **State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2012**

I. Overview of State Agencies Providing Long-Term Services and Supports

Department of Social Services (DSS): DSS provides a broad range of services to people who are elderly or have disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers over 90 programs. By statute, it is the State agency responsible for administering a number of programs under federal legislation, including the Social Security Act (which includes Medicaid), the Food Stamp Act and the Older Americans Act, managed by the State Unit on Aging (SUA). DSS administers the Connecticut Home Care Program for Elders (CHCPE), a portion of which is State-funded, the Connecticut Home Care Program for Adults with Disabilities that is also state funded, and other programs such as the Personal Care Assistance (PCA) Waiver Program, the Acquired Brain Injury (ABI) Waiver Program, the Katie Beckett Model Waiver Program, the Department of Developmental Services Home and Community Based Waiver Program, the Department of Mental Health and Addiction Services Medicaid Waiver program, the Connecticut AIDS Drug Assistance Program and the Connecticut Pharmaceutical Assistance Contract to the Elderly (ConnPACE). DSS also received approval from the Centers for Medicare and Medicaid (CMS) for a 1915(i) State Plan Home and Community-Based Services option for individuals age 65 and older who are at risk of nursing home placement but not yet nursing facility level of care. Under recent grant programs from both CMS and the Administration on Aging (AOA), there are currently three fully functioning Aging and Disability Resource Centers (ADRC's) operating in the state and overseen by the SUA. In addition, the SUA is currently finalizing agreements with two additional ADRC's for the provision of services across the state to older adults, persons with disabilities and caregivers.

Department of Developmental Services (DDS): DDS provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, and family support to approximately 15,858 persons with intellectual disabilities and their families. In addition, the Department provides Birth to Three services to approximately 5,144 children and their families. As of June 2012, 62 percent of those people eligible to receive services from DDS were living in their own or their family home, 23.7 percent lived in public or private community living arrangements, 2.5 percent lived in community training homes, 3.8 percent lived in campus settings and 2 percent were in skilled nursing facilities.

Department of Mental Health and Addiction Services (DMHAS): DMHAS has 18 Local Mental Health Authorities that provide a vast array of community mental health services for persons with mental illness. In addition, DMHAS operates inpatient hospitals and facilities for persons with severe addiction and/or psychiatric problems. DMHAS also contract with private not for profit agencies who provide an array of substance abuse and mental health services across the state. In SFY 2012, DMHAS served 56,107 persons with mental illness in the community and 1,831 persons with mental illness in inpatient facilities. Also in SFY 2012, a total of 59,738 persons received substance abuse in the community and 3,220 received inpatient services.

Department of Economic and Community Development (DECD): DECD is the lead agency for housing in the state of Connecticut and oversees all State statutes related to accessible housing. In addition to being a key partner in the financing and policy making for assisted living and supportive housing, it administers capital grants for the development and operation of congregate housing, and the conversion of adaptable living units to accessible units for persons with disabilities. The agency is also responsible for a statewide registry of accessible housing.

Department of Transportation (DOT): (DOT) provides about $160 million a year in subsidies to bus and paratransit systems throughout the state. The fixed route bus system provides discounted (half-fare) rides to seniors and people with disabilities. Out of a total of 39 million riders annually on the fixed-route system, about two million rides are provided annually to elderly and disabled customers. DOT administers the Federal Section 5310 program, which provides vehicle grants to municipalities and non-profit organizations. Over 100 vehicles funded by this grant program are operating around the state. In addition, the federal Americans with Disabilities Act (ADA) requires that demand-responsive paratransit services be provided to pre-qualified individuals who are not able, due to their disability, to utilize the local fixed-route bus system. ADA paratransit services are available to origins and destinations within 3/4 mile of the local bus route and are operated during the same days and hours as the local bus service. The State currently spends over $25 million annually to support ADA services, and provides over 850,000 rides annually. The DOT-subsidized bus and paratransit operations serve 107 towns in the state. The State Legislature appropriated $3 million in fiscal 2012 and 2013 to a "State Matching Grant Program to Provide Demand Responsive Transportation to Seniors and People with Disabilities." This program allows municipalities to apply for a portion of the funds, determined by a formula, and requires an equal match by the municipality. The Federal Transit Administration New Freedom Program provides grant funds for transportation related programs that go beyond the requirements of the Americans with Disabilities Act of 1990. These grants are made available through the DOT and must be derived from locally-coordinated human services transportation - public transit plan.

