Balancing the System:

Working Towards Real Choice for Long-Term Care in Connecticut

A Report to the General Assembly
January 2010

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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, 2009)

Legislators
Senator Edith G. Prague, Co-Chair, Select Committee on Aging
Representative Joseph C. Serra, Co-Chair, Select Committee on Aging
Senator John A. Kissel, Ranking Member, Select Committee on Aging
Representative John H. Frey, Ranking Member, Select Committee on Aging
Senator Jonathan A. Harris, Co-Chair, Public Health Committee
Representative Elizabeth B. Ritter, Co-Chair, Public Health Committee
Senator Dan Debicella, Ranking Member, Public Health Committee
Representative Janice R. Giegler, Ranking Member, Public Health Committee
Senator Paul R. Doyle, Co-Chair, Human Services Committee
Representative Toni E. Walker, Co-Chair, Human Services Committee
Senator Robert J. Kane, 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
Deborah Duval, Department of Developmental Services
Pam Giannini, 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
Amy Porter, Department of Social Services
Kim Samaroo-Rodriguez, Department of Children and Families
Michael Sanders, Department of Transportation
Janet Williams, Department of Public Health

Staff
Barbara Parks Wolf, Office of Policy and Management

Former Committee Participants
Joan Leavitt, Department of Public Health
Beth McArthur, Department of Developmental Services
Rick Robbins, Department of Economic and Community Development

APPENDIX C.

Long-Term Care Advisory Council Membership

Organization	Representative
Legislative Member	Representative Peter F. Villano (Co-Chair)
CT Commission on Aging	Julia Evans Starr (Co-Chair)
CT Association of Residential Care Homes	Sonja Zandri
Personal Care Attendant	Debbie Legault
CT Association of Area Agencies on Aging	Kate McEvoy
CT Council for Persons with Disabilities	Mildred Blotney
CT Association of Health Care Facilities	Richard Brown
CT Assisted Living Association	Christopher Carter
CT Association of Adult Day Care	Maureen Dolan
Bargaining Unit for Heath Care Employees/ 1199 AFL-CIO	Deborah Chernoff
CT Family Support Council	Laura Knapp
Consumer	Michelle Duprey
AARP – CT	Brenda Kelley
CT Association of Home Care, Inc.	Brian Ellsworth
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	Rolando Martinez
CT Alzheimer's Association	Christianne Kovel
CANPFA	Margaret Morelli
Family Caregiver	Susan Raimondo
CT Coalition of Presidents of Resident Councils	Veronica Martin
American College of Health Care Administrators	George Giblin
Consumer	Sue Pedersen
Consumer	Vacant
Nonunion Home Health Aide	Vacant

Friends of the Advisory Council

Senator Jonathan Harris
Senator John Kissel
Bill Eddy, CT Commission on Aging, Member
Quincy Abbot, ARC/CT
Mary-Ann Langton, CT Council on Developmental Disabilities
Claudio Gualtieri, AARP-CT
Stacey Walker, CT Association of Resident Service Coordinators in Housing
Stan Kosloski, CT Disability Advocacy Collaborative
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 2009 to diverse organizations and individuals throughout Connecticut with an interest in long-term care. A draft of the full Plan and appendices was distributed for comment in November 2009. In total, public comments were received from 69 people and 21 organizations.

Quincy Abbot, Parent and member of ARC/CT

Sheila S. Mulvey

Ken Przybysz

Alzheimer's Association, Policy Committee
- Patricia K. Clark
- Christine I. Andrew

AARP
- Brenda Kelley, Connecticut State Director
- Claudio Gualtieri, AARP Program Coordinator, Public Affairs
- Ed Dale, AARP Senior Legislative Representative, AARP State Affairs

Brain Injury Association of Connecticut
- Carrie Kramer, Brain Injury Services Director
- Julie Peters, Executive Director
- Ruth Ann Graime, Brain Injury Specialist
- Melinda Montovani, Brain Injury Specialist

Center on Aging, University of Connecticut
- Julie Robison, PhD, Assistant Professor

Community Companion and Homemaking Services
- Nancy Trawick-Smith

Connecticut Association of Centers for Independent Living
- Gary E. Waterhouse
- Tony LaCava, Executive Director, Disability Resource Center of Fairfield County
- Marc Gallucci, Esq. Executive Director, Center for Disability Rights
- Carmen Correa, CACIL Board Member, Center for Disability Rights
- Candace Low, Executive Director, Independence Unlimited
- Eileen Healy, Executive Director, Independence Northwest
- Scott Robbins, CACIL Board Member, Independence Northwest

Connecticut Association of Health Care Facilities
- Matthew V. Barrett, Executive Vice-President

Connecticut Association of Not-for-profit Providers For the Aging
- Mag Morelli, President

Connecticut Commission on Aging
- Julia Evans Starr
- Deborah Mignault
- Bill Eddy

Connecticut Community Care, Inc.
- Molly Rees Gavin (representing the 16 member Board and the staff)
- Onell J. Calderas, Quality Assurance Specialist
- Terry Sullivan, Clinical Software Director

Connecticut Council on Developmental Disabilities
- Mary-Ann Langton, Disability Policy Specialist

Connecticut Disability Advocacy Collaborative
- Stan Kosloski, Project Director

Connecticut Family Support Network
- April Dipollina, Parent and Regional Coordinator,

Connecticut Legal Rights Project, Inc.
- Jan VanTassel, Esq.

East Hartford Health and Rehab
- Brian Capshaw, Resident Council President

Friends of Retarded Citizens of Connecticut Inc.
- Edward D. Walen
- S. Bondy; R. Wood
- K. Hlavac
- C. Stramandinoli
- D. Picozzi

Keep the Promise Coalition
- Cheri Bragg, KTP Coordinator
- Jan VanTassel, Esq., Executive Director, CT Legal Rights Project, Co-Chair of Keep the Promise Coalition
- Sheila Amdur, MSW, Co-Chair, Keep the Promise Coalition
- Kate Mattias, JD, MPH, Executive Director, National Alliance on Mental Illness, CT (NAMI-CT)
- Judith Stein, Esq., Executive Director, Center for Medicare Advocacy, Inc.
- Lynn Warner, Executive Director, The Arc of Connecticut
- Pamela DonAroma, Executive Director, Futures, Inc.
- Jennifer C. Jaff, Esq., Executive Director, Advocacy for Patients with Chronic Illness, Inc
- Marc Anthony Gallucci, Esq., Center for Disability Rights
- Karen Kangas, Ph.D., Executive Director, Advocacy Unlimited
- Candace Low, Executive Director, Independence Unlimited
- Cathy Ferry, Executive Director, Disability Network of Eastern CT (DNEC)

- Stan Kosloski, Project Director, CT Disability Advocacy Collaborative
- Hal Gibbber, Executive Director, FAVOR, Inc.
- Michelle M. Duprey, Esq., Director, Department of Services for Persons with Disabilities, City of New Haven, CT
- Joy Liebeskind, Coordinator, CT Lifespan Respite Coalition, CT Family to Family Health Information Center
- Eileen Healy, Executive Director, Independence Northwest
- Pat Settembrino, Executive Director, South Central Regional Mental Health Board
- Jennifer Carroll, Statewide Coordinator, Connecticut Family Support Network
- Merva Jackson, Executive Director, AFCAMP
- Julie Peters, Executive Director, Brain Injury Association of CT
- Nancy B. Shaffer, M.A., State Long Term Care Ombudsman, Office of the State Long Term Care Ombudsman
- Tony LaCava, Executive Director, Disability Resource Center of Fairfield County
- Kate McEvoy, Esq., Connecticut Association of Area Agencies on Aging
- Robert E. Davidson, Ph.D., Executive Director, Eastern Regional Mental Health Board
- Domenique S. Thornton, Esq., General Counsel, Mental Health Association of Connecticut, Inc.
- Susan Raimondo, Senior Director, Advocacy & Programs, National Multiple Sclerosis Society, Connecticut Chapter

National Association of Social Workers, CT Chapter
- Stephen A. Karp, MSW
- Sherry Ostrout, President
- Waldo Klein, Treasurer and Committee on Aging member
- Jennifer Glick, Committee on Aging Member
- Jennifer Bennett, Chairperson, Committee on Aging
- Molly Rees Gavin, Former President

Senior Resources – Agency on Aging
- Joan Wessell
- Cathy Ferry, Disabilities Network of Eastern Connecticut

Valley Association for Retarded Children and Adults (VARCA)
- Robert Wood

Western CT Area Agency on Aging, Inc.
- Dolores Winans

APPENDIX E.

LONG-TERM CARE PLANNING EFFORTS

A. Long-Term Care Planning Committee Efforts

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 care issues, coordinating policy development and establishing a long-term care plan. The Planning Committee is comprised of representatives from ten 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 care services 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 care 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. The Planning Committee members felt that given the short timeframe, it would not be possible to develop a comprehensive Plan and rather produced a Preliminary Long-Term Care Plan that provided a description of Connecticut's long-term care system in order to

develop a baseline for future Plans. In addition, the Preliminary Plan was focused on long-term care 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 care 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. Working in partnership with the Long-Term Care Advisory Committee, the Planning Committee began work on the Plan in 2003. The Advisory Council worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing priorities and recommendations, and obtaining public input.

The Advisory Council assumed responsibility for seeking and gathering broad public input on the draft Plan from diverse organizations and individuals throughout Connecticut with an interest in long-term care. Public comment was solicited in the fall of 2003. Comments were received from over 100 consumers, professionals and advocates, with representation from 23 public and private organizations.

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 goal was to develop a website that provides easy access to comprehensive information on private and public long-term care services and supports in Connecticut, including home care, community care, housing and institutional/ nursing home care. 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.

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 furthered 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. Connecticut was awarded this $24.2 million five year grant from the federal Center for Medicare and Medicaid Services (CMS) in January 2007. The objective of the MFP Rebalancing Demonstration is to rebalance long-term care services from institutional care to home-based services. Connecticut has established five rebalancing benchmarks, one of which is to increase the percentage of Medicaid long-term care clients receiving home and community based care to 57% by 2011. The program serves individuals across the age span with physical disabilities, mental illness and intellectual disabilities.

APPENDIX F.

Status Report:
2007 Long-Term Care Plan for Connecticut
October 2009

Status Report

2007 LONG-TERM CARE PLAN FOR CONNECTICUT

OCTOBER 2009

Status Report – October 2009
2007 LONG-TERM CARE PLAN FOR CONNECTICUT

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
(a) A. Balancing -- The Long-Term View		
(i) 1. Balancing the ratio of home and community-based and institutional care		
▪ ***Connecticut should work to develop a system that provides for more choice, increasing the percentage of Medicaid long-term care clients receiving home and community-based care from 51 percent in 2006 to 75 percent by 2025, requiring approximately a one percent increase in the percentage of Medicaid long-term care clients served in the community every year.***	The federal Centers for Medicare and Medicaid (CMS) awarded $24 million for CT's Money Follows the Person (MFP) Rebalancing Demonstration proposal. The purpose is to rebalance long-term care services from institutional care to home-based services. Demonstration funding was awarded on January 1, 2007. The operating protocol was submitted on April 30, 2008. There are five rebalancing benchmarks in the MFP Rebalancing Demonstration. One of the benchmarks is to increase the percentage of Medicaid long-term care clients receiving home and community based care to 57% by 2011. In the Department of Developmental Services (DDS), the percentage of individuals receiving home and community-based support increased by 5.4 percent in SFY 2007 while	P.A. 07-73: Renames the Department of Mental Retardation as DDS. It specifies that the name change does not change the criteria for determining eligibility for the department's services. June Special Session, P.A. 07-1: Appropriates additional funds to DDS to establish an Autism Division. SFY 2009: $1,000,000 June Special Session, P.A. 07-4, Sections 109 – 114: Establishes a division of autism spectrum services within DDS for individuals with autism regardless of age. Up to $200,000 of the unexpended balance of funds appropriated to DDS in P.A. 06-186, section 1, for a pilot program for autism services will not lapse on June 30, 2007 and will continue to be available in SFY 2008 to study the

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	institutional services decreased by 1 percent. In SFY 2008, as of March 31, the percentage of individuals receiving home and community-based services has increased by 1.8 percent over the SFY 2007 figures, and the percentage of individuals receiving service in institutional settings has declined by 2.8 percent to date. Since the Spring of 2008, the Department of Mental Health and Addiction Services (DMHAS) has transitioned approximately 80 nursing home residents with mental illness back to community residential settings with support services. On April 1, 2009, the Medicaid Home and Community-based Services Waiver for Persons with Serious Mental Illness became operational. Over the next three years, 216 DMHAS clients who are at-risk for nursing home placement, and also meet other eligibility requirements, will receive wrap-around services in the community. The DMHAS Waiver is also part of the Money Follows the Person initiative.	feasibility of an amendment to the state Medicaid plan or a federal waiver to establish and implement a Medicaid home and community-based program for adults with autism spectrum disorder, but who are not mentally retarded. P.A. 08-63: Expands, from 50 to 75, the number of people who can participate in the DDS pilot program for adults with autism spectrum disorders but not mental retardation. DDS is required to ensure that eligible adults living outside the pilot's current service area (parts of New Haven and Middlesex counties) have access to the expanded slots. Also, the Act extends the pilot's end date for nine months, from October 1, 2008 to June 30, 2009. DDS must report on the pilot's results by January 1, 2009. June Special Session, P.A. 07-1: appropriates funds to implement the MFP Rebalancing Demonstration. SFY 2008: $2,720,800 SFY 2009: $5,630,700 June Special Session, P.A. 07-2, Section 5: Increases from 100 to 700 the number of individuals to be served

