Status Report

2010 LONG-TERM CARE PLAN FOR CONNECTICUT

JUNE 2010

Status Report – June 2010
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RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
GOAL 1. Balancing the ratio of home and community-based and institutional care		
Develop a system that provides for more choice and opportunities for community integration as alternatives to all institutional settings, and increases the proportion of individuals receiving Medicaid home and community-based care from 53 percent in 2009 to 75 percent by 2025, requiring approximately a one percent increase in the proportion of individuals receiving Medicaid long-term care in the community every year.	The Department of Mental Health and Addiction Services (DMHAS) has implemented two programs that address this goal: (1) the Nursing Home Diversion and Transition (NHDT) Program, which strives to keep clients out of nursing homes and in the community with a variety of supportive services; and (2) the Mental Health Home and Community-Based Services (HCBS) Waiver, which is one of four in the country. Both programs collaborate with the Money Follows the Person (MFP) Demonstration Grant. And the NHDT Program is working with some Area Agencies on Aging around specific clients who have mental health and/or substance abuse problems. To date, during SFY 2010, the NHDT Program has diverted approximately 31 individuals from nursing home	

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	admission and 80 nursing home residents have been transitioned back to the community. Under the Mental Health Waiver, at the end of the 3rd quarter, 33 individuals have been enrolled and are living in the community. Additionally, DMHAS, along with other community providers, is collaborating with St. Luke's Eldercare in Middletown to implement The Gatekeeper Program. This program identifies at-risk elders in the community who may be in need of supportive services. The goal is to avert serious crises and assist older adults in remaining in the community, living as independently as possible.	
GOAL 2. Balancing the ratio of public and private resources		
Increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25 percent by 2025. Such an increase in private insurance and other sources of private funding would reduce the burden both on Medicaid and on individuals' out-of-pocket expenses. Nationally, private		

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insurance represented 7.2 percent of long-term care spending in 2005.		
STRUCTURAL		
1. Create greater integration of State level long-term care administration and functions serving both older adults and people with disabilities and their families.		
a. Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid, Older Americans Act and Veterans Administration (VA) funds rather than divides them.	Since 2009 two additional Aging and Disability Resource Centers (ADRCs) opened in Connecticut. One in the Western region and one in the North Central region serving people with disabilities and people of advanced age. The State Unit on Aging (SUA) in cooperation with the Agency on Aging of South Central Connecticut and the VA Connecticut Health Care System developed and is implementing a Veteran's Directed Home and Community Based Services Program (VDHCBS) in the south central region of Connecticut with the expectation of going statewide in the future. VDHCBS provides veterans of all ages the	**Public Act 10-179, Section 24:** Postpones the establishment of the Department on Aging for one year, until July 1, 2011. Requires The Department of Social Services (DSS) to administer aging programs until an aging commissioner is appointed and administrative staff are hired. Permits the governor, with Finance Advisory Committee approval, to transfer funds between DSS and the Department on Aging in SFY 2012.

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	opportunity to self-direct their HCBS, manage individuals' budgets and hire Personal Care Assistants (PCAs) of their choice. In 2009, the SUA was awarded an Administration on Aging grant to implement a Lifespan Respite Program in Connecticut. This three year grant seeks to coordinate resources among agencies across the lifespan and ease caregiver access to respite services for individuals of all ages and disabilities.	
b. Ensure linkages between the Long-Term Care Services and Supports and ADRC Website and other websites that include specific long-term care service information.	Continuous information is sought from both the Aging and Disability Resource Networks to update the Long-Term Care Supports and Services/ADRC Website. Linkages continue to be added to the SUA website so consumers can access information from whatever site they happen to land on or in.	
c. Provide for global budgeting with flexibility and authority to fund an array of long-term care services and supports, to be adjusted annually based on the projected needs of the population and for inflation.	The SUA has been overseeing several initiatives to provide flexible budgeting for long-term care services including: • Embedding a cash and counseling option into the Older Americans Act National Family Caregiver Support	