The Department of Public Health (DPH): The mission of DPH is to protect and improve the health and safety of the people of Connecticut. DPH is the state's leader in public health policy and advocacy. The Department is a partner to local health departments for which it provides advocacy, training and certification, technical assistance, consultation, and specialty services such as risk assessment that are not available on the local level. Additionally, DPH establishes health priorities and evaluates the effectiveness of health initiatives. The agency also has regulatory functions which focus on the quality of services provided by licensed professionals, health care institutions, child day care providers, laboratories, ambulances, and environmental health entities. Resources are also dedicated to epidemiology, vital statistics, health education, and surveillance.

Department of Children and Families (DCF)**:** DCF provides a variety of community-based and institutional services for children and adolescents with disabilities and their

parents. The department's mandates include Prevention, Child Protection, Juvenile Justice Services and Behavioral Health. Services are provided through contracted providers as well as State operated facilities. DCF is part of the Behavioral Health Partnership, along with DSS and DMHAS, with the goal to provide access to a more complete, coordinated, and effective system of community-based behavioral health services and support.

Office of Protection and Advocacy for Persons with Disabilities (P&A):
P&A is an independent State agency created to safeguard and advance the civil and human rights of people with disabilities. By providing various types and levels of advocacy assistance, P&A seeks to leave people with disabilities and their families better informed, equipped, and supported to advocate for themselves and others. During 2011, P&A provided information, referral, or short-term assistance to 7,365 people, while 716 individuals received a more intensive level of advocacy representation. The P&A Abuse Investigation Division (AID) investigated or monitored 1,104 investigations into reports of suspected abuse or neglect of adults with mental retardation. Also, P&A staff provided training to over 2,600 individuals on disability rights topics and disseminated information to more than 3,200 people. More than 13,500 P&A publications and program brochures were distributed. The P&A website is constantly updated and includes current news and a calendar of upcoming events; P&A program descriptions and agency publications; legislative updates; links to websites for disability rights and resources; and reports on developments in the field of disability rights. Last year, 38,380 visitors obtained information through the site. (www.ct.gov/opapd). P&A staff supported community based disability advocacy groups across Connecticut, providing training and technical assistance on organizational development issues and disability rights. The agency continued its support for African Caribbean American Parents of Children with Disabilities (AFCAMP), Padres Abriendo Puertas (PAP); ADAPT and the Americans with Disabilities Act Coalition of Connecticut.

Department of Rehabilitation Services (DORS): DORS receives both federal and state dollars to provide a broad array of services, equipment and supports to individuals with disabilities that promote independent living, community participation and employment. DORS implements these services and supports through a variety of programs. The Bureau of Rehabilitation Services (BRS) administers the Title I Vocational Rehabilitation and Title VI Supported Employment (SE) programs of the Rehabilitation Act of 1973, as amended. BRS services are provided to adults who have a mental or physical impairment that is an impediment to employment. Supports are individualized to each job seeker and may include services such as personal assistance for evaluation and training purposes. BRS also manages Disability Determination Services, the entity charged with processing applications for the Social Security disability programs. The Driver Training Program for Persons with Disabilities provides driver instruction for qualified permanent Connecticut residents who require specialized equipment to operate a motor vehicle. The Bureau of Education and Services for the Blind (BESB) offers a comprehensive array of services to improve the independent living skills of adults and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training, and teaching to improve activities

of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs. The Workers' Rehabilitation Program assists injured workers in a return to gainful employment in the most timely and cost effective manner possible while taking into account the needs of the individual. The Commission on the Deaf and Hearing Impaired (CDHI) works to advocate, strengthen and implement state policies affecting individuals who are deaf or hard of hearing. Services and supports include: interpreting services for deaf and hard of hearing persons interacting with the public; counseling and assistance regarding many types of job related concerns; and individual, marital, family and group counseling services to deaf and hard of hearing persons and hearing family members.

Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. A 125-bed Adult Care Facility, operated by DVA, is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, Alzheimer's and related dementia care, end of life care, palliative care, long term care, rehabilitation, respite care, mental health and psychological counseling. The Residential Facility is certified by the Federal Department of Veterans Affairs and has 488 licensed beds. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

II. State Long-Term Services and Supports Programs in Connecticut – SFY 2012

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Connecticut Home Care Program (CHCP)	Adult day health care Adult foster care Assisted living services Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Info & referral MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emergency response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Age 65 and over. Must have at least one critical need (bathing, dressing, toileting, transferring, eating/ feeding, meal preparation, medication administration). Medicaid income limit = $2,094/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. State funded income limit = no limit. State funded asset limit = Indiv $34,092/ couple $45,456 (one or both receiving services)	<u>Total Participants</u> Total - 14,700 Waiver – 10,437 State – 4,263 <u>Age</u> 65-84: 62.5% 85+: 37.3% <u>Gender</u> male: 26.2% female: 73.8% <u>Race/Ethnicity</u> W = 67.5% AA = 13.2% Hisp = 16.5% Asian = 0.9% Am Ind = 0.2%

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	CT Home care Program for adults with Disabilities (CHCPD)	Adult day health care Adult foster care Assisted living services Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Info & referral MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emerg. response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Ages 18-64 Must be diagnosed with a degenerative neurological condition Must need assistance with at least 3 critical needs Must not be Medicaid active or eligible Financial eligibility is the same as the state funded portion of the CT Home care Program for elders	<u>Total Participants</u> 50 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Personal Care Assistance Waiver Note: Information updated for SFY 2006	Personal care assistance services Personal emergency response system	Personal residences	Age 18-64. Chronic severe and permanent disabilities. Would otherwise require nursing facility care. Capable of self-direction. Medicaid income limit = $1,809/ month. Income in excess of 200% FPL applied to care.	<u>Total Participants</u> 895 <u>Age</u> Under 50: 360 Over 50: 525 <u>Gender</u> Male: 381 Female: 514 <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Acquired Brain Injury Waiver (ABI)	Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living	Personal care residence Group residence	Age 18-64. Brain injury that is not a result of a developmental disability or degenerative condition. Dysfunction is not primarily the result of a mental illness. Would otherwise be institutionalized. Medicaid income limit = Less than 200% FPL. Medicaid asset limit = Individual $1,600	<u>Total Participants</u> 404 <u>Age</u> 18-49: 264 50+: 140 <u>Gender</u> Male: 278 Female: 126 <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 22 years old (those who are over age 22 as of 12/31/11 have the option to remain on the waiver) Would otherwise require care in a nursing home ICF/MR or chronic disease hospital. Medicaid income limit = $1,692. Medicaid asset limit = $1,000. Income of parent or spouse not counted.	Total Participants 198 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Volunteers from the Heart	Volunteers may shop for clients, provide transportation to shopping or medical appointments, provide some budgeting assistance or escort their clients to the doctor's office. Volunteers also act as advocates, linking their clients to appropriate community services.	Personal residences Doctor's offices Hospitals Shopping centers	Age 60 and Over.	Total Participants Volunteers - 29 Clients – 163 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	CHOICES	Health insurance counseling Information & referral	Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Age 60 and over. Under 60 if Medicare eligible.	Total Participants Individual Clients - 38,919 Age 65 and over=32,377 64 and under=6,542 Gender F=24,716 M=11,358 Not available=2,845 Race/Ethnicity N/A
DSS	SMP – Senior Medicare Patrol	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	Total Participants Volunteers - 40 Presentations – 65 Beneficiaries who attended presentations – 1,860 Reached by community education events – 11,012

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	CT Partnership for Long-Term Care - Information & Education Program	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers Variety of public venues	Age 18-89	Total Participants Calls for information - 603 Individuals counseled - 365 Attended public forums 430 Age 44-66 attended forums Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	Adult day care Care management Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emergency response system Short-term respite care Information and referral Support groups Cognitive training Self-directed care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	No age requirement. Alzheimer's or a related dementia. $41,000 income $109,000 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	Total Participants 839 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Retired Senior and Volunteer Program	Information & referral Volunteer services	Schools, airports, state institutions, community social agencies, police departments	Age 55 and over.	Total Participants Volunteers - 2,624 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DSS	Supportive Services and Health and Wellness: Older Americans Act Title lllB and Title lllD	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emergency response system Recreation services Respite care Transportation Medication monitoring	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	Total Participants 13,288 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Elderly Nutrition Program: Older Americans Act Title lllC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery	Congregate meals: senior community cafes, congregate housing, restaurants, schools, churches Home delivered meals: residential homes	Age 60 and over and their spouses/ caregivers	Total Participants Congregate meals: 832,916 meals served to 18,554 participants Home delivered meals: 1,233,154 meals served to 6,239 participants Nutritional counseling = 1,185 individuals *Nutrition Education =