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		by the MFP Rebalancing Demonstration. P.A. 08-180: Increases from 700 to 5,000 the number of individuals who can be served under the State's plan for participating in the federal MFP Demonstration program. In addition, DSS is required to develop a plan to establish and administer a similar home and community-based services project for adults who may not meet the MFP institutionalization requirement. Finally, a non-lapsing General Fund account must be established to hold enhanced federal matching funds the State receives for MFP. P.A. 08-1, November Special Session, Section 7: DSS must expedite the establishment of the MFP Demonstration program to facilitate placing 140 eligible persons in the program by June 30, 2009. P.A. 09-1, Sec. 1: Long-Term Care Reinvestment Account: Postpones until July 1, 2009 the establishment of a separate, non-lapsing Long-Term Care Reinvestment account in the General Fund to hold the enhanced

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		federal matching funds the state receives for the MFP demonstration program. The date by which the DSS commissioner must report on expenditures from the account to the Human Services and Appropriations committees is also postponed, from January 1, 2009 to January 1, 2010. P.A. 09-17: Requires DSS to provide status reports on the MFP Demonstration program to the Human Services and Aging Committees, semi-annually, starting October 1, 2009. June Special Session, P.A. 09-3: Funding is provided to reflect anticipated costs and case load requirements for the MFP program. SFY 2010: $4,756,666 SFY 2011: $11,398,328 June Special Session, P.A. 09-3: Revises the operational protocol to limit the number of transitions under the MFP Chronic Care Waiver to no more than 2% of the 700 clients expected to be transitioned under the MFP demonstration period. At the end of the biennium, DSS will reassess this policy to determine

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		where the state's limited resources should best be targeted. SFY 2010: ($110,000) SFY 2011: ($1,850,000) June Special Session, P.A. 09-3: Funding is provided for individuals transferring out of Southbury Training School, nursing facilities, or ICF/MRs under MFP and into community settings. Funding will cover 13 individuals in SFY 2010 and 20 additional individuals in SFY 2011. SFY 2010: $258,944 SFY 2011: $2,644,928 September Special Session, P.A. 09-5, Sec. 84-85: Postpones from July 1, 2009 until July 1, 2011 the establishment of a non-lapsing long-term care reinvestment General Fund account to hold the enhanced federal matching funds the state receives for the federal MFP Demonstration program. Also postponed from July 1, 2010 to January 1, 2012 the date by which DSS must begin reporting annually to the General Assembly on the expenditures from the MFP account. September Special Session, P.A. 09-5,

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Sec. 87: Postpones from July 1, 2009 until July 1, 2012 the date by which DSS must submit a plan to the General Assembly to implement the MFP II demonstration program. Also postponed is the implementation date of the MFP II program from July 1, 2009 to July 1, 2012. June Special Session, P.A. 07-1: Appropriates new funds for the PCA Waiver enabling DSS to serve additional people in the program. SFY 2008: $1,272,843 SFY 2009: $1,272,843 June Special Session, P.A. 07-1: Appropriates funds to fully fund the Katie Beckett waiver covering 200 slots. In each year of the biennium, $550,000 is appropriated to fund the additional slots and $250,000 is provided for case management services for medically fragile children. SFY 2008: $800,000 SFY 2009: $800,000 June Special Session, P.A. 07-1: Provides rate increases to home care providers under the CT Home Care Program for Elders. SFY 2008: $7,758,375

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		SFY 2009: $8,313,105 June Special Session, P.A. 07-2, Section 29: Expands the state-funded portion of CT Home Care Program for Elders by establishing a state-funded pilot program serving 50 people with disabilities ages 18 to 64 who are either inappropriately institutionalized or at risk of in appropriate institutionalization. P.A. 08-88: Increases the asset limits in the state-funded pilot home and community-based services program for adults ages 18 to 65 to match the asset limits of the state-funded CT Home Care Program for Elders. Currently, assets are limited to 100% and 150% of the minimum community spouse protected amount (CSPA) for single and married applicants, respectively. The bill increases the limits to 150% and 200% of the minimum CSPA, respectively. June Special Session, P.A. 09-3: Additional funding is provided for the CT Home Care Program for Elders to reflect anticipated cost and caseload trends. SFY 2010: $28,564,289

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		SFY 2011: $51,879,379 September Special Session, P.A. 09-5, Sec. 66: Increases the current costs sharing requirement under the CT Home Care Program for Elders. SFY 2010: [$10.9 million] SFY 2011: [$10.9 million] P.A. 09-1, Sec. 4: Eliminates funding for the State Department on Aging for SFY 2009. SFY 2009: [$430,396] September Special Session, P.A. 09-5, Sec. 19: Postpones the re-establishment of the Department on Aging until July 1, 2011. SFY 2010: [$449,000] September Special Session, P.A. 09-5, Sec. 63: Further directs DSS to seek a Medicaid home and community-based waiver for up to 100 individuals with HIV/AIDS currently receiving services under the Medicaid program. SFY 2010: $1.6 million SFY 2011: $4.1 million
Home and Community-Based Infrastructure		
▪ Examine the possibility of providing greater uniformity	Addressing the fragmentation and	P.A. 07-83: Requires, rather than

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among the different Medicaid home and community-based waivers in terms of requirements such as age and income limits, and of providing maximum flexibility and choice as to how waiver funds can be utilized. Within the confines of federal Medicaid law that prohibits combining individuals who are (1) aged and disabled, (2) intellectually disabled or developmentally disabled, or (3) mentally ill into a single waiver, the State should explore any options that may be available, particularly options that do not discriminate against persons with psychiatric disabilities.	complexity of the existing Medicaid waiver and Medicaid State Plan service delivery system is a priority under the MFP Rebalancing Demonstration initiative. As part of this effort, a plan to address the gaps in services for persons at the highest level of need as an alternative to institutionalization was designed. A new Medicaid waiver will be submitted for federal approval in 2009. Persons at the highest level of need in the target groups of physical disability and elders will be eligible. The federal Centers for Medicare and Medicaid Services published a proposed rule on June 22, 2009 that would amend existing regulation on Medicaid home and community-based services waivers, giving states the option to design waiver programs that serve more than one target population.	allows, legislative approval of federal Medicaid waiver applications proposed to be submitted to the federal government by DSS.
▪ Maximize the involvement of individuals with disabilities and family members of individuals with disabilities in the development and implementation of CT's long-term care system.	In March 2007, the DMHAS Mental Health Transformation Grant Oversight Committee approved the formation of a Consumer/ Family/ Youth Advisory Council. This Council assists all other Transformation Grant committees and work groups, bringing a collective voice of consumers and individuals in recovery and families to the process of	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	mental health system transformation. Prior to submitting the waiver application to the federal Centers for Medicare and Medicaid Services (CMS), DMHAS sought input from mental health advocates and consumers and family members. A DMHAS Mental Health Waiver Advisory Council was established and its first meeting occurred in April 2009. The advisory council is comprised of advocates, consumers and family members, and providers of services to persons with mental illnesses. The main responsibility of the council is to provide opportunity for input from individuals and families, review key quality findings and data trends in order to make recommendations for system improvements. Meetings are held quarterly and are open to the public. Under the MFP Rebalancing Demonstration, the steering committee and workgroups include a broad range of stakeholders. All meetings are open to the public. DDS sought family and consumer input and feedback in the development of renewals and amendments to its existing	

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	Individual and Family Support Waiver and Comprehensive Waiver. Additionally, DDS holds regional Family Forums four times a year where waiver related topics are discussed.	
▪ Explore the opportunity to strengthen consumer directed care provided by the Cash and Counseling provision of the federal Deficit Reduction Act of 2005.	Cash and counseling was incorporated as an element of the MFP Rebalancing Demonstration. The federal Administration on Aging awarded $500,000 for DSS Aging Services Division's Nursing Home Diversion and Modernization proposal. This is an 18 month project in the south central region of the state. A major objective of this project is to provide consumers with flexible services options utilizing a cash and counseling model with funds from Older Americans Act Title III-E Caregiver and state-funded Statewide Respite Care programs currently serving individuals who are not eligible for Medicaid.	
▪ Explore the opportunity to expand home and community-based care provided by the Expanded Access to Home and Community-Based Services (HCBS) and Presumptive Eligibility provision of the Deficit Reduction Act (DRA) of 2005.	On April 1, 2009, the Medicaid Home and Community-based Services Waiver for Persons with Serious Mental Illness became operational. The MFP Rebalancing Demonstration includes this exploration as one of the	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	five benchmarks.	
▪ Explore training opportunities for conservators, guardians, families, probate system staff, medical personnel, social workers, and others about supporting choice, autonomy and dignity and the assistance available for transitioning from institutions to the community and the services available in the community after transition.	Under the MFP Rebalancing Demonstration, materials and training will be designed and implemented. Under the DMHAS Home and Community-based Services Waiver, Recovery Assistant Services are a new service to DMHAS. Recovery Assistants are educated about, and trained to, assist clients in the community by promoting individual recovery, including attention to client choice, autonomy, and dignity. DMHAS is a member of the work force development task force for MFP.	
▪ Review CT statutes to identify opportunities to enhance protections of persons with disabilities when there is a conservator involved.		P.A. 07-116: Changes procedures for appointing conservators and designating their powers. Procedures are set for appealing probate court decisions and filing habeas corpus petitions. The act also changes the term of someone who is subject to involuntary representation by a conservator from ward to a conserved person. P.A. 07-117: Specifies the probate court's authority in cases where forced

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		medication is administered to individuals with mental illness, and the involuntary release of their medical records.
Nursing Facility Transitions		
▪ CT should continue its support of programs to assist individuals in transitioning out of nursing facilities and other institutions. The Nursing Facility Transition Program (NFTP), also called My Community Choices, has shown that with the proper supports and services, individuals with severe disabilities can successfully transition to, and remain in, the community.	The MFP Rebalancing Demonstration expands the number of transition coordinators to 20 by September 2008. Moving 700 people from institutions to the community is one of five goals in the demonstration. Transition services in addition to those offered under the MFP Rebalancing Demonstration will focus on transitioning persons who have been institutionalized less than six months. These additional transition efforts are included as a benchmark under the MFP Rebalancing Demonstration. Five individuals will be hired in full time positions to support the effort. The benchmark will measure an increase in the probability of returning to the community within the first six months of an institutional stay. Within the DMHAS Older Adult Services (OAS) Unit, two programs have been established. First, the DMHAS Home and Community-based Waiver; and second the Nursing Home	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Diversion and Transition Program (NHDT). Under the NHDT Program, six nurse clinicians focus on diverting clients from nursing home placement unless medically necessary, as well as transitioning back to the community those clients already residing in a nursing home who do not qualify for MFP. Since July 1, 2008, approximately 150 individuals have been seen for diversion with approximately 50% successfully diverted from nursing home placement. Again, over the past year, OAS staff has transitioned back to the community approximately 80 nursing home residents with mental illness.	
▪ Connecticut should build on the successful components of the Nursing Facility Transition Project NFTP and strive to sustain those elements into the future. For example, the Common Sense Fund, used under the NFTP to provide transition expenses such as security deposits and home modifications should be made a standard benefit. In addition, the State should explore providing reimbursement for peer mentoring and encouraging community activities.	Flexible funds such as the Common Sense Fund will continue under the MFP Rebalancing Demonstration.	
▪ Connecticut should continue its landmark decision to allocate a number of Section 8 vouchers for individuals transitioning from nursing facilities, developed as part of	DSS will provide Rental Assistance Program (RAP) benefits for those persons moving to the community under	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
the Nursing Facility Transition Project.	the MFP Rebalancing Demonstration.	
▪ Connecticut should work with housing providers, such as Residential Care Homes, Congregate Housing, Department of Developmental Services (DDS) Residential Services and others to maximize the housing and service and supports opportunities for individuals transitioning from nursing facilities.	DDS has initiated enhanced oversight of nursing home admissions for rehab placement in SFY 2007 to begin immediate planning to assure that an appropriate residential setting is available when the person is ready for discharge to decrease long-term admissions. This continues in 2008.	P.A. 09-73: State Supplement Program applicants who transfer assets within 24 months before applying for assistance are generally ineligible for State Supplement for a period of time based on the value of the asset. Eligibility is not affected if the applicant can provide convincing evidence that the transfer was made for another reason. This bill adds a second exception by allowing transfers to "special needs trusts" by individuals who (1) are living in residential care homes (RCH) or New Horizons, Inc. and (2) have available income that is above 300% of the maximum federal Supplemental Security Income (SSI) program benefit for an individual ($ 2,022 per month in 2009) and below the private rate that the RCH or New Horizons charges.
Prescreening Efforts		
▪ Connecticut should expand its present commitment to prescreening all applicants to nursing facilities age 65 and older, regardless of their payer status, to include all nursing facility applicants, regardless of their age or payer source. Helping a private pay nursing facility	As part of enhanced oversight of nursing home admissions, DDS OBRA Coordinators monitor admissions and progress closely and assure that the individual, family and provider, if	June Special Session, P.A. 07-2, Section 63: Requires that DMHAS, in consultation with DSS, review the status of each nursing facility resident with a mental illness at least annually