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	Program (Title III-E) and the state funded Connecticut Statewide Respite Care program. • The development of the Veteran's Directed Home and Community Base Services program which provides veterans of all ages the opportunity to self-direct their HCBS, manage individual budgets and hire PCAs of their choice.	
d. Simplify administration through a reduction in duplication and the development of standardized contracting, a unified application and assessment instrument for services and efficient application procedures.		**Public Act 10-126:** Requires DSS, whenever it sends its annual eligibility redetermination form to a person participating in the Connecticut Home Care Program for Elders (CHCPE), to notify the access agency or Area Agency on Aging (AAA) administering the program for that person. DSS contracts with three agencies in different areas of the state to provide coordination, assessment, and monitoring services for CHCPE: Connecticut Community Care, Inc., (the access agency), South Central AAA, and Southwestern AAA.
e. Ensure linkages with the CHOICES Program, ADRCs, Centers for Independent Living, and	DMHAS is represented on the ADRC Steering Committee and has reviewed	

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providers of mental health services for all ages.	the mental health referral section of the Operations Manual, as well as submitted information on contacts and resources. The three ADRC's in Connecticut include members of CHOICES, AAAs, Centers for Independent Living and mental health providers. This will continue as more ADRCs are added. Continued efforts to share available information and resources across all programs take place regularly.	
f. Develop systems and technology to share long-term care data. ▪ Improve technology in state systems to implement electronic records and make valuable data readily retrievable. ▪ Assist all health care providers with the implementation of electronic records and the implementation of the statewide electronic data exchange. ▪ Build data capacity and systems integration that facilitates more efficient care management for people receiving services.		

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2. Simplify Connecticut's Medicaid structure.		
a. If the federal government revises their rules to allow it, establish a universal Medicaid home and community-based services waiver based on function, not age or diagnosis. Allow for flexibility to address a variety of specific needs.		
b. If it is determined that a universal Medicaid waiver is not feasible, every effort should be made to ensure that eligibility criteria and level of need reporting forms are consistent across waivers.		
c. As an alternative to a universal Medicaid home and community-based services waiver, include home and community-based services, such as personal care assistance, in the State Medicaid Plan. Include programs for adults with developmental disabilities who do not have intellectual disabilities.		
d. Make pilot programs that are proven successful a permanent feature of the Medicaid program. Require evaluation of all pilot programs after three years, including cost-effectiveness.		

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e. Streamline Medicaid eligibility procedures, reduce response time to individuals and develop a web-based on-line application process for Medicaid services.		
f. Ensure interagency accessibility to eligibility application information to streamline the application process for many state programs.		
g. Explore locating DSS eligibility service workers with ADRCs to reduce Medicaid eligibility determination response time.		
3. Address access and reimbursement for key Medicaid services.		
a. Explore opportunities to work with Connecticut's medical and dental schools and allied health professions to increase access to health care screening and preventive and restorative dentistry. For example, establish a DDS Dental Coordinator and possible University of Connecticut dental fellowship to address the lack of community dental care for persons with cognitive disabilities.		

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b. DSS should assess the feasibility of increasing Medicaid reimbursement rates to attract providers willing to serve individuals with disabilities. Psychiatric, dental, and podiatric services were identified in the Long-Term Care Needs Assessment as a particular problem for those receiving services through the Medicaid program. Difficulties involving access and financing persist, as well as finding medical personnel who are sensitive and respectful to the needs of people with disabilities.		
c. Reinvest the federal Medicaid match obtained through the Money Follows the Person demonstration into long-term care initiatives such as statewide ADRCs, expanded home and community-based programs, nursing facility transition and diversion programs, workforce development, support for informal caregivers, assistive technologies and prevention and wellness programs.		
d. Maximize reimbursement of state long-term care expenditures through an ongoing review process.		
e. Consider setting Medicaid rates based on objective quality measures.		