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
					14,131 Units *Federal reporting does not require the count of people for this service, only units.
DSS	CT's National Family Caregiver Support Program: Older Americans Act Title lllE	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups Cognitive training Self-directed care	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over. Two or more ADL limitations. Children 18 yrs of age or younger for grandparent support.	<u>Total Participants</u> Respite – 355 Supplemental services – 538 One-on-one assistance – 7,486 Counseling, support groups, training – 852 (the method for reporting this figure changed in 2011) Total caregivers caring for older adults = 1,168 Total grandparents and kinship caregivers caring for children and persons 18-59 with disabilities = 159

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
					Age Caregivers: N/A Gender: N/A Race/Ethnicity N/A
DSS	Congregate Housing Services	Adult day care Care management Chore services Companion services Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system Transportation Medication monitoring	Congregate housing	Age 60 and over. Frail adults with temporary or permanent disabilities.	Total Participants 269 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
		Foot care			
DSS	Senior Community Service Employment Program	Information & referral Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over. Income not exceeding 125% of the federal poverty level.	Total Participants 186 Age 55-64: 127 65-744: 54 75+: 5 Gender male: 69 female: 117 Race/Ethnicity W = 117 AA = 60 Hisp = 13 Asian = 3 Am Ind = 0
DSS	Medicare Legal and Education Assistance Project	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	Total Participants 10,764 direct client assistance Age N/A Gender N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
					Race/Ethnicity N/A
DSS	Elderly Health Screening Program	Mental health screening/ counseling Nutrition education Health promotion/ wellness education Geriatric assessment Health screening: breast, prostate, cholesterol, eye, Diabetes, oral health, cardiovascular, etc.	Personal Residences Congregate Housing Elderly Housing Any community setting Community Health Centers Public Health Departments	Age 60 and over.	Total Participants 2,138 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Evidenced-Based Health Program	Chronic Disease Self-Management Program (CDSMP), Statewide Fall Prevention Program	Agencies on Aging VNA's, hospitals Community centers, Senior Centers Health departments Municipal agencies		Total Participants 684 CDSMP course completers* 850 Older adults received information on epidemiology of fall and associated risks 450 participated in one or more fall prevention programs 57 older adults

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
					received medication reviews through UCONN School of Pharmacy student program 138 EMT providers in 5 shoreline towns received training to reduce injuries related to fall and list assist related incidents *Cumulative figures
DSS	Community Choices (Aging & Disability Resource Centers)	Assessment; Assistance; Advocacy; Care Transitions; Case Consultation; Decision Support; Follow-Up; Information; Options Counseling; Benefits, Employment, and Long Term Support; Referral; Short Term Support	Agencies on Aging Centers for Independent Living Connecticut Community Care Some hospitals Personal residences Other public places By phone	Age 18 and over with a disability, older adult, or caregiver. Reside in the South Central, Western, or North Central regions of the state	Total Participants 2,076 Outreach Events 239
DSS	Prevention of Elder Abuse, Neglect and Exploitation	Strengthen and carry out programs or activities by raising awareness to prevent, detect, intervene, investigate and respond to elder abuse, neglect and	No specific setting	Age 60+	

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
		exploitation. -support of multi-disciplinary teams directed at advocacy to curtail elder abuse - financial exploitation education and training			
DDS	Home and Community-Based Services Waivers	Personal support Individualized home support Adult companion services Group day services Individualized day services Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Parenting Support Senior Supports Vehicle modifications Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination	Personal residences Community living arrangement Community training home Community day program site Community employment	Individuals over the age of three. Person with mental retardation needing ICF/MR level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	<u>Total Participants</u> Comprehensive Waiver 4685 Individual and Family Support Waiver 3803 Employment and Supports Waiver 150 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DDS	Intermediate Care Facility for persons with Mental Retardation (ICF/MR)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/MR	No age limit. Person with mental retardation needing ICF/MR level of care. Medicaid program: Income less than 300% of SSI and assets less than $1600.	<u>Total Participants in DDS operated ICF/MRs</u> 612 <u>Age</u> 0-18: 0 19-54: 248 55-64: 200 65+: 164 <u>Total Participants in privately operated ICF/MRs</u> 367 <u>Age</u> 0-18: 9 19-54: 239 55-64: 76 65+: 43 <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Case management-Mental Health	Info & Referral Transportation Case management	Personal Residences RCH NF Shelters Supportive housing sites Psychosocial clubs	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care. No private insurance to pay for comparable services.	Total Participants 12207 Age 18-20 300 21-25 822 26-34 1779 35-44 2278 45-54 3791 55-64 2520 65+ 638 Unknown 79 Gender Female 5469 Male 6733 Unknown 5 Race Am Ind 49 Asian 62 Black 2635 Mixed 1590 Hawaiian 8 Other 1091 Unknown 65 White 6707 Ethnicity Hispanic 2194 Non-Hispanic 9499 Unknown 514