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applicant understand their community options and possibly avoid or delay their entrance into a nursing facility is not only advantageous to the individual and family but is a wise investment for the State. Similar prescreening for all institutions should be developed for individuals with disabilities.	applicable, are educated about options and alternative in the community. The DMHAS Diversion and Transition Program collaborates with DSS to monitor appropriate nursing home referrals and facilitate discussion for safe alternatives for discharge. The implementation of a new web based screening system is a benchmark under the MFP Rebalancing Demonstration. The benchmark will measure the decrease in the number of persons discharged from hospitals to institutions. A Request for Proposal (RFP) was posted for a web based system. DHMAS will be part of the RFP review committee. This process will enhance diversion efforts for persons who could be supported in the community with services. In October 2008, DSS conducted an educational seminar on the prescreening process for individuals with mental illness and intellectual disabilities.	to determine whether the resident requires the level of services provided by the nursing facility or specialized services for mental illness. June Special Session, P.A. 09-3: To prevent inappropriate admissions to nursing facilities, funding is appropriated to develop a state-of-the-art, online screening system to allow DSS to assume responsibility for screening individuals with mental illness and intellectual disabilities. The savings in the budget assumes the closure of approximately 100 nursing home beds in SFY 2011 and additional closures in the future. SFY 2010: ($3.8 million) SFY 2011: ($8.3 million)
▪ As part of the prescreening efforts, the State, in conjunction with providers and other entities working in the community with individuals with disabilities, should	DMHAS conducted two educational seminars at the CT Hospital Association to review and update information.	

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enhance their existing educational efforts with hospitals, physicians, nursing facilities, and other institutions regarding available community options.	Presentations were also done at four private hospitals.	
Adjustments to Institutional Capacity		
▪ As nursing facilities and other institutions close, or occupancy levels are reduced, CT should continue to conduct a needs analysis to: 1) determine if any of the beds are needed elsewhere in the system; and 2) de-license or reclassify the remaining beds. As this occurs, there is an opportunity to redirect the appropriate level of resources to enhance home and community-based services and supports. Currently, the general practice is that savings from any reduction in institutional beds goes to the General Fund. In order to allow for a redistribution of resources, at the time the beds are removed from the system, a determination should be made as to the cost to provide services for those institutional beds and the costs to provide services to the same number of individuals in the community. If the redistribution occurs, the result will be an increase in home and community-based service expenditures coupled with an increase in the number of individuals served in the community. The difference between the cost of paying for the institutional beds and the cost for community care could be savings to the General Fund.	DSS continues to analyze and monitor the need for beds. Several methods are used to reduce unneeded capacity such as de-licensing or reclassifying beds. DDS has successfully transferred Southbury Training School staff no longer needed due to reduction in the census to be trained to provide in-home family support services. DDS will continue to do this as resources permit.	P.A. 07-209: Modifies the hearing and notice requirements related to the closing of a long-term care facility. Specifies that no facility may close before public hearings are held and DSS approves the request. DSS may impose a fine of up to $5,000 on any facility that does not comply with the closure specifications. P.A. 08-91: Directs DSS to establish a pilot program, within existing resources, to support the development of up to 10 small house nursing homes in the state. The goals of the pilot are to improve the quality of life for nursing home residents and provide nursing home care in home-like, rather than institutionalized, settings. DSS in consultation with the Long-Term Care Planning Committee must evaluate and approve up to 10 small house nursing home proposals. Small house nursing homes participating in the pilot are exempt from certificate of

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		need requirements and processes. September Special Session, P.A. 09-5, Sec. 43: Caps the small house nursing home pilot program to one project and up to 280 beds through June 30, 2011. SFY 2011: ($1.5 million)
▪ Connecticut should create incentives for under utilized 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. Such conversions could help mitigate the large capital expense of building the new housing options that will be needed to help accommodate the increase in individuals receiving services and supports in the community. These conversions can also help institutional operators remain in the long-term care field and utilize their staff as service providers in the community. Such incentives could include low-cost financing for conversions and tax credits. Development of any new community housing options should emphasize consumer direction and choice.		
▪ Connecticut should assess the need for extending the moratorium on construction of new nursing home beds when the enabling legislation sunsets in 2007.		P.A. 07-209: Extends the moratorium on new nursing home beds from June 30, 2007 to June 30, 2012.
Federal Reform		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Connecticut should continue to advocate for changes to federal Medicaid law that will facilitate an expansion of home and community-based options. In the past, CT 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 CT Home Care Program for Elders (CHCP). This proposal would have allowed individuals the same access to home and community-based care as they have for nursing facility care. Unfortunately, CT's proposal was rejected by CMS. CT should resubmit this proposal and continue its efforts in this regard. If successful in its effort to expand the income requirements under the CHCP rules, CT should examine the feasibility of utilizing similar income requirements under its other home and community-based waiver programs, resulting in equal access to home and community-based care and nursing facility care for individuals of all ages and disabilities.		
▪ Current Medicaid law prohibits the reimbursement of room and board charges for those living in the community, including in assisted living communities. CT should continue its efforts to remove this prohibition or expand other federal programs such as Section 8, allowing more aggressive development of community living options.		
▪ Work with Congress and the Centers for Medicare and Medicaid Services to eliminate the "homebound"		

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definition for Medicare home health care or, at a minimum, liberalize this requirement with respect to individuals with long-term disabilities.		
(ii) 2. Balancing the ratio of public and private resources		
▪ ***Connecticut should strive over the next 20 years to increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25 percent. 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 percent of long-term care spending in 2004.***		
Planning Ahead for Long-Term Care		
▪ Connecticut should create new options to encourage personal responsibility and planning and identify and maximize existing non-governmental resources.		P.A. 07-130: Establishes a CT Home Care Option Program for the Elderly (HOPE) and a CT Home Care Trust Fund, administered by the state comptroller. The program and fund must help people plan and save for the costs of certain elderly services that (1) are either not covered by a long-term health insurance policy or supplement services covered by such a policy or by Medicare and (2) will allow them to remain in their homes or live in a non-institutional setting as

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		they age. Participants are allowed to establish individual saving accounts within the fund and a designated beneficiary is allowed to withdraw funds from an account to pay for qualified home care expenses. It exempts interest earned on fund accounts from the state income tax and makes any unspent funds remaining in an account when a beneficiary dies part of his or her estate. P.A. 08-140: Exempts dividends and capital gains earned on contributions to an account in the Homecare Option Program for the Elderly (HOPE) from the designated account beneficiary's state income tax. Interest earned on such contributions is already exempt. The Act expands the specified people who can benefit from a HOPE account to include any designated beneficiary. Previously, only a person who entered the HOPE participation agreement or who is later designated as that person's spouse or civil union partner could benefit. Finally, the bill adds certain requirements and stipulations concerning the status of the HOPE trust fund, its relationship to the state, and how deposits must be

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		administered. P.A. 07-226: Changes the elimination period requirement under a long-term care policy. In addition to the existing requirement for an elimination period that is up to 100 days of confinement, the act permits an elimination period of between 100 days and two years of confinement if an irrevocable trust is in place that is estimated to be sufficient to cover the person's confinement costs during this period.
▪ Connecticut, working with the federal government, should develop incentives for individuals to save for their future long-term care needs. Preferential tax treatment for dedicated long-term care savings accounts could provide some additional opportunities to infuse private resources into the system without forcing individuals to impoverish themselves. CT should also explore opportunities on the state level to provide tax relief for unreimbursed medical and long-term care expenses.		
▪ Connecticut should continue, and enhance, the efforts of the CT Partnership for Long-Term Care (Partnership), the State's public/private alliance to help educate CT residents about the importance of planning ahead for future long-term care needs through the purchase of high quality private long-term care insurance (LTCI). While the Partnership has had a significant impact on the	The CT Partnership has continued its outreach and educational activities conducting numerous Public Forums, presentations and trainings throughout the state.	P.A. 07-28: Prohibits an insurer from issuing or delivering a long-term care policy on or after July 1, 2008 unless it had offered the prospective insured an optional nonforfeiture benefit during the policy solicitation or application process. The offer may be

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purchase of private long-term care insurance, with over 45,000 Partnership policies purchased, there is much more that can be done. 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 home care. If individuals understood that LTCI could actually help them remain at home or in the community it might become a more attractive option.		in the form of a rider to the policy. If the nonforfeiture option is declined, the insurer must give the insured a contingent benefit if the policy lapses (i.e., terminates because the insured stops paying the premium). The contingent benefit must be available to the insured for a period of time after any substantial premium increase.
▪ The State should pursue possible funding under the federal Long-Term Care Awareness Campaign. This demonstration project sponsored by the U.S. Department of Health and Human Services is designed to help states increase consumer awareness of the need of long-term care and financial planning.	In September 2007, Governor Rell applied to participate in the federal Long-Term Care Awareness Campaign in the fall of 2007, in collaboration with the Partnership for Long-Term Care, Commission on Aging, Long-Term Care Planning Committee, Long-Term Care Advisory Council, CHOICES Program, and State Comptrollers Office. The CT proposal was not selected.	
▪ The State should take advantage of any opportunities to enhance the educational capabilities of the Partnership through the use of public and private resources. Alliances with local communities should be explored to bring the issue of long-term care planning into as many communities as possible. In addition, partnerships with the state's media outlets should be enhanced to enlist the media's support in the efforts to educate CT residents about this important issue.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Connecticut should explore the development of various products, including a high-risk pool for long-term care insurance to enable individuals who are currently uninsurable to obtain the coverage they need.		
▪ Connecticut should continue its efforts on the federal level to enact an "above the line" tax deduction for the purchase of long-term care insurance. Such a tax deduction would also result in a State tax deduction as long as CT's tax system is tied to an individual's federal Adjusted Gross Income. If federal action on this issue is not taken, CT should explore its own tax incentives for long-term care insurance, such as tax credits or deductions. Any effort to provide tax incentives should be targeted or focused to ensure that the market is truly expanded to include those where the insurance might be unaffordable.		
▪ Connecticut should explore and develop other models for private long-term care insurance. Such models could include a combination disability and long-term care insurance policy or variations on existing combination life insurance and long-term care insurance policy.		
▪ Connecticut should examine the state and federal reverse annuity mortgage (RAM) programs to see if any enhancements can be made to increase the usage of this program. An effective RAM program could allow individuals to use their home equity to remain in their homes longer or even to use the resources to purchase long-term care insurance if that is an affordable and		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
accessible option for them. RAMs may become more popular in light of the DRA provision on home equity and Medicaid eligibility for long-term care services described earlier.		
(b) B. Focus Areas		
(i) 1. Community Options		
▪ Enhance the capacity of communities to accommodate the needs of individuals with disabilities. Encourage communities to take an active role in planning and supporting long-term care for their residents.		
▪ Encourage communities to provide a more supportive infrastructure including more affordable housing, expanded and coordinated transportation options, and side walks, cross walks and curb cuts.	The MFP Rebalancing Demonstration funds five positions to identify existing affordable, accessible housing at a local level. Planning has begun to implement an Independent Transportation Network (ITN) model in the following areas: Middletown, New Britain, West Hartford, Enfield and Torrington.	June Special Session, P.A. 07-1: Appropriates $250,000 to DSS in support of the Independent Transportation Network (ITN) program. Of this, $125,000 will be used to provide five $25,000 grants to each of the existing ITN projects, and $125,000 will fund five $25,000 grants to new projects. SFY 2008: $250,000 SFY 2009: $250,000
▪ Encourage the adoption of actions developed within Model Communities and Interroburst conferences to reduce the isolation felt by individuals with disabilities living in the community and their families.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Encourage public education on the role all citizens can play within their communities in addressing long-term needs of their friends, neighbors and fellow citizens.		
▪ Connecticut should support additional Interroburst forums to explore the meaning of community and to reduce the isolation of individuals and families.		
▪ Continue support of the monthly series "Able Lives" aired on CT Public Television in 2006 to educate the public on the lives of individuals with disabilities and effect the change needed to create more inclusive communities. This program is sponsored by the CT Council on Developmental Disabilities and other state and private agencies.	Through March 2007, ten shows were produced and aired on CPTV. Additional funding is now being sought to continue producing and airing more shows. DDS was a primary co-sponsor of this series in 2007. The Medicaid Infrastructure Grant built on the success of the Able Lives series and sponsored the production of Able Lives, Inc., a 5-part series focused on workers with disabilities.	
▪ Explore the benefits and potential for adding a service to the CT Home Care Program for Elders that allows payment to Adult Day Care Centers for therapies, making them approved rehabilitation sites. This should include consideration of licensing and Medicaid reimbursement issues.		September Special Session, P.A. 09-5, Sec. 77: Requires DSS to provide a rate increase for providers of adult day care services under the CT Home Care Program for Elders. SFY 2010: $700,000 SFY 2010: $700,000