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4. Further reform and coordinate the nursing facility/ institutional admission prescreening process.		
a. Expand the current State commitment to prescreen all applicants to nursing facilities age 65 and older, regardless of their payer status, to include all nursing facility applicants, regardless of age or payer source. Similar prescreening for applicants of all institutions for individuals with disabilities should be developed.		
b. Implement a systematic, web-based, comprehensive prescreening program for persons seeking admission in a nursing facility or other institution, regardless of age or payer source. As part of this system, track length of stay in the institution.	DMHAS collaborates with the DSS Alternate Care Unit around the Ascend web-based Pre-Admission Screening Resident Review (PASRR) program. Under this program, and under the Nursing Home Diversion and Transition Program, DMHAS is tracking the nursing home length of stay of referred individuals with mental illness.	
c. Enhance existing educational efforts with hospitals, physicians, nursing facilities, and other institutions regarding prescreening and available community options in collaboration with providers and other entities working in the community with individuals	By June 30, 2010, DMHAS will have met with 17 institutional providers (hospitals and nursing homes) and 12 community providers to educate them about community options that may be	

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with disabilities.	obtained through the DMHAS Nursing Home Diversion and Transition Program and the Mental Health Waiver. DMHAS' connection with the PASRR program is also discussed. A Resource Guide has been developed as a result of these meetings.	
d. Identify people who have housing to return to and preserve its availability as part of the prescreening process.	The Level II Evaluation form used under the PASRR program identifies whether or not the person has housing to return to after a nursing home stay.	
INFORMATION/ ACCESS		
5. Provide true individual choice and self-direction to all users of long-term care.		
a. Expand self-directed care options under home and community-based services programs. ▪ Allow individuals and family members to choose their own care providers, including individuals from within their own informal care network, particularly family members, and allow individuals to control their own budgets.	The SUA has been overseeing several initiatives to provide flexible budgeting for long-term care services including: • Embedding a cash and counseling option into Older Americans Act National Family Caregiver Support Program (Title III-E) and the state funded Connecticut Statewide	

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▪ Operate programs with as much flexibility as possible, including the ability to arrange for as many care provider hours as necessary, in whatever configuration across providers as is appropriate and preferred by the person. (See Recommendation #12) ▪ Ensure that self-directed programs are an option, not a requirement or condition, for receiving home care services.	Respite Care program. This was piloted as part of the federal Administration on Aging nursing home diversion grants which are set to end 9/30/10. The SUA is looking for ways to finance fiscal intermediary services in order to keep the option available to consumers beyond 9/30/10 and to expand its availability statewide. • The development of the Veteran's Directed Home and Community Base Services program which provides veterans of all ages the opportunity to self-direct their HCBS, manage individuals' budgets and hire PCAs of their choice.	
b. Offer where feasible a self-directed care option for programs, including but not limited to the DSS National Family Caregiver Support Program (for those caring for relatives age 60 and older) and the Connecticut State Respite Care Program (for individuals with Alzheimer's disease) using the existing model being piloted under the Nursing Home Diversion Modernization Grants. Also, investigate funding options to support Fiscal Intermediary Services under these and other	One of the services offered under the DMHAS Mental Health Waiver is the Recovery Assistant. This service combines personal care, homemaker, companion, and in-home respite all into one. The Recovery Assistant helps the client learn, manage and self-direct his/her own care. The SUA has been overseeing an	

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programs to allow individuals the flexibility to choose and hire their own personal care workers and control their budgets, similar to what are allowed under the current DDS Medicaid waivers.	initiative to provide flexible budgeting for long-term care services by embedding a cash and counseling option into Older Americans Act National Family Caregiver Support Program (Title III-E) and the State funded Connecticut Statewide Respite Care program. This service delivery option was piloted in the south central and western regions as part of the federal Administration on Aging Nursing Home Diversion Grants which are set to end 9/30/10. The SUA is looking for ways to finance fiscal intermediary services in order to keep the option available to consumers beyond 9/30/10 and to expand its availability statewide.	
c. Implement Cash and Counseling as a tool to increase program flexibility and choice. Consider options available under Section 1915 of the federal Deficit Reduction Act to implement Cash and Counseling. Make case management available to those who wish to use it but optional for individuals who are able to manage their own care.	Case management services are provided through the National Family Caregiver Support Program and the Connecticut Statewide Respite Care program. Each AAA provides case management services to address the specific needs of caregivers.	
d. Increase public and professional understanding of individual choice, recovery, independence and self-determination.	SUA staff have done several presentations to professional and consumer groups regarding individual	