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services available 24/7.	Personal residences Community settings	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Would otherwise require more intensive and restrictive services. No private insurance to pay for comparable services.	Total Participants 660 Age 18-20 152 21-25 152 26-34 67 35-44 70 45-54 125 55-64 77 65+ 17 Gender Female 297 Male 363 Race Am Indian 3 Asian 6 Black 80 Mixed 70 Hawaiian 1 Other 68 Unknown 2 White 430 Ethnicity Hispanic 99 Non-Hispanic 526 Unknown 35

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric out-patient clinic for adults, or a State-operated facility.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of safety; Symptomology/ behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual. No private insurance to pay for comparable services.	Total Participants 479 Age 18-20 14 21-25 52 26-34 80 35-44 116 45-54 136 55-64 62 65+ 19 Gender Female 280 Male 198 Unknown 1 Race/ Am Indian 4 Asian 2 Black 36 Mixed 32 Other 10 Unknown 1 White 394 Ethnicity Hispanic 34 Non-Hispanic 434 Unknown 11

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/ maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 36758 Age 18-20 1250 21-25 2948 26-34 6137 35-44 7016 45-54 10206 55-64 6600 65+ 2450 Unknown 151 Gender Female 20611 Male 16141 Unknown 6 Race Am Indian 117 Asian 266 Black 4620 Mixed 2975 Hawaiian 54 Other 4735 Unknown 317 White 23674 Ethnicity Hispanic 6882 Non-Hispanic 27954 Unknown 1922

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 258 Age 18-20 7 21-25 26 26-34 55 35-44 33 45-54 81 55-64 47 65+ 9 Gender Female 81 Male 177 Race Asian 2 Black 57 Mixed 42 Other 6 White 151 Ethnicity Hispanic 26 Non-Hispanic 225 Unknown 7

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mental Health Residential - Supervised Housing	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness. No private insurance to pay for comparable services.	Total Participants 834 Age 18-20 100 21-25 111 26-34 101 35-44 128 45-54 242 55-64 123 65+ 29 Gender Female 288 Male 546 Race Am Ind 1 Asian 7 Black 157 Mixed 118 Other 40 Unknown 2 White 509 Ethnicity Hispanic 100 Non-Hispanic 685 Unknown 49

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mental Health Residential - Supported Housing	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Teaching/ coaching of daily life skills.	Supportive housing	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate skill deficits in the area of independent living as a result of the psychiatric disability. No private insurance to pay for comparable services.	Total Participants 1950 Age 18-20 6 21-25 67 26-34 223 35-44 381 45-54 766 55-64 440 65+ 64 Unknown 3 Gender Female 897 Male 1052 Unknown 1 Race Am Indian 12 Asian 3 Black 592 Mixed 326 Hawaiian 1 Other 129 Unknown 3 White 884 Ethnicity Hispanic 364 Non-Hispanic 1524 Unknown 62

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Psychosocial Rehabilitation	Independent living and community reintegration skill development.	Community setting	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	Total Participants 6466 Age 18-20 111 21-25 381 26-34 784 35-44 1181 45-54 2265 55-64 1391 65+ 339 Unknown 14 Gender Female 2576 Male 3887 Unknown 3 Race Am Ind 10 Asian 32 Black 395 Mixed 774 Hawaiian 3 Other 462 Unknown 27 White 3763 Ethnicity Hispanic 915 Non-Hispanic 5288 Unknown 263

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care. No private insurance to pay for comparable services.	Total Participants 1898 Age 18-20 123 21-25 203 26-34 297 35-44 318 45-54 441 55-64 209 65+ 130 Unknown 177 Gender Female 880 Male 1014 Unknown 4 Race Am Ind 2 Asian 8 Black 209 Mixed 238 Hawaiian 1 Other 203 Unknown 20 White 1217 Ethnicity Hispanic 343 Non-Hispanic 1475 Unknown 80