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
(ii) 2. Informal Caregivers		
▪ In order for individuals with disabilities to remain at home or in the community as long as possible, support for family caregivers should take a variety of coordinated forms. These could include information and training, respite services to caregivers, tax benefits and incentives, payment to informal caregivers, transportation alternatives, physical, occupational and speech therapy alternatives, and disability supports.	Under the Community-integrated Personal Assistance Support Services (C-PASS) Grant to the University of CT Center on Disabilities, a training curriculum on hiring and managing personal assistance services was created and, as of the Spring of 2007, is available on various websites. DDS increased its family support capacity through the addition of in-home family support workers and the opening of an additional respite home in SFY 2007. In 2008, DDS operates 11 respite centers statewide. Under "Choices At Home: CT's Nursing Home Diversion Modernization Project" the DSS Aging Services Division, in partnership with the Agency on Aging of South Central CT, is implementing a pilot program with the goal of assisting seniors who are at high risk for nursing home placement, but not yet eligible for Medicaid, to remain in their own homes. By providing respite services that allow a caregiver to employ someone of their own choosing and providing expanded supplemental services such as assistive technologies and home modifications,	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	this pilot will provide flexible service options to those who wish to remain in the community for as long as possible.	
▪ In addition to continuing existing respite care efforts, CT should replicate its successful Alzheimer's Respite Care program to provide respite services for any caregiver of individuals with disabilities of all ages. Respite across the lifespan should be available to provide an easy access to an array of affordable, quality respite services; ensure flexibility to meet diverse needs, and assist with locating training and paying respite providers. As CT begins to increase the amount it spends on home and community-based care while reducing its institutional expenditures, it should allocate resources towards the support of informal caregivers through respite care and caregiver training programs.	DSS implemented the CT Home Care Program for Disabled Adults (CHCPD) program in 2008 to provide home care services to individuals with disabilities who require long term home care services. The CT Statewide Respite Care Program does not limit services to those of a particular age, but is disease specific and partners with the Alzheimer's Association to offer a significant education and outreach component to this population. Under the National Family Caregiver Support Program (NFCSP) relative caregivers providing care for adult children with disabilities can now be served. Also, under NFCSP, family caregivers of a person with Alzheimer's disease or a related dementia may be served regardless of the age of the person with dementia. In 2008, DSS Aging Services was awarded the Nursing Home Diversion and Modernization Grant from the federal Administration on Aging (AoA). Under this grant, an Aging and	P.A. 07-86: Allows people over age 65 receiving community Medicaid, which does not provide respite care, to participate in the Statewide Respite Program. It does this by changing the people excluded from this program from those covered by Medicaid to those covered by the CT Home Care Program for Elders. June Special Session, P.A. 07-1: Appropriates an additional $1 million in each year of the biennium to the Statewide Respite Program. SFY 2008: $1,000,000 SFY 2009: $1,000,000 P.A. 09-75: For the Alzheimer's Respite Care Program: 1) Increases the annual income limit from $30,000 to $41,000 and increases its asset limit from $80,000 to $109,000; 2) Beginning July 1, 2009, requires DSS to annually increase the income and asset limits to reflect Social Security cost of living adjustments; and 3) Adds Personal Care Assistant services to the list of respite care services the

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Disability Resource Center (ADRC) will be developed in CT that will better coordinate services and improve communication between the various agencies that serve individuals across the lifespan. Also, the Diversion grant will expand caregiving options by offering Cash and Counseling to participants in the CT Statewide Respite Care Program and the National Family Caregiver Support Program, allowing individuals to choose and hire their own caregivers. DMHAS is credentialing agencies across the state to provide Community Support Services which are rehabilitative services performed in the community.	program provides.
▪ The State should 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.	The National Family Caregiver Support Program cannot expand current services without a funding increase. In FFY 2008, the funding for this program was decreased.	
▪ Connecticut should explore the potential for supporting overnight respite care in settings other than institutions. This should include consideration of licensing and Medicaid reimbursement issues.	Currently, the CT Statewide Respite Care Program and the National Family Caregiver Support Program offer overnight respite stays in assisted living facilities. Respite is not limited to institutions in these programs.	P.A. 08-158: Requires DSS to amend the Medicaid State Plan to add hospice services, beginning January 1, 2009.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Respite training should be considered as part of the curriculum within appropriate programs at state colleges and universities and other educational settings. Such curriculum also should include a component to assist individuals with disabilities and their family members in promoting self-determination.	The CT Lifespan Respite Coalition was involved in an effort with Gateway Community College to implement this initiative.	
▪ Training should be developed for public and private providers to better assist families and other informal caregivers to develop the supports necessary to allow a person with disabilities to live in their community.	Through the Community-integrated Personal Assistance Support Services (C-PASS) Grant, Fact Sheets on various topic areas are in the final stages of being produced. They will help employers of personal assistants to train their new employees around different topics that impact on their work. All providers participating in the MFP Rebalancing Demonstration are required to participate in values based training.	
▪ Connecticut should continue its efforts on the federal level to enact a tax credit for those providing informal care.		
(iii) 3. Long-Term Care Workforce		
▪ Connecticut should 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	The www.RewardingWork.org website is well underway. As of June 2007, over 1,920 people had registered on the site as people interested in working as personal assistants. The website is also	P.A. 07-76: Allows unlicensed "assistive personnel" employed in residential care homes to perform limited health-related activities for residents, including obtaining and

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
viable career, these types of jobs will need to provide the necessary worker benefits and supports. In addition, optional training for PCAs should be considered part of the curriculum within appropriate state colleges and universities and other educational settings.	being marketed to people with disabilities to increase awareness of the website as a hiring resource. Collaborative efforts have occurred between the University of CT A.J. Pappanikou Center for Excellence in Developmental Disabilities (UCEDD), Bureau of Rehabilitation Services, DDS and Allied Community Resources to spread information about this website. DDS actively promotes the use of www.RewardingWork.org as a staff recruitment tool for families and consumers who choose to self direct their supports and services. With the implementation of P.A. 09-64, DSS will add more flexible, consumer directed service delivery options.	recording blood pressure and temperature with certain digital equipment, obtaining and documenting weight, and assisting in the use of a glucose monitor and documenting blood glucose levels. P.A. 09-64: Requires DSS to provide personal care assistance (PCA) services under the CT Homecare Program for Elders (CHCPE) if these services are (1) not available under the Medicaid state plan, (2) more cost effective on an individual client basis than existing Medicaid state plan services, and (3) approved by the federal government.
▪ Connecticut should work with organizations to continue the efforts of the Community-integrated Personal Assistance Support Services (C-PASS) grant as it pertains to training employers how to hire and manage personal care assistants, as well as to continue the www.RewardingWork.org website.	The University of CT A.J. Pappanikou Center for Excellence in Developmental Disabilities (UCEDD) is working collaboratively with Bureau of Rehabilitation Services, the DDS and Allied Community Resources to provide materials that will be placed on websites. DDS is an active supporter of the C-PASS outcomes and have modified the	

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	existing UCEDD C-PASS curriculum to reflect DDS policies and procedures. This updated curriculum was used with the Self Advocate Coordinators (SACs) in a three day train-the-trainer training in April, 2007. The SACs are currently in the process of implementing a pilot project where they are each training 2-3 consumers on the content of the curriculum. The UCEDD has researchers who are tracking the before and after experiences of the trainees to determine both the quality of the content and the skill of the SACs as trainers. This pilot ended September 30, 2007 with a graduation ceremony for eight consumers and their families. DDS has an ongoing program to train individuals to become employers when they wish to self direct all or part of their services. The Self Advocates serve as peer trainers.	
▪ Connecticut should evaluate the Personal Care Assistance Pilot under the CT Home Care Program for Elders to determine the potential for making personal care assistance a permanent benefit.		P.A. 07-130: Eliminates the 250 person limit on the number of participants in the state-funded Personal Care Assistance Pilot.
▪ Connecticut should develop programs to address the professional workforce shortage. Strategies could include attracting students into the field with scholarships and grants, developing career paths	Manchester Community College offers a Disability Specialist Program that prepares individuals to work for professional service delivery agencies,	Funding is appropriated to the Department of Public Health (DPH) to establish a loan forgiveness program for historically under represented

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allowing for increases in responsibility, status and wages, enhancing public perception of these jobs, and professionalization of paraprofessional positions. There is also potential for re-training individuals who lose their job in such sectors as manufacturing for a new career in long-term care.	companies who wish to comply with the Americans with Disabilities Act and individuals with disabilities who are employing men and women who provide personal assistance services.	students pursuing careers in nursing. SFY 2008 - $125,000 SFY 2009 - $125,000 P.A. 09-148, Section 18: Establishes a task force to study the state's health care workforce. By July 1, 2010, the task force must develop a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medial personnel, including, physicians, nurses and allied health professions.
▪ Connecticut should increase the capacity of educational institutions (i.e. state colleges and universities and high schools) to provide training for professional long-term care workers in order to address the current need for and projected growth of these workers in the state.		Funding is appropriated to DPH to support initiatives to address nursing and allied health workforce shortages. Such initiatives may include, but not be limited to, a faculty scholarship program, a nursing faculty student loan program, grants to higher education institutions for faculty positions, a recruitment and retention campaign to promote awareness of nursing and allied health careers, and support for an allied health workforce policy board. SFY 2008 - $375,000 SFY 2009 - $375,000 P.A. 09-130: Requires the Department of Higher Education to

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		maximize federal revenue in support of a nursing program at Northwester CT Community College.
▪ Connecticut should promote the use of distance learning programs to enhance the skills of direct support professionals.	DDS obtained *The College of Support* distance learning direct support professional on-line training products for use by DDS private providers for a small administrative fee, and for free for individual consumers and families who hire consumer-directed staff to enhance the skills of direct support professional in a cost effective manner.	
▪ Home care agencies, nursing homes, and other long-term care providers should consider ways to increase the numbers of direct care workers and provide incentives for recruiting and retaining workers.		P.A. 07-34: Requires that each Alzheimer's special care unit or program annually provide a minimum of one hour of Alzheimer's and dementia specific training to all unlicensed and unregistered staff program.
▪ Recruitment of bilingual workers is needed to assure services are accessible and acceptable to individuals whose primary language is not English.		
(iv) 4. Housing		
▪ Over the next biennium, support the efforts of the Accessible Housing Registry to identify accessible units and increase their utilization.	The updated Accessible Housing Registry became available in July 2007 at www.CTHousingSearch.org. DECD continues its special marketing efforts	

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	for this resource. The five housing coordinators hired under the MFP Rebalancing Demonstration will work with landlords to increase the number of privately funded units on the Accessible Housing Registry.	
▪ Expand and preserve the stock of housing for elders and persons with disabilities.	Request for Proposals for two rounds of Next Steps Supportive Housing Development have been completed. This Supportive Housing Initiative is to provide housing and support services to individuals and families who are homeless and have a mental health disorder, substance abuse disorder, or HIV/AIDS. The first round of Next Steps Supportive Housing will consist of 8 projects that will create 131 new units of affordable housing of which 70 units will be set aside for supportive housing. Currently two projects have been completed creating 18 units of affordable housing of which 13 units are supportive. The second round of Next Steps will create 156 units of affordable housing, of which 102 units will be dedicated to supportive housing. All of these projects are currently in the development process.	P.A. 08-123: Authorizes DMHAS to provide an additional 500 "Next Steps" supportive housing units for people with mental illness. Funding for these units comes from mortgages, tax credits, and grants from the CT Housing Finance Authority (CHFA) and the Department of Economic and Community Development (DECD). The Act authorizes the State to provide annual debt service payments on an additional $35 million in bonds issued by CHFA. September Special Session, P.A. 09-7, Sec. 20: Authorized funds to provide rental assistance and services for the Next Steps Initiative's Round 3 development projects and pay for debt service for the bonds issued to finance the projects.