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	choice, self-direction etc., including presenting on cash and counseling and the VDHCBS at venues such as state retiree meetings, State Alzheimer's Conference, the National Association of Social Work State Conference and the National Home and Community Based Services conference.	
e. Identify appropriate funding and provide training opportunities about choice, autonomy and dignity and the assistance available for transitioning from institutions to the community and the services available in the community after transition. ▪ Training should be available for people with disabilities, conservators, guardians, families, probate system staff, medical personnel, social workers, clergy, attorneys and others. Training of people with disabilities, families and professionals should include recognizing signs of abuse and neglect. ▪ Training should be updated to include recent revisions to the conservatorship statutes which promote self-determination. ▪ There should be training on Social Roles Valorization that would help human service workers better understand the value of social		

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roles and the do's and don'ts of supporting people in the community. Social role valorization starts with the assumption that it is important for people who need long-term care to live in valued residential situations and take on valued roles in the community. This relates both to a person's individual competencies and social image in the community.		
6. Address education and information needs of the Connecticut public.		
a. Continue and enhance the efforts of the Connecticut Partnership for Long-Term Care (Partnership), the State's public/private alliance to help educate Connecticut residents about the importance of planning ahead for future long-term care needs through the purchase of high quality private long-term care insurance (LTCI). The Partnership should continue its strategy of presenting LTCI as an option that can help individuals remain in their homes or communities longer, preventing or delaying the need for nursing facility care.	The Connecticut Partnership for Long-Term Care (the Office of Policy and Management in cooperation with DSS SUA and the AAAs) held five public forums on long-term care insurance and the importance of planning ahead between 10/1/09-5/30/10. Approximately 400 consumers were educated.	
b. Coordinate efforts of the Connecticut Partnership for Long-Term Care with the long-term care support options counseling efforts of the ADRCs.	This past year AAA's have taken on a larger role with the Connecticut Partnership for Long-Term Care as the	

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	SUA lost staff to this program to retirement. It is a good fit with the CHOICES and ADRC programs. ADRC staff as well as select CHOICES staff and counselors attended the Connecticut Partnership for Long Term Care agent trainings in order to receive detailed training on long-term care costs in Connecticut, the need to plan ahead for long-term care and the Connecticut Partnership for Long Term Care. Connecticut Partnership for Long Term Care materials have been purchased for ADRCs and CHOICES for Long-Term Support Options Counseling purposes.	
c. Develop targeted information campaigns about long-term care services and supports in collaboration with high-visibility, convenient community partners, such as hospital discharge planning offices, community and senior centers, Area Agencies on Aging (AAAs), ADRCs, public libraries, mental health agencies, advocacy groups, physicians, clergy and teachers. These campaigns should integrate existing internet resources such as the Long-Term Care Website. Additional training and resources should be provided to those who are the most frequent sources of long-term care information and advice, such as		

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social workers and heath care providers, as well as Probate Court officials and conservators.		
d. Initiate a campaign of cultural change around long-term care, especially targeting health care professionals (physicians, nurses, social workers, occupational therapists, physical therapists, etc.). These professions often influence consumer choices.	DMHAS has been aggressively marketing the Nursing Home Diversion and Transition (NHDT) Program and Mental Health Waiver to hospitals, local mental health authorities, and nursing homes to educate them about the community options for persons with mental illness.	
7. Develop and implement a statewide system of Aging and Disability Resource Centers for providing information, referral, assistance and long-term care support options.		
a. Use the existing model from the DSS State Unit on Aging, through leveraging of available funding sources including the federal Administration on Aging, to enhance ADRC services in south central and western Connecticut.	No new state or federal funding is currently available.	
b. Implement new ADRCs in the remaining three areas of the state: eastern, southwestern, and north central. Base further development of the model upon	In May 2010, a third ADRC was established in the North Central region.	