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others. No private insurance to pay for comparable services.	Total Participants 8564 Age 18-20 546 21-25 926 26-34 1578 35-44 1611 45-54 1897 55-64 1033 65+ 598 Unknown 375 Gender Female 4131 Male 4428 Unknown 5 Race Am Ind 11 Asian 42 Black 1085 Mixed 964 Hawaiian 5 Other 691 Unknown 55 White 5711 Ethnicity Hispanic 1449 Non-Hispanic 6672 Unknown 443

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over. Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder. No private insurance to pay for comparable services.	Total Participants 1831 Age 18-20 96 21-25 233 26-34 350 35-44 364 45-54 425 55-64 263 65+ 95 Unknown 5 Gender Female 571 Male 1260 Race Asian 16 Black 364 Mixed 252 Hawaiian 1 Other 190 Unknown 4 White 1004 Ethnicity Hispanic 299 Non-Hispanic 1459 Unknown 73

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DMHAS	Substance Abuse Residential - Long-Term Care	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development	Structured recovery environment	Adults age 18 and over. General Assistance recipients with significant problems with behavior and functioning in major life activities due to substance abuse.	Total Participants 172 Age 21-25 13 26-34 32 35-44 49 45-54 62 55-64 16 Gender Female 52 Male 120 Race Black 9 Mixed 32 Other 1 White 130 Ethnicity Hispanic 16 Non-Hispanic 149 Unknown 7

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DECD	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail. One ADL minimum. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 985 residents Age 65+: 985 Gender N/A Race/Ethnicity N/A
DECD	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	Total Participants 2,505 units in 36 facilities Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DECD	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled. Certified disabled by Social Security Board or other federal board or agency as being totally disabled. Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	Total Participants 1,257 Age 0-64: 581 65+: 676 Gender N/A Race/Ethnicity N/A
DECD	Housing Assistance and Counseling	Assisted living services Info and referral	Elderly Housing (federal 202 or 236)	Age 62 and over. Requires assisted living services (at least 1 ADL) as determined by Care Plan.	Total Participants 59 Age 65+: 59 Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DOT	Local Bus Services	Transportation (Local bus at half fare)	Community	All ages Seniors and people with a qualifying disability.	Total Participants 2,000,000 passenger trips (of 39,000,000 total trips) Age N/A Gender N/A Race/Ethnicity N/A
DOT	ADA Paratransit Van Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	Total Participants Over 18,000 registered users Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DOT	State Matching Grant Program	Demand Responsive Transportation to Seniors and People with Disabilities	Municipality applies for funds and provides matching funds	Seniors and people with disabilities of all ages.	Total Participants 140 municipalities applied Age N/A Gender N/A Race/Ethnicity N/A
DOT	Federal Transit Administration – New Freedom Program	Transportation related services that go beyond the Americans with Disabilities Act of 1990	Services must be derived from a locally-coordinated public transit human services transportation plan.	People with disabilities of all ages	Total Participants Not available Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies Homemaker Home Health Agencies	Institutions identified under CGS 19a-490. Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A
DVA	Veterans' Health Care Services	Licensed Chronic Disease Hospital provides continuous professional comprehensive healthcare services including: General medical care Alzheimer's/dementia care End of life care Palliative care Long term care Rehabilitation Respite care	John L. Levitow Healthcare Center (onsite)	Veterans as defined by CGS 27-103 who served honorably, are residents of Connecticut, and have a chronic disease/illness.	<u>Average Monthly Census</u> 110 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Services and Supports Program	Services	Settings	Eligibility	Demographics July 1, 2011 – June 30, 2012
		Mental health and Psychological counseling			
DVA	Residential and Rehabilitative Services	Provides domiciliary level of care to facilitate rehabilitation and return to independent living including: Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	Average Monthly Census 340 Age N/A Gender N/A Race/Ethnicity N/A

III. State Long-Term Services and Supports Program Expenditures in Connecticut – SFY 2012

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Connecticut Home Care Program (CHCPE) (For SFY 2008)	$263,241,046	$46,743,224 (includes CHCPD expenditures)	$216,497,822			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$865,277	$865,277 (Included in CHCPE expenditures)				
DSS	Personal Care Assistance Waiver	$25,981,444		$25,981,444			
DSS	Acquired Brain Injury Waiver (ABI)	$42,299,580		$42,299,580			
DSS	Katie Beckett Model Waiver	$30,240		$30,240			