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	DECD has awarded $500,000 to the Corporation for Independent Living to administer the MFP Grants for Accessibility Program. In addition, DECD has provided $2 million since 1996 for loans and grants for accessibility to expand the housing stock for elders and person with disabilities. Over the past two years, DECD has funded the Fair Housing Center to assist it in carrying out its mission. The Fair Housing Center has provided DECD staff and DECD clients, which include both public and private housing owners, managers, and developers, and cities and towns, with training on fair housing laws including affirmative marketing, and especially in the areas of civil rights and anti- discrimination laws for people with disabilities including the elderly. DECD focused on the Americans with Disabilities Act (ADA), and federal and state fair housing laws. With assistance from the Fair Housing Center, DECD updated all of their affirmative action forms and applications allowing housing providers to better serve individuals with disabilities and to understand their rights. In addition, DECD made training available to third party providers who provide services to	

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	people with disabilities. They in turn can now advise their clients to recognize the signs of discrimination.	
▪ Enforce current standards in CT regulation and statute, including the Building Code, which require builders of new developments to create a certain percentage of wheelchair accessible units.	All Next Step units developed adhere to state law regarding the percentage of wheelchair accessible units. In addition, in the rating and ranking process, projects that propose a higher percentage of handicapped accessible units than state law requires receive extra points in the review process.	
▪ Promote universal design with architects and housing developers.		
▪ Increase outreach to landlords about resources and financing to make their units accessible.	Housing coordinators under the MFP Rebalancing Demonstration will provide outreach to landlords about resources and financing available to make their units accessible. DECD has awarded $500,000 to the Corporation for Independent Living to administer the MFP Grants for Accessibility Program. In addition, DECD has provided $2 million since 1996 for loans and grants for accessibility to expand the housing stock for elders and persons with disabilities.	P.A. 08-93: Allows certain elderly and disabled individuals accepted into state or federally subsidized housing to terminate their existing leases or rental agreements without penalty if they provide 30 days written notice to their landlord. The bill applies to low-income seniors age 62 and older and individuals certified as disabled by a federal board or agency.
▪ Increase the utilization of Section 8 Vouchers in	Under the MFP Rebalancing	

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communities throughout CT so additional vouchers may be requested from HUD.	Demonstration, persons transitioning from a nursing home to the community will receive a Rental Assistance Program (RAP) certificate. DMHAS also manages the Shelter Plus Care Program, a federally funded program that matches housing and services to individuals and families that are homeless and have a mental health or substance abuse disorder or HIV/AIDS. Although this housing program is permanent, one of the goals is to move those individuals who stabilize and no longer need the support services aspect of Shelter Plus Care to Section 8 certificates, which creates a new unit for a homeless individual while also increasing the utilization of Section 8 in CT.	
▪ 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 individuals with disabilities.	To address the need for Resident Service Coordination (RSC) training and evaluation, the UConn Center on Aging, University of CT Health Center, received a grant in 2008 from the Department of Economic and Community Development. By May 31, 2010, the Center on Aging will complete training program modules, a RSC training website, and RSC knowledge and partnership building evaluation	June Special Session, P.A. 07-1: Appropriates $1 million funding in the Department on Economic and Community Development budget for resident services coordinators. SFY 2008: $1,000,000 SFY 2009: $1,000,000

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	tools. As part of this grant, the Center on Aging will also develop an evaluation strategy for assisted living services in state-supported housing sites.	
▪ Expand assisted living options beyond those available to the elderly.	Both DDS home and community-based Medicaid waivers offer assisted living as a service.	
▪ Ensure that all State agencies that construct or rehabilitate housing or provide rental assistance report the accessible units to the accessible housing registry.	Appearing on the accessible housing registry are Supportive Housing projects in which CHFA or HUD provides capital funding resources and in which DMHAS provides support service funding.	
▪ Maintain current building codes for type A units and require local building officials to report such units to the Department of Economic and Community Development as part of the building permit process.		
(v) 5. Employment		
▪ Improve the transition process for young adults moving from school to post-secondary education or employment.	The Medicaid Infrastructure Grant (MIG), a five-year federal grant designed to improve employment for persons with disabilities, has been working to increase employment opportunities for young adults with disabilities. Specifically, the MIG has: ▪ Improved its employment information for young adults, parents	

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	and educators on www.Connect-Ability.com, including a youth blog; ▪ Developed and administered a survey of school districts to better understand existing work opportunities available to young adults with disabilities; ▪ Begun the creation of a searchable database of community rehabilitation providers. Collaborations with other advocacy groups and state agencies who serve young adults have resulted in greater access to information about available services and eligibility criteria. The National Governor's Association workgroup of 11 state agencies developed a searchable database of agencies' services and eligibility requirements for young adults. The Bureau of Rehabilitation Services (BRS) developed a Transition web page outlining BRS services, policies, school liaison locations, frequently asked questions (FAQs), independent living information and a Toolkit of resources and materials for students, parents and schools/counselors.	

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	Educational collaboratives have been organized in all regions to bring together representatives from local DMHAS employment providers and clubhouses with the local college counseling staff. The collaboratives focus on strategies for improving the outcomes of students in recovery including more coordination of educational supports, peer mentoring, and more effective referrals for additional resources. DMHAS Young Adult Services (YAS) has placed employment staff on YAS teams to engage and support youth in preparing for and entering employment. DMHAS is participating in a Dartmouth University-sponsored national project to increase the involvement of family members in their family members' employment services. Four Local Mental Health Authorities are surveying family members to identify barriers and strategies for greater involvement. DMHAS staff will team with local family members to train families throughout the targeted regions on employment supports and the role of family members in strengthening employment outcomes.	

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	DDS has joined with the National Association of State Directors of Developmental Disabilities Services and the State Employment Leadership Network (SELN) as one of the initial state MR/DD agencies to focus on re-energizing the growth and effectiveness of supported employment and access to competitive employment for people supported by DDS. In late 2008, DDS will launch an Employment First initiative.	
▪ Increase expectations for people with disabilities in achieving career potential.	The Medicaid Infrastructure Grant (MIG) has created a web-based technical assistance component at www.connect-ability.com as well as a call-in center. Both are designed to assist persons with disabilities and employers in connecting with one another. The MIG has also launched a statewide marketing campaign specifically designed to increase expectations about people with disabilities as workers. This campaign includes TV, radio, newspaper, journals and other media. The Bureau of Rehabilitation Services (BRS) and DMHAS have entered in to a partnership which co-locates BRS Vocational Rehabilitation Specialists in	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	three Local Mental Health Authorities to improve employment outcomes for persons within the DMHAS services system. The goal is to integrate employment planning into the treatment process when an individual enters the DMHAS system and wants to gain or resume competitive employment. There is a research and evaluative component to the pilot which will measure outcomes over time. In response to research on the efficacy of vocational services for people living with mental health issues, Northwest Mental Health Authority is collaborating with Street Smart Ventures in order to potentially create a business designed to meet the needs of Young Adults. Street Smart Ventures operates on the belief that entrepreneurship, work and learning can be integrated into highly motivating and mentor-rich activities to teach life skill, work skill, and academic skill. Such a partnership is beneficial when working with at-risk youth and young adults. DDS hosted a Self-advocates Supported Employment forum in May 2007 for individuals supported by the department to provide training and information to	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	enhance expectations and access to supported employment supports. DDS will launch an Employment First initiative in late 2008. Formation of an Employment advisory Council is planned for 2009. DMHAS provides staff training on multiple employment issues and strategies, as well as on-site technical assistance to strengthen provider employment programs. Multiple trainings have focused on evidenced-based supported employment practices. On-site technical assistance promotes the viability of employment as a key tool for recovery and articulates the role of staff from multiple disciplines in supporting employment. Staff from DMHAS provider agencies are working closely with DSS to recruit Ticket to Work "Employment Networks" (ENs). These ENS will receive financial incentives to help individuals become economically self-sufficient through employment. Multiple trainings have been delivered to supportive housing providers to raise staff awareness regarding local employment systems. Participants	

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	explore strategies for helping tenants return to work and learn protocols for linking tenants with local services. Several Department of Labor offices and their Disability Navigators have received training over the past year on assisting DMHAS consumers to return to work.	
▪ Increase the recruitment, employment and retention of individuals with disabilities into CT businesses.	The Medicaid Infrastructure Grant (MIG) has been working with CT's Business Leadership Network to increase peer-to-peer strategies for employers interested in increasing their recruitment of job seekers with disabilities. The MIG has also been developing tools for employers around recruitment, hiring and retention, including the project's first e-learning tools which will be launched at the Employment Summit in June, 2008. Six Local Mental Health Authority systems in CT have adopted the evidenced-based (EBP) supported employment model which has been proven to yield higher rates of employment and retention. Training in the EBP is offered ten times each year	

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	through DMHAS Recovery Institute. Fidelity audits are conducted to assess each site's adherence to the model. Case management in DMHAS supportive housing and One Stop staff in several regions are participating in employment training to raise awareness of their roles in supporting employment for persons in recovery.	
▪ Increase access to transportation to and from work for individuals with disabilities.	The Medicaid Infrastructure Grant (MIG) has included a wealth of transportation information on its website, and is expanding this information to support job seekers with disabilities in areas of the state where information was not readily available. A Transportation Forum entitled Making Connections was held in May 2008 and brought together key stakeholders to identify major barriers and crystallize an action plan.	
▪ Provide technical assistance to support the development of effective strategies for increasing employment of people with disabilities.	The Medicaid Infrastructure Grant (MIG) technical assistance center has provided information to almost 400 callers to the call-in center, and an additional 17,000 unique visitors have gone to the Connect-Ability website.	

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	The MIG is also working to make the State of CT a model employer by encouraging Commissioners to work with the project to develop agency-specific work plans to increase the recruitment and/or retention of state employees with disabilities. Monthly employment staff roundtable discussions at DMHAS are held on various topics to build capacity in the field. Topics that have been addressed include transportation options, strategies for remediating cognitive disabilities, and various "tools" that have been useful. The next discussion will focus on peer supports for employment. DMHAS has initiated a parallel employment planning process in the addictions community. Addictions stakeholders are meeting regularly to develop a common vision, goals and best practices for persons in addictions recovery. All Local Mental Health Authorities (LMHA) submit annual reports to DMHAS on the status of their employment services, with goals for moving toward a more recovery-oriented system. Agencies are asked to	

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	report on their quality improvement and oversight capacity, how employment services are introduced and encouraged for all, how staff and consumers are trained on issues relating to employment, how their systems are tapping other community resources, and data collection processes. The LMHAs are given feedback from DMHAS' Employment Review Team. Through participation with the State Employment Leadership Network (SELN), the Department of Developmental Service has access to national technical assistance and best practice resources to bring to CT.	
(vi) 6. Transportation		
▪ Whenever new housing resources are being developed for individuals with disabilities or the general public, consideration should be given to the availability of public transportation resources.		
▪ Whenever new supportive employment opportunities are being developed for individuals with disabilities, consideration should be given to the availability of public transportation resources.		
▪ The Department of Transportation, the Office of Policy and Management, State agencies and stakeholders	Through the PATHS Transportation Initiative, the University of CT A.J.	

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involved in serving or transporting clients and individuals with disabilities should engage a facilitated long-term planning process to evaluate the existing transportation system. The goal of this evaluation should be to improve the existing transportation system to achieve uniform coverage and to better meet the medical and social needs of CT citizens with disabilities to allow them to participate fully in community life.	Pappanikou Center for Excellence in Developmental Disabilities (UCEDD) held a Transportation Summit to gather together stakeholders including people with disabilities, legislators, and the CT Department of Transportation (DOT) to explore current and future planned transportation services for people with disabilities. DOT is engaged in an ongoing planning process to identify gaps in service and develop strategies to address those transportation gaps specifically for people with disabilities as one of the targeted groups. This process, known as the locally-developed coordinated public transit human services transportation plan (LOCHSTP) is now in its second year of developing and implementing new project proposals. PATHS has supported people with disabilities in attending regional transportation planning meetings in all five regions of the state. DOT has kicked off its effort to improve coordination among state human service agencies providing transportation through the United We Ride effort, which is supported by two small federal planning grants.	