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evaluation of the existing ADRCs and tracking of their quality and efficiency.		
c. Build on the existing model with Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) as the core regional partners providing comprehensive information and assistance and explore other disability and mental health models and regional partners to maximize the variety and creativity of approaches. Continue to integrate disability specific agencies in the ADRC network, including mental health agencies and advocacy organizations.	The North Central ADRC, established in May 2010, is a collaboration among the SUA, North Central Area Agency on Aging, Independence Unlimited, and Connecticut Community Care, Inc.	
d. Train ADRC staff, utilize a comprehensive resource database, create management information system (MIS) database tracking, and enhance the Long-Term Care Website to include interactive features.	ADRC staff receives ongoing training.	
e. Build on the connection with the CHOICES program, the widely recognized information and assistance program operating out of the AAAs.	The CHOICES program and ADRCs are working very closely together.	
WORKFORCE		

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8. Address the long-term care workforce shortage.		
a. Enhance public perception of long-term care jobs and professionalize paraprofessional positions.		
b. Promote flexibility of workplace employment policies and practices. Flexibility is important not only for older workers who may need to work longer than planned, but also for caregivers.		
c. Develop career paths allowing for increases in responsibility, status and wages.		
d. Create loan forgiveness programs for students graduating into professions where there is a shortage of workers, requiring employment within long-term care settings that have the greatest need.		
e. Develop, coordinate and expand education and training programs targeted to areas of workforce shortages.	DMHAS is offering two-year scholarships for peers to be trained to work with Mental Health Waiver clients.	**Public Act 10-3, Section 29:** By January 1, 2011, the education commissioner and the vocational-technical school system

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▪ Attract students into the field with scholarships and grants. Education and training curricula should be considered beginning in high school. ▪ Provide re-training for individuals who lose their job in such sectors as manufacturing and institutional care for new careers in long-term care, especially home and community-based care. ▪ Expand efforts at collaboration among the Connecticut Department of Labor, the Workforce Investment Boards and the Older Workers program to address the needs of workers who have lost their jobs and need to be retrained in order to support themselves. ▪ Promote distance learning as an option for workforce shortage areas. ▪ Provide opportunities for college students seeking internships or community service. College students are often interested in a year of community service after college, but before entering the work world.	American Recovery and Reinvestment Act of 2009 (ARRA) dollars provided this year to expand efforts of the older worker program in Connecticut allowed for the retraining and education of older workers in new skills to obtain employment.	superintendent must establish and administer licensed practical nurse programs at six vocational-technical schools. The school locations must be distributed on an equitable geographic basis throughout the state. The requirement applies unless the education commissioner notifies the Education Committee by November 1, 2010 that he will not establish the programs and the reasons why. If the appropriation for the programs is too little to cover their costs, the bill allows program tuition to be increased to cover the shortfall. **Public Act 10-8:** Specifically authorizes the Connecticut State University System (CSUS) to award doctoral degrees in nursing education. It expands the CSUS's degree-granting authority, which currently includes doctoral degrees in education; master's degrees and other graduate study in education; and liberal arts and career programs at the bachelors, masters, and sixth year level.
f. Inventory existing direct care workforce initiatives to identify duplication and gaps.		

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g. Review the current licensing certification statutes for formal caregivers to be sure that appropriate skills, training and roles are required as the system of formal caregiving evolves.		
h. Engage Workforce Investment Boards to develop approaches to increase the size of the formal long-term care workforce, including training, education and incentives. The wage gaps, including benefits, between public and private frontline workers and across those workers who care for different populations should be addressed. Transportation issues must also be addressed.		
i. Allow individuals to choose their own care-providers and increase flexibility in Connecticut's self-direction model to increase availability of workers and help to address the workforce shortage. (See Recommendation #5)	The SUA has implemented two self-directed care models that allow individuals to select the caregiver of their choice: 1) a cash and counseling option through the Older Americans Act National Family Caregiver Support Program (Title III-E) and Connecticut Statewide Respite Care Program in south central and western Connecticut and 2) the Veteran's Directed Home and Community Based Services option in the south central region of the state.	