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Volunteers from the Heart	$29,839	$29,839				
DSS	CHOICES	$965,789	$413,962			$551,827 (DHHS/CMS)	
DSS	SMP – Senior Medicare Patrol	$185,000				$185,000	
DSS	CT Partnership for LTC - Information & Education Program	$9,000	$9,000				
DSS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	$2,254,425	$2,254,425				
DSS	Retired Senior and Volunteer Program	$102,998	$102,998				

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Supportive Services (Title lllB) and Health and Wellness (Title lllD) and Administration	$4,275,958	$100,216 State Match		$4,175,742		
DSS	Elderly Nutrition Program (Title lllC and NSIP)	$10,630,185	$2,495,942		$6,479,100	$1,504,816 (NSIP)	
DSS	CT's National Family Caregiver Support Program (Title lllE)	$1,729,998			$1,729,998		
DSS	Congregate Housing Services	$485,990				$140,003 (SSBG) $345,987 (HUD)	
DSS	Senior Community Service Employment Program	$976,537					$976,537
DSS	Medicare Legal and Education Assistance Project	$323,411	$320,411			3,000	

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Elderly Health Screening Program	$361,683	$361,683				
DSS	Evidenced-Based Health Program	$133,930					133,930
DSS	Community Choices (Aging & Disability Resource Centers)	$785,404	$0	$0	$0	$785,404	
DSS	Prevention of Elder Abuse, Neglect and Exploitation	$59,907				$59,907 OAA Title VII	
DSS	Legal Assistance	$254,131			$254,131		
DDS	Home and Community Based Services Waivers	$702,872,687		$702,872,687			

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$216,729,043		$216,729,043 Does not include private ICF/MRs which are funded by DSS			
DMHAS	Case Management	$42,185,766	$39,642,659	$76,609		$1,104,850	$1,361,649
DMHAS	Assertive Community Treatment	$19,024,468	$18,826,896	$117,203		$0	$80,369
DMHAS	MH Intensive Outpatient	$929,442	$545,282	$52,819		$158,192	$173,149
DMHAS	MH Outpatient Therapy	$90,031,237	$69,696,495	$7,063,916		$477,385	$12,793,441
DMHAS	MH Residential Group Home	$37,516,865	$23,701,946	$5,310,855		$0	$8,504,064

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Supervised Housing	$36,944,634	$34,312,026	$52,140		$0	$2,580,467
DMHAS	MH Supported Housing	$40,952,402	$26,406,921	$355,512		$11,867,648	$2,322,320
DMHAS	MH Psychosocial Rehabilitation	$17,757,693	$14,888,207	$0		$1,547,297	$1,322,189
DMHAS	Crisis Stabilization	$8,906,427	$7,682,727	$0		$605,719	$617,981
DMHAS	Mobile Crisis Services	$14,012,307	$12,362,967	$96,312		$1,138,359	$414,669
DMHAS	Long Term Psychiatric Hospitalization	$126,662,940	$123,310,273	$640,004		$0	$2,712,663
DMHAS	Substance Abuse Residential Long Term Care	$2,068,865	$1,093,112	$0		$138,330	$837,423

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	Substance Abuse Residential Long Term Treatment	$31,828,232	$19,460,435	$288,287		$3,047,696	$9,031,814
DMHAS	Substance Abuse Residential Transitional / Halfway House	$4,922,504	$2,443,330	$0		$177,101	$2,302,073
DECD	Congregate Operating Subsidy Program	$6,539,126	$6,539,126				
DECD	Elderly Rental Registry and Counseling	$1,036,679	$1,036,679				
DECD	Elderly Rental Assistance Program	$2,110,198	$2,110,198				
DECD	Housing Assistance and Counseling	$399,463	$399,463				

State Agency	Long-Term Care Program	Total Expenditures SFY 2012	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DOT	Local Bus Services	$174,812,127	$120,021,859			$1,468,698	$3,515,957 (local) $49,458,737 (passenger fares)
DOT	ADA Paratransit Van Services	$30,734,892	$28,374,122				$254,815 (local) $1,630,230 (passenger fares)
DOT	State Matching Grant Program	$2,931,232	$2,931,232				
DOT	Federal Transit Administration - New Freedom Program	$522,318	$205,837			$299,980	$37,648
DVA	Veterans' Health Care Services	$13,439,111	$13,153,967				$285,144
DVA	Residential and Rehabilitative Services	$4,040,202	$1,297,631				$2,742,571