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	PATHS is offering ongoing technical assistance to DOT for the United We Ride Project.	
▪ Towns, community service providers and Department of Transportation services should collaborate to increase cost-efficient and flexible transportation. Collaboration will reduce instances when agency or municipal vehicles sit idle for part of the day or when multiple transportation services under a variety of agencies travel to similar destinations.		
▪ Some people with disabilities do not always feel safe as passengers on public transportation. Lack of compliance with safety procedures and improper use of equipment are cited as problems. Drivers, despite mandated reporting requirements, do not always report incidents. Drivers and dispatch workers should be mandated to receive awareness and safety training by using people with disabilities as trainers.		P.A. 07-134: Requires that (1) anyone transporting someone being transferred into or out of a motor vehicle while in a wheelchair to provide and use a device designed to secure the person in the wheelchair while transferring him from the ground to the vehicle or the vehicle to the ground and (2) operators of certain specific types of newly registered vehicles provide additional protection through the use of a device that secures the wheelchair to the motor vehicle's mechanical lift, or otherwise prevents or seeks to prevent the person from falling from the vehicle.
(vii) 7. Access to Information and Services		

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▪ Over time, provide maintenance and ongoing updating of the Long-Term Care Services and Supports Website, which was finalized and released to the public in the fall of 2006. The website provides accessible information to all individuals in need of long-term care services and supports, regardless of age or disability.	Office of Policy and Management staff, working with staff from the Commission on Aging, is providing maintenance and ongoing updating of the Long-Term Care Services and Supports Website. DSS is now partnering with the Commission on Aging and the Office of Policy and Management on the Long-Term Care Services and Supports Website to update the website and provide information about the Aging and Disability Resource Centers.	
▪ Explore the development of long-term care information resources for those consumers without Internet access.		
▪ Over the next biennium and over time, distribute the *Nursing Facility Transition Project Handbook* to all present and future Nursing Facility residents.		
▪ Over the next biennium and over time, distribute the *Department of Mental Retardation (DMR) Consumer and Family Guide to the DMR Home and Community-based Services Waivers* and *Understanding the DMR Home and Community-based Waivers: An Introduction to Your Hiring Choices Guide* to all present and future DDS consumers. (Note: guides were published before the Department name change in October 2007)	DDS distributes its guides to case managers and families, transition coordinators and consumers through a variety of educational events and individual planning meetings for consumers. The guides are also available in Spanish and all versions are posted to the DDS website.	
▪ Expand existing information and referral resources in order to establish and evaluate a Nursing Facility	DSS received federal grant funding from the Administration on Aging (AoA) for	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Transition Project hotline that will serve as an information resource for those interested in transitioning to the community.	the Nursing Home Diversion and Modernization Grant designed to divert older adults from entering nursing homes by providing alternate services which enables them to stay in their homes. One item of this grant is the development of a pilot ADRC in the south central region of the state. The pilot is underway and simultaneously, a statewide ADRC Steering Committee has been convened to discuss the development and replication of the pilot statewide. Two regional ADRCs have been established in CT. The first was established in South Central CT on October 1, 2008 and the second was established on May 1, 2009. The MFP Rebalancing Demonstration is responsible for designing and implementing a statewide outreach campaign including information and referral for transition services. The Demonstration will have a dedicated toll free line.	
▪ Initiate public/private partnerships to enhance public education regarding all aspects of the long-term care system in CT. This should be done, in part, by building upon existing resources such as CHOICES and Infoline.	CHOICES continues counseling CT residents on Medicare Part D and is making preparations to offer Long-Term Care Options Counseling to CT	P.A.07-155: Expands the statutory role of the DSS CHOICES health insurance assistance program in disseminating information and

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Include business, government, legislative, and faith-based organizations, and community as well as consumer partners in this campaign to recognize strengths and needs of all individuals and families, to attract more workers to the health care arena, and to increase community concern and commitment to change.	residents.	providing advice to Medicare beneficiaries to include the federal Medicare Part D prescription drug program and long-term care options in the state. CHOICES is also required to collaborate with other state agencies and entities in developing consumer-oriented websites that provide information on Medicare plans, including Medicare Part D plans and available long-term care options. It adds CHOICES to the group charged with developing the state's long-term care website (the Office of Policy and Management, the Select Committee on Aging, the Commission on Aging, and the Long-term Care Advisory Council), which began operating in 2006. June Special Session, P.A. 07-1, Sections 59(g) and (h): Transfers $1 million in each of SFY 2008 and SFY 2009 from the Tobacco and Health Trust Fund to the DSS for the CHOICES program. SFY 2008: $1,000,000 SFY 2009: $1,000,000
▪ Support specific programs to disseminate information about transportation resources to both users and human service providers. Tools such as websites, the "Getting	Connect-Ability is considering funding an enhancement to the transit bus scheduling system that will allow web-	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
on Board" brochures used by case workers facilitating access to jobs for people with disabilities, and Infoline are resources for individuals to access information about transportation services available in their region.	based trip planning for people with disabilities.	
(viii) 8. Prevention		
▪ Utilize health promotion resources and initiatives outside of State government and attempt to coordinate the various efforts.		
▪ Encourage further development of Visitation Programs for individuals and families in home, community and structured settings.		
▪ Establish a working Fall Prevention partnership between the DSS Aging Services Division and the Department of Public Health (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 the elderly, fall prevention programs should be available to individuals of all ages.	CT's proposal on Fall Prevention and Chronic Disease Management was selected for funding by the federal Administration on Aging. The grant is for three years for $250,000 each year. DSS and DPH have been working in partnership to implement the Administration on Aging (AoA) evidence-based health grant, Empowering People to Take More Control of Their Health. A Fall Prevention education and assessment training program is being implemented in the Western region with a focus on Resident Service Coordinators and in the Southern region with case managers	In the 2007 Legislative Session, the CT Collaboration for Fall Prevention (CCFP) received $1 million dollars in total funding for SFY 2008 and SFY 2009 to decrease the number of falls among older adults statewide through assessment and training and to identify opportunities in which state policy could be modified to change attitudes and knowledge related to fall prevention. The CCFP has been engaged in community-based fall prevention efforts in CT since the year 2000. September Special Session, P.A. 09-5, Sec. 52-54: Establishes, within

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	in the CT Home Care Program for Elders.	available appropriations, a fall prevention program at DSS. Funding for the program is to be taken from the Insurance Fund via the current industry assessment process. SFY 2010: $500,000 SFY 2011: $500,000
▪ Explore opportunities to prevent the incidence, and delay the progression, of chronic diseases, such as better integration of the delivery of acute and long-term care across settings, use of prescription drugs, increased use of technology such as telemedicine, and increased patient education and self management.		
▪ Explore implementation of Wellness and Nutrition programs and the use of managed health care coordination for individuals served by the Department of Developmental Services (DDS) who live on their own or with their families as a means to identify and prevent emergent serious health conditions.	In the Spring of 2007, the North Region initiated a managed supported health care initiative in the DDS, hiring a nurse consultant to provide health care coordination to an identified group of individuals supported in a variety of settings to assess the effectiveness of the model. The initiative continues in 2008, serving 35 consumers. A final report will be available in fall 2008. Wellness activities were piloted in all DDS regions for people who live in their own homes with supports. DDS will include health care coordination in its amendment applications for both DDS Medicaid home and community-based waivers.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ Explore opportunities to work with CT's medical and dental schools and allied professions to increase access to health care screening and preventive and restorative dentistry for individuals with disabilities. For example, establish a DMR Dental Coordinator and possible University of CT dental fellowship to address the lack of community dental care for persons with cognitive disabilities.	In 2007, DDS established a DDS Dental Coordinator position to work collaboratively with UCONN and private providers. The Dental Coordinator was hired in September 2007. A dental services status report and recommendations was presented to key DDS staff in Spring 2008 as a basis for developing goals for the 2009 DDS business plan.	
▪ Reduce the incidence of disabilities in newborns by increasing awareness of mercury poisoning and Fetal Alcohol Syndrome.		
(ix) 9. Quality of Care		
▪ Develop improved quality measures for persons with disabilities in the community under person-centered, consumer-directed programs. Such measures must reflect the individuals' own preferences and desires and allow reasonable risks while still avoiding unreasonable risks.	An improved quality assurance system for home and community-based services is a priority under the MFP Rebalancing Demonstration. In the DMHAS Annual Consumer Satisfaction Survey, a five-item recovery domain has been added. Consumers are asked to respond to such items as "I am involved in my community," "I am able to pursue my interests," "I feel like I am in control of my treatment," etc.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DDS has designed measures for implementation with the DDS Quality System Review (QSR) system anticipated for use in SFY 2008. QSR is operational in DDS despite problems launching the web-based data application that once deployed will allow DDS to fully implement the QSR. Deployment is expected early in SFY 2009.	
▪ Connecticut should 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.	The MFP Rebalancing Demonstration places a priority on access to and successful integration of assistive technology as a valuable tool for persons with disabilities living in the community. Staff training is planned. The MFP Rebalancing Demonstration is partnering with the State's Assistive Technology Project. The evaluation component of the MFP Rebalancing Demonstration will study the impact of technology on the level of independence, consumer satisfaction and need for personal assistance.	
▪ Develop a plan to modernize the physical plants of existing nursing facilities.		
▪ Expand the role of the Long-Term Care Ombudsman's Office, which oversees nursing facilities, residential care facilities and assisted living facilities, to include other		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
long-term care settings and include consumer education about the availability of these services. Provide adequate funding for such an expansion.		
▪ Encourage a plan for emergency management supports for people with disabilities and elderly persons. This should include networking with local, state and national organizations, as well as working on information that can be used to encourage personal preparedness.	A significant amount of work has occurred between emergency management personnel and disability advocates, including the University of CT A.J. Pappanikou Center for Excellence in Developmental Disabilities (UCEDD), the Office of Protection and Advocacy and the Developmental Disabilities Network. Guidance documents and shelter recommendations and checklists were provided to all municipalities to assist with including people with disabilities and older adults in the municipality plans. A Universal Access model is being encouraged to help municipalities prepare for including people with a variety of needs in a general shelter. In addition, training is being provided by the UCEDD and other disability advocates to first responders and emergency personnel for working with people with disabilities. Regional forums are being planned for all five regions of the state to educate people with disabilities, older adults, families and disability organizations about personal preparedness and community	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	involvement in working with emergency personnel to plan for the needs of everyone. Over the past year, the DSS Aging Services Division has been working with the Department of Emergency Management and Homeland Security, Red Cross, Office of Protection and Advocacy and DPH to link these groups at the local level and hold local forums on personal preparedness. DDS has worked with the National Association of State Directors of Developmental Disabilities Services extensively with regard to emergency management, has presented at national meetings and is part of national and regional work groups. DDS is recognized for its well developed emergency response system for people with intellectual disabilities. DDS staff participate in periodic emergency preparedness drills and "table top exercises" lead by the Department of Emergency Management and Homeland Security and FEMA.	

APPENDIX G.

State Long-Term Care Programs and Expenditures

SFY 2008 – 2009

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

II. **State Long-Term Care Programs in Connecticut – SFY 2009**

III. **State Long-Term Care Program Expenditures in Connecticut – SFY 2009**

I. Overview of State Agencies Providing Long-Term Care 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 Rehabilitation Act managed by the Bureau of Rehabilitation Services, the Food Stamp Act and the Older American Act. 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 Connecticut AIDS Drug Assistance Program, and the Connecticut Pharmaceutical Assistance Contract to the Elderly (ConnPACE). Under recent grant programs from both Centers for Medicare and Medicaid Services (CMS) and the Administration on Aging (AOA), the department has begun initiatives to develop both Aging and Disability Resource Centers (ADRC's) and piloted Cash and Counseling services to people with disabilities and older people.

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 15,400 persons with intellectual disabilities and their families. In addition, the Department provides Birth to Three services to approximately 5,000 children and their families. As of June 2009, 72 percent of those people eligible to receive services from DDS were living in their own or their family home, 18.5 percent lived in public or private community living arrangements, 2 percent lived in community training homes, 3.5 percent lived in campus settings and 2.2 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 2009, DMHAS served 57,095 persons with mental illness in the community and 3,851 persons with mental illness in inpatient facilities. Also in SFY 2009, a total of 69,083 persons received substance abuse in the community, and 8,402 received inpatient services.

Department of Economic and Community Development (DECD): DECD oversees all State statutes related to accessible housing. In addition to being a key partner in the assisted living demonstrations, it administers capital grants for 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 $110 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 37 million riders annually on the fixed-route system, about 2 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 $20 million annually to support ADA services, and provides over 750,000 rides annually. The DOT-subsidized bus and paratransit operations serve 107 towns in the state. The State Legislature appropriated $5 million annually 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 and DSS have formed the Behavioral Health Partnership 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 individual outcomes.

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 the 2009 fiscal year, P&A provided information, referral, or short-term assistance to 10,323 people, while 1,480 individuals received a more intensive level of advocacy representation. The P&A Abuse Investigation Division (AID) investigated or monitored 1,182 investigations into reports of suspected abuse or neglect of adults with mental retardation. Also, P&A staff provided training to over 2,000 individuals on disability rights topics and disseminated information to more than 5,900 people. More than 12,500 P&A publications and program brochures were distributed. The P&A website, which also posts all agency publications in printable formats, received over 775,000 hits during the 2009 fiscal year and provided an additional resource for disability information.

Board of Education and Services for the Blind (BESB): 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, 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.

Commission on the Deaf and Hearing Impaired (CDHI) – CDHI works to advocate, strengthen and implement state policies affecting deaf and hard of hearing individuals. 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; individual, marital, family and group counseling services to deaf and hard of hearing persons and hearing family members; and orientation seminars on deafness and deaf culture. There are approximately 204,334 hearing impaired people in Connecticut.