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j. Expand the use of the non-traditional workforce, such as personal care assistants (PCAs) and personal care managers, to help address the increased number of individuals desiring home and community-based care. To make the positions competitive and a viable career, these types of jobs must provide the necessary worker benefits and supports, including health insurance. Low cost opportunities for health insurance for PCAs should also be explored.	Under the Mental Health Waiver, DMHAS developed a new position for workers called "Recovery Assistant." The RA works with waiver clients, helping them learn how to do for themselves, and combines the services of a homemaker, personal care, companion, and in-home respite. Over 200 people have been trained thus far. At this time, RAs are employed by home care agencies.	
k. Support the creation and availability of PCA registries such as *rewardingwork.com*.		
l. Recruit bilingual multicultural individuals to long-term care positions.		
9. Provide support to informal caregivers.		
a. Provide support for informal caregivers and family members in a variety of coordinated forms, such as information and training, respite services, tax benefits and incentives, payment to informal caregivers, transportation alternatives, physical,	The SUA has been overseeing an initiative to provide flexible budgeting for long-term care services by embedding a cash and counseling option into Older Americans Act National	**Public Act 10-179: Section 1:** Increase appropriation for Alzheimer's Respite Program from $2,294,338 to $2,794,338 in SFY 2011.

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occupational and speech therapy alternatives, and mental health and disability supports such as peer support, mobile crisis information, psychoeducation, disability education, wellness and recovery planning, and counseling. Assessment and periodic reassessments of the capabilities and needs of family caregivers should also be provided, especially when there may be specific caregiving challenges such as caring for individuals with dementia and Alzheimer's disease.	Family Caregiver Support Program and the state funded Connecticut Statewide Respite Care program. This service delivery option was piloted as part of the federal Administration on Aging nursing home diversion grants which are set to end 9/30/10. The SUA is looking for ways to finance fiscal intermediary services in order to keep the option available to consumers beyond 9/30/10 and to expand its availability statewide.	**June Special Session, Public Act 10-2: Section 1:** Reduces the DSS appropriation for Alzheimer Respite Care by $500,000 in SFY 2011.
b. Increase availability of and access to respite and adult day programs statewide without age and specified disability restrictions. Inventory existing programs and coordinate easier access to respite services by individuals of all ages and disabilities. For example, replicate the Alzheimer's Respite Care program to provide respite services for any caregiver of individuals with disabilities of all ages. Such expanded respite care services would need to be flexible enough to accommodate any unique caregiving challenges for individuals with specific disabilities, such as Alzheimer's disease.	The Lifespan Respite Grant, received by the SUA, seeks to inventory existing respite services to individuals across the lifespan, as well as to establish best practices for future development of innovative respite options for caregivers of all ages and disabilities.	
c. Explore the potential for supporting overnight respite care in settings other than institutions, such as evening or overnight adult day care. This should		

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include consideration of licensing and Medicaid reimbursement issues.		
d. Build on and expand current efforts supported under the National Family Caregiver Support Program, enhancing the basic information, training and respite services that are already provided.		
e. Support partnerships across State agencies to share information on age and disease specific programming for caregivers and develop coordinated sources for caregivers to obtain information on available respite services, utilizing ADRCs.		
f. Expand and support caregiver respite service options through the availability of flexible respite services, including respite services provided in an individual's or caregiver's home. (See Recommendation # 5)		
g. Explore informal peer support training as a means to meeting needs without increasing the cost associated with licensed or other professional personnel.	Coordination with the Chronic Disease Self-Management Program and the National Family Caregiver Support Program is taking place in order to provide training to caregivers and	

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	consumers on how to manage chronic health conditions and lessen the adverse effects of caregiver stress and anxiety.	
QUALITY		
10. Promote efforts to enhance quality of life in various settings.		
a. Include a structure and process to ensure quality oversight throughout the system.		
b. Develop improved quality measures for persons with long-term care needs in the community under person-centered, self-directed programs. Such measures must reflect the individuals' own preferences and desires and allow reasonable risks while still avoiding unreasonable risks. The individual's right to "Dignity of Risk" should be honored. An individual must be able to give "informed consent" to undertaking a risk that might otherwise be considered a compromise of quality of care.	The UConn Research Project is evaluating the outcomes of the DMHAS Mental Health Waiver Program.	
c. Increase the quality of care in the various long-term care settings by including educational programs,		