Department of Veterans' Affairs (DVA) – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. In October 2008, DVA opened the new state of the art 125-bed Adult Care Facility. The facility is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, physical therapy, occupational therapy, respiratory therapy, an Alzheimer unit, and hospice care. In SFY09, the average monthly hospital census was 111. The Residential Facility is certified by the Federal Department of Veterans Affairs and has 488 licensed beds. In SFY09, the average monthly residential census was 340. 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 Care Programs in Connecticut – SFY 2009

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 = $2,022/ month. Medicaid asset limit = Indiv $1,600/ couple $3,200. State funded income limit = no limit. State funded asset limit = Indiv $32,868/ couple $43,824 (one or both receiving services)	<u>Total Participants</u> Total - 14,800 Waiver - 9,387 State - 5,413 <u>Age</u> 65-84: 63.9% 85+: 35.8% <u>Gender</u> male: 25.7% female: 74.3% <u>Race/Ethnicity</u> W = 70.0% AA = 13.1% Hisp = 14.5% Asian = 0.8% Am Ind = 0.1%

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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> 41 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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.	Total Participants 748 Age Under 50: 340 Over 50: 408 Gender Male: 321 Female: 427 Race/Ethnicity N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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> 369 <u>Age</u> 18-49: 241 50+: 147 <u>Gender</u> Male: 254 Female: 115 <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 64 years old Would otherwise require care in a nursing home or ICF/MR. Medicaid income limit = $1,692. Medicaid asset limit = $1,000. Income of parent or spouse not counted.	Total Participants 187 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Seniors Helping Seniors	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 - 34 Clients – 158 Age N/A Gender N/A Race/Ethnicity N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 - 67,737 Age N/A Gender N/A 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 - 67 Presentations – 15 Beneficiaries who attended presentations – 550 Reached by community education events – 43,612

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DSS	Home Share Programs	Home sharing for adults in exchange for a monetary contribution or performance of services such as housekeeping, shopping, etc. Contractor provides housing counseling for all applicants, enrolls appropriate people in the home share program, and matches compatible people to share a home.	Private homes	At least one adult in a match must be over the age of 60.	Total Participants 349 people counseled 37 people enrolled in home share program 9 matches made Age N/A Gender N/A Race/Ethnicity N/A
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	Age 18-89	Total Participants Calls for information - 748 Individuals counseled - 748 Attended public forums 2,000 Age 44-66 attended forums Gender N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
					Race/Ethnicity N/A
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	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. $30,000 income $80,000 assets Co-pay of 20% of cost of service required (may be waived upon financial hardship)	Total Participants 924 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 - 4,286 Age < 60: 208 60-74: 971 75+: 1,703 Gender N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
					Race/Ethnicity N/A
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 18,253 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	Senior Community Cafes Residential Homes	Age 60 and over and their spouses/ caregivers	Total Participants Congregate meals: 945,022 meals served to 15,022 participants Home delivered meals: 1,382,372 meals served to 7,678 participants

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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	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 – 810 Supplemental services – 386 One-on-one assistance – 7,681 Counseling, support groups, training – 2,029 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> 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	Congregate housing	Age 60 and over. Frail with temporary or permanent disabilities.	<u>Total Participants</u> 269 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		Medication monitoring 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.	<u>Total Participants</u> 179 <u>Age</u> 55-64: 116 65-84: 63 <u>Gender</u> male: 49 female: 130 <u>Race/Ethnicity</u> W = 117 AA = 53 Hisp = 16 Asian = 2 Am Ind = 3
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.	<u>Total Participants</u> 13,954 direct client assistance <u>Age</u> N/A <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
					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, cardiovascular, etc. Foot care	Personal Residences Congregate Housing Elderly Housing Any community setting Community Health Centers Public Health Departments	Age 60 and over.	Total Participants 2,943 Age N/A Gender N/A Race/Ethnicity N/A
DSS	Evidenced-Based Health Program	Chronic disease self-management, Fall prevention assessment,	Agencies on Aging		Total Participants 241 service providers and older adults
DSS	Nursing Home Diversion Modernization	Cash and Counseling, information, assistance and support	Agencies on Aging	Cash & Counseling: A signed physician's statement attesting to the fact that the care recipient has Alzheimer's or a related dementia Cannot be on CHCPE Income: at or below	Total Diversion I and Diversion II Participants 530

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
				$41,000/yr Assets: At or below $109,000 Information Assistance and Support: Ages 18 and older	
DSS	CT Consumer Law Project for Elders	Legal council regarding consumer problems	No specific setting		<u>Total Cases Handled</u> 1,462 <u>Community Outreach Events</u> 17
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 Vehicle modifications	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 4,620 Individual and Family Support Waiver 3,899 <u>Age</u> N/A <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		Specialized medical equipment and supplies IFS family training Behavioral support Healthcare coordination			<u>Race/Ethnicity</u> N/A
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> 723 <u>Age</u> 0-18: 0 19-54: 334 55-64: 233 65+: 156 <u>Total Participants in privately operated ICF/MRs</u> 357 <u>Age</u> 0-18: 2 19-54: 252 55-64: 74 65+: 29 <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
					Race/Ethnicity N/A
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 NA Age NA Gender NA Race/Ethnicity NA
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.	Total Participants NA Age NA Gender NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
				No private insurance to pay for comparable services.	Race/Ethnicity NA
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 NA Age NA Gender NA Race/Ethnicity NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 NA Age NA Gender NA Race/Ethnicity NA
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 371 Age NA Gender NA Race/Ethnicity NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 1,044 Age NA Gender NA Race/Ethnicity NA
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 1,879 Age NA Gender NA Race/Ethnicity NA
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	Total Participants NA Age NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
				vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs. No private insurance to pay for comparable services.	<u>Gender</u> NA <u>Race/Ethnicity</u> NA
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.	<u>Total Participants</u> NA <u>Age</u> NA <u>Gender</u> NA <u>Race/Ethnicity</u> NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 NA Age NA Gender NA Race/Ethnicity NA
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 NA Age NA Gender NA Race/Ethnicity NA
DMHAS	Substance Abuse Residential - Long-Term Care	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention	Structured recovery environment	Adults age 18 and over. General Assistance recipients with significant problems with behavior	Total Participants NA Age NA

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		Employment skill development		and functioning in major life activities due to substance abuse.	<u>Gender</u> NA <u>Race/Ethnicity</u> NA
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.	<u>Total Participants</u> 951 residents <u>Age</u> 65+: 951 <u>Gender</u> N/A <u>Race/Ethnicity</u> 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	<u>Total Participants</u> 2,505 units in 36 facilities <u>Age</u> N/A <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
					Race/Ethnicity N/A
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 1,416 Age 0-64: 457 65+: 959 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 Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DOT	Local Bus Services	Transportation (Local bus at half fare)	Community	All ages Seniors and people with a qualifying disability.	Total Participants 1,750,000 passenger trips (of 37,000,000 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 Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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 134 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 Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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	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	Provides a continuum of health care, social and rehabilitative services including: General medical and nursing care Alzheimer's and dementia care Hospice and respite care Physical, occupational and respiratory therapy Long-term substance abuse rehabilitation program	Health care facility (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	<u>Average Monthly Census</u> 111 <u>Age</u> N/A <u>Gender</u> N/A <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
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
DCF	Care Coordination	Serves children or youth who have serious emotional disturbance (SED), are involved in multiple-agencies, and may be at risk for removal of home or community. It is a home-based intervention that allows for the care coordinator to work with the family to develop a family vision and using the family's strengths and a Child and Family Team to assist the family in achieving that vision.	It is a home-based intervention and all 169 towns and cities are served through 8 provider organizations.	Families may self refer or referrals are received from DCF and other community providers. Birth to age eighteen Services can be received up to age 21 if client is still receiving services from their local educational authority.	Capacity to serve 1,500 families per year.

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Children with Complex Medical Needs – Foster Care	Foster Care for a small population of children that have medical needs beyond the common childhood illnesses.	Foster Homes - Some children may have the need for special medical equipment.	Children and youth placed in the custody of DCF voluntarily or involuntarily Birth to 18	SFY 2009- 231 certified foster homes, with an additional 78 homes in the certification process.
DCF	Community Life Skills	The Community Based Service Model for life skills training is one of the components of the Community Life Skills Program. The central focus of the community-based program is the development and/or enhancement of the participant's knowledge of essential life skills to promote preparation for adulthood and self reliance. Through program design and content, it provides youth with the opportunity for learning, problem solving, and enhancement of self esteem.	Varied settings within the community.	DCF involved youth residing in out of home placement within the community.	Adolescents and Young Adults ages 15-21

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Community Emergency Services: Emergency Mobil Psychiatric Services Emergency Mobil Services (EMS)/Care Coordination	This service provides emergency services including mobile response; psychiatric assessment; medication consultation, assessment, and short-term medication management; behavioral management services; substance abuse screening and referral to traditional and non-traditional services for any family with a child in crisis. This service was re-procured in SFY 08/09 with enhanced program standards, quality improvement, and statewide Call Center through United Way 211.	Statewide Community Providers providing emergency referrals, and consultation.	Statewide EMPS providers have a centralized, toll-free phone number to serve as a point of entry and to provide person-to-person assistance and connection to crisis services. The centralized number is accessible 24 hours per day, 7 days per week, 365 days per year. In the event of a psychiatric emergency, a trained screener will, within 15 minutes, facilitate direct contact with a licensed EMPS staff member or other emergency service as necessary.	Children and Youth ages 5-18
DCF	Connecticut Children's Place (CCP)	Provides diagnostic, brief treatment, residential care and educational instruction for abused and neglected children between the ages of 10 and 18 from all over the state.	Residential - Children live in three cottages, each with a capacity for 14 children.	Children placed in the custody of DCF voluntarily or involuntarily	Youth, and adolescents ages 10-18

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Crisis Stabilization Beds	Crisis stabilization is a 24 hour, short term residential program that offers the child and family a "cooling off" period from a particular crisis. This short term intervention is designed to enable crisis stabilization staff an opportunity to make good, appropriate assessments and interventions that may prevent a longer out of home disruption.	There are two crisis stabilization programs in Connecticut. One located in Farmington on the UCONN Medical Center Campus a program of Wheeler Clinic and one in Hamden a program of the Children's Center.	Crisis stabilization will accept all referrals made by Emergency Mobile Psychiatric Service (EMPS) providers that follow a certain criteria.	Children, Youth, and adolescents ages 7-18
DCF	Emergency Shelters	Providing emergency placement of children and youth until the most appropriate placement is located for the child or youth.	Facilities can have up to 20 beds	Children placed in the custody of DCF voluntarily or involuntarily	Youth, and adolescents ages 9-18
DCF	Extended Day Treatment	A community-based program that offers a structured, intensive, therapeutic milieu with integrated clinical treatment services. Services are provided year round during non-school hours for an average period of six	Schools, child guidance clinics, hospitals, residential programs.	Families may self refer or referrals are received from DCF and other community providers. A candidate for admission to an EDT program must meet the Intermediate Level of Care criteria, as defined	Youth, and adolescents ages 5-17

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		months.		in the Connecticut Behavioral Health Partnership's Guidelines for Making Level of Care Decisions.	
DCF	Family Support Team	Family Support Teams provide an array of intensive treatment and support services to children, youth and families in their homes and communities.	Services are delivered in the home and community, and may be provided for an indeterminate length of time. FST staff also provide 24-hour/7-day emergency crisis response.	FST services are currently available only to children and families with DCF-involvement. Referrals to FST are made by the DCF Area Offices.	Youth, and adolescents ages 9-18
DCF	Family Violence Outreach	Providing support, advocacy, education, and case management services to families dealing with issues of domestic violence	Statewide offices to provide referral, consultation, home visits, and services to address a wide variety of domestic violence issues.	Families may self refer or referrals are received from DCF and other community providers	NA
DCF	Foster Care: (Relative and Non-Relative)	Provides a family environment for children who are temporarily unable to live in their biological homes. Together with other services provided to foster parents, families and children, these homes facilitate the reunification of children with their families or establish another	Home Settings Statewide	Children, Youth, and Adolescents in the care and custody of DCF	Birth to 18 SFY 2005 – 2193 active foster homes

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		permanent family for the children.			
DCF	Foster Care Supports	Providing support, advocacy, education, and case management services to foster families in the attempt to maintain a child's placement. Also, collaboration with Connecticut Association of Foster and Adoptive Parents (CAFAP)	Varied settings within the community depending on activity. (counseling, sports, in-home therapy, aftercare services, social activities, etc.)	DCF Foster Families	NA
DCF	Group Homes	Provides a continuum of living options for youth ages 14 and up moving toward successful adulthood, the goal being the least restrictive, most community-based possible. They will focus on life skills programming, educational planning along with vocational planning.	Community home-like settings with multiple staff.	Youth in the care and custody of DCF	Youth ages 14-18 Average Capacity is 6-10 youths
DCF	High Meadow- Closing February 2010	Provides residential treatment for severely emotionally disturbed adolescents who require intensive and comprehensive services,	Residential -42 beds providing treatment that can only be effected in a setting which protects the youth and/or community in a 24-hour a day	Children placed in the custody of DCF voluntarily or involuntarily	Youth, and adolescents ages 12-17

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		but who do not require the most restrictive environment available.	structured program.		
DCF	Independent Living Program: Community Housing Assistance Program (CHAP) Transitional Living Apartment Program (TLAP) programs.	Youth live in a semi-supervised subsidized housing environment, which includes receive case management services that promotes the acquisition of independent living skills, educational, vocational, pre-employment, and job placement opportunities.	Varied settings within the community	Youth who have been or return to state care may be eligible to receive housing support.	Youth ages 18-23
DCF	Intensive Home Based Services – Functioning Family Therapy (FFT)	Family Support Teams offer intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties.	Provides home-based treatment to children, youth and families in their homes and communities.	Eligibility for FST services does not require DCF-involvement. Referrals to FST are typically made by the DCF Area Offices, System-of-Care Collaboratives, and community providers.	Youth, and adolescents ages 9-18

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Intensive Home Based Services: Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST)	IICAPS offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. MDFT offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to substance abuse or co-occurring disorders. MST offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to problems of delinquency, disruptive behavior and/or substance abuse.	Provides home-based treatment to children, youth and families in their homes and communities. Services are typically delivered for an average of 5 to 6 months. All service staff also provide 24-hour/7-day emergency crisis response.	Eligibility for all programs does not require DCF involvement. Referrals to all programs are typically made by the DCF Area Offices, System-of-Care Collaboratives, Juvenile Justice staff, inpatient psychiatric hospitals or community providers	Youth, and adolescents ages 9-15

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Lifelong Family Ties Project	A child centered program that moves outward from the child's perception of people important to him/her to identify life connections through current and past family and community ties. The goal of the program is to create life long connections for the child in the following way: either through a permanent placement resource, a mentoring relationship, a supportive relationship and/or other positive connections to the child's kin network.	Varied settings within the community. Currently 2 local providers.	Children/youth identified for this program are those who have been legally free for adoption and for who past efforts at finding an adoptive family have been unsuccessful for a year or more.	Children, Youth, and adolescents ages 5-18 Capacity to serve approximately 50 children per year.
DCF	Outpatient Adolescent Substance Abuse Treatment	Services shall include but not be limited to diagnostic evaluation, family, group and individual therapies, medication services, crisis or emergency interventions to assist families and youth with substance abuse use and dependence.	Home and community settings statewide	Families may self refer or referrals are received from DCF and other community providers	Youth ages 14-18

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Positive Youth Development	Nine statewide contractors are promoting this initiative to accomplish three main goals in their communities; Select an evidence-based or promising practices positive youth development prevention program in a small community; 2) Support parents in their role as parents; 3) Provide recreational and enrichment opportunities for children participating in the program and their families.	Home and community settings statewide	Families may self refer or referrals are received from DCF and other community providers	NA
DCF	Residential Care Facilities	Facilities are 24-hour mental health facilities that operate for the purpose of effecting positive change and normal growth and development for emotionally disturbed, behaviorally disordered, and socially maladjusted youth.	Clinical settings state and nationwide	Youth are referred through a holistic treatment plan, involving DCF staff and mental health professionals.	Adolescent females and males age 13-17

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Respite Care Services	Provides temporary care to the caregiver of the child or adolescent with serious emotional disturbances. With the goal of reducing the stress of the caregiver and avoiding "burnout," and preventing family disruption (or out–of–home placement)	Home-based and community-based settings, six providers covers the entire state.	Referrals are received from DCF and Care Coordinator providers	Children 6- 18 years old Capacity to serve 325 children per year
DCF	Riverview Psychiatric Hospital	The hospital provides comprehensive care to children and adolescents with severe mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.	Hospital	Children placed in the custody of DCF voluntarily or involuntarily	Youth, and adolescents ages 9-18
DCF	Safe Homes	The purpose of a SAFE Home is to provide a safe and stable environment for children who experience out-of-home placement for the first time. SAFE Homes should facilitate keeping sibling groups together, provide the opportunity for children to remain in close proximity to their own communities and	Community home-like settings with multiple staff. Children are placed in a SAFE Home for an average of thirty (30) days, up to a maximum of forty-five (45) days, in order to allow DCF and SAFE Home staff the opportunity to make appropriate permanency and service planning	Serves children who are referred by DCF	Children ages 3-12

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
		allow children to attend their own schools.	decisions, thus minimizing the possibility of future placement disruptions.		
DCF	Supportive Housing Program	Subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency and well being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and abuse issues). Housing is secured in conjunction with the family and DSS provides a Section VIII voucher.	Home Settings Statewide The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF.	Current Involvement with DCF	Capacity: 500 families

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2008 – June 30, 2009
DCF	Support Staff and Therapeutic Support Staff	Support Staff and Therapeutic support staff provide interaction through a one-to-one relationship with a trained, supervised, caring adult. Focus is on increasing self-esteem, habilitation, resiliency, the development and improvement of social skills and peer relations, and promoting age appropriate behaviors in normative, non-clinical settings Support Staff and Therapeutic Support Staff provide guidance, advocacy and education to youth with complex behavioral health needs through the use of structured, home and community-based interactions and activities.	Home-based and community-based settings available statewide through DCF Discretionary dollars.	Referrals are received from DCF and Care Coordinator providers	Youth, and adolescents ages 11-17 Capacity depends on number of referrals per year.

III. State Long-Term Care Program Expenditures in Connecticut – SFY 2009

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Connecticut Home Care Program (CHCPE) (For SFY 2008)	$233,617,263	$51,964,883	$181,652,380			
DSS	Connecticut Home Care Program for Adults with Disabilities (CHCPD)	$680,000	$680,000				
DSS	Personal Care Assistance Waiver	$19,971,087		$19,971,087			
DSS	Acquired Brain Injury Waiver (ABI)	$36,799,460		$36,799,460			
DSS	Katie Beckett Model Waiver	$25,963		$25,963			
DSS	Seniors Helping Seniors	$25,865	$25,865				

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	CHOICES	$1,886,074	$1,294,340			$591,734 (DHHS/CMS)	
DSS	SMP – Senior Medicare Patrol	$180,000				$180,000	
DSS	Home Share Programs	$101,619	$101,619				
DSS	CT Partnership for LTC - Information & Education Program	$7,819	$7,819				
DSS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)	$2,106,753	$2,106,753				
DSS	Retired Senior and Volunteer Program	$92,700	$92,700				

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	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	$5,312,285	$234,402 State Match		$5,077,883		
DSS	Elderly Nutrition Program (Title lllC and NSIP)	$10,929,468	$2,750,723		$6,645,998	$1,532,747 (NSIP)	
DSS	CT's National Family Caregiver Support Program (Title lllE)	$1,774,267			$1,774,267		
DSS	Congregate Housing Services	$352,864				$60,797 (SSBG) $292,067 (HUD)	
DSS	Senior Community Service Employment Program	$1,128,346				$1,128,346	
DSS	Medicare Legal and Education Assistance Project	$450,473	$322,473			128,000	

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Elderly Health Screening Program	$332,602	$332,602				
DSS	Evidenced-Based Health Program	$211,410				$211,410	
DSS	Nursing Home Diversion Modernization	$1,149,396				$241,392 Nursing Home Diversion I $236,988 Nursing Home Diversion II	
DSS	CT Consumer Law Project for Elders	$110,000				$110,000	
DDS	Home and Community Based Services Waivers	$631,522,326		$631,522,326			
DDS	Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	$214,143,313		$214,143,313 Does not include private ICF/MRs			

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
				which are funded by DSS			
DMHAS	Assertive Community Treatment (ACT) (For SFY 2008)	$26,599,592	$26,598,799	$793	$44,075	$655,490	$27,299,156
DMHAS	Case Management Total	$30,118,312	$28,621,030	$1,497,282	$41,000	$1,746,245	$31,905,558
DMHAS	Crisis Stabilization (For SFY 2008)	$5,407,694	$5,229,020	$178,674		$11,144	$5,418,839
DMHAS	Long Term Psychiatric Hospitalization (For SFY 2008)	$119,088,453	$119,088,453	$0	$160,659	$1,251,927	$120,501,040
DMHAS	MH Intensive Outpatient (For SFY 2008)	$635,900	$477,708	$158,192	$18,064	$465,883	$1,119,847

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DMHAS	MH Outpatient Therapy (For SFY 2008)	$53,843,535	$53,267,022	$576,513	$3,156,420	$10,149,639	$67,149,594
DMHAS	MH Psychosocial Rehabilitation (For SFY 2008)	$17,393,484	$15,543,873	$1,849,611		$1,090,103	$18,483,587
DMHAS	MH Residential Group Home (For SFY 2008)	$17,069,449	$17,069,449	$0	$2,767,275	$4,065,765	$23,902,489
DMHAS	MH Supervised Housing (For SFY 2008)	$22,785,907	$22,060,988	$724,919		$2,112,564	$24,898,471
DMHAS	MH Supported Housing (For SFY 2008)	$29,606,023	$22,072,491	$7,533,531	$10,194	$1,551,315	$31,167,532
DMHAS	Mobile Crisis Service (For SFY 2008)	$16,933,717	$15,280,349	$1,653,368	$105,019	$3,214,939	$20,253,675
DMHAS	Substance Abuse Residential Long Term Care	$1,991,959	$1,626,216	$365,743		$98,803	$2,090,762

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	(For SFY 2008)						
DMHAS	Substance Abuse Residential Long Term Treatment (For SFY 2008)	$19,654,500	$17,111,968	$2,542,532	$317,935	$2,693,266	$22,665,701
DMHAS	Substance Abuse Residential Transitional / Halfway House (For SFY 2008)	$2,397,222	$2,268,567	$128,655	$4,482	$348,762	$2,750,466
DECD	Congregate Operating Subsidy Program	$6,076,723	$6,076,723				
DECD	Elderly Rental Registry and Counseling	$1,228,749	$1,228,749				
DECD	Elderly Rental Assistance Program	$1,644,346	$1,644,346				

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DECD	Housing Assistance and Counseling	$571,000	$571,000				
DOT	Local Bus Services	$145,000,000	$110,000,000			$1,100,000	$4,000,000 (local) $33,000,000 (passenger fares)
DOT	ADA Paratransit Van Services	$24,900,000	$22,300,000			$210,000 (Sec 5307)	$1,000,000 (local) $1,550,000 (passenger fares)
DOT	State Matching Grant Program	$3,688,950	$3,688,950				
DOT	Federal Transit Administration - New Freedom Program	$37,722	$18,861			$18,861	
DVA	Veterans' Health Care Services	$15, 897,714	$5,010,596	$9,976,774			$892,344

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DVA	Residential and Rehabilitative Services	$1,931,273	$ 1,617,952				$313,321
DCF	Care Coordination (Local Systems Of Care)	$702,716	$702,716				
DCF	Children with Complex Medical Needs	$4,688,543	$4,668,543			$20,000	
DCF	Community Life Skills	$947,254	$466,138			$481,116	
DCF	Community Emergency Services	$57,700	$57,700				
DCF	Connecticut Children's Place (CCP)	$14,818,274	$13,357,574			$1,460,700	

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DCF	Crisis Stabilization Beds	$1,934,604	$1,934,604				
DCF	Emergency Shelters	$0	$0				
DCF	Short Term Assessment & Respite (Replaced Emergency Shelters)	$10,310,294	$10,310,294				
DCF	Extended Day Treatment	$7,022,623	$7,022,623				
DCF	Family Support Team	$7,169,218	$7,169,218				
DCF	Family Violence	$2,100,866	$1,777,508			$323,358	
DCF	Foster Care	$27,380,633	$27,380,633				

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DCF	Foster Care Supports	$4,011,405	$3,586,406			$424,999	
DCF	Group Homes	$75,274,610	$75,274,610				
DCF	High Meadow	$11,653,211	$11,653,211				
DCF	Independent Living	$9,641,007	$8,344,252			$1,296,755	
DCF	Intensive Home Based Services – Functioning Family Therapy (FFT)	$2,068,492	$2,068,492				
DCF	Intensive Home Based Services	$0	$0				
DCF	Lifelong Family Ties Project	$578,288	$578,288				

State Agency	Long-Term Care Program	Total Expenditures SFY 2009	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DCF	Outpatient Adolescent Substance Abuse Treatment	$1,170,943	$1,170,943				
DCF	Positive Youth Development	$758,597	$758,597				
DCF	Residential Care	$74,783,872	$74,783,872				
DCF	Respite Care Services	$517,904	$91,912			$425,992	
DCF	Riverview Psychiatric Hospital	$33,260,568	$33,260,568				
DCF	Safe Homes	$15,095,899	$15,095,899				
DCF	Supportive Housing Program	$7,185,909	$7,185,909				
DCF	Therapeutic Child Care	$1,477,555	$1,477,555				