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identification of mechanisms that encourage longevity of employment, team building concepts and education of the public regarding the continuum of care. Include education about evidenced-based programs such as fall prevention, Gatekeeper Program, Healthy IDEAS (Identify Depression, Empowering Activities for Seniors), and Chronic Disease Self- Management.		
d. Incorporate the needs of older adults and persons with disabilities in all state emergency planning.		
e. Employ a state disability coordinator who can organize and coordinate emergency preparedness trainings with people with disabilities for fire responders, emergency medical technicians (EMT), police and community teams.		
f. Support the purchase and maintenance of assistive technology. More emphasis should also be placed on the use of robotics in the home to assist with activities of daily living. Expenditures for assistive technology can be minor when compared to the extended cost of human services for personal assistance. This technology can allow an individual to maintain or regain independence and reduce their reliance on paid services.	Assistive technology devices are an available service through the National Family Caregiver Support Program. Under the Nursing Home Diversion Modernization Grant pilot (ending 9/30/10), the cap for such services was significantly increased to allow for additional supports to consumers who wish to remain in their own homes	

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g. Utilize federal and state health promotion resources through adoption of Evidence-Based Programs.	DMHAS, as well as other agencies, is collaborating with St. Luke Eldercare to implement the Gatekeeper Program in Middlesex County. This program is an example of an evidenced-based practice. SUA has successfully obtained grants from Centers for Medicare and Medicaid Services (CMS) and Administration on Aging Chronic Disease Self Management Programs in partnership with Department of Public Health (DPH). These are evidenced-based programs that have been rolled out across the state. The State SUA has received a grant continuation for the 2007 Evidence-Based Program Grant to introduce the Tai Chi: Movement for Better Balance evidence-based program in the Western and South Central Regions. The SUA was awarded a $400,000 ARRA Chronic Disease Self-Management Program grant from the Administration on Aging to systematically embed the Chronic	The Yale Connecticut Collaboration for Fall Prevention (CCFP) received an allocation from the state legislature to continue the Statewide Fall Prevention Project to provide training for clinicians and other target groups in the community with strategies for fall risk assessment and intervention.

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	Disease Self-management Program statewide in supportive partnership with Medicaid, ADRC's and the Area Agencies on Aging.	
h. Establish a working Fall Prevention partnership between the DSS Aging Services Division and the DPH to expand current DPH fall prevention projects (i.e. home safety assessments, fall prevention seminars, medication safety programs, and fall prevention exercise classes) to serve new populations and geographic areas. Conduct social marketing, distribute public education materials, and utilize the media. Coordinate these activities with other existing Fall Prevention programs in the state. While fall prevention efforts are primarily focused on older adults, fall prevention programs should be available to individuals of all ages.		Fall Prevention Program received additional funding in SFY 2010 and 2011 from the insurance fund in the amount of $950,000 for the two years.
i. In addition to family guardians and conservators, investigate establishing a public guardian/ conservator in Connecticut and require that all guardian/conservators be trained (www.guardianship.org).		
j. Address the isolation and segregation of older adults and people with disabilities by emphasizing connection to natural supports and community as	DMHAS funds the Senior Outreach Program which is comprised of seven outreach workers statewide who connect	

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well as social and recreational opportunities. This should include strategies to link individuals with informal, non-paid networks. Support for transportation options to aid and encourage participation is also important.	older adults in need of substance abuse services. Drawing upon natural supports and community services, outreach is conducted in private homes, nursing homes, senior centers, hospitals, by telephone, etc.	
11. Address the scope and quality of institutional care.		
a. Develop a plan to modernize the physical plants of existing nursing facilities when feasible and appropriate. Modernized and high quality skilled nursing facilities are needed as an available option for consumers of long-term care.		
b. Explore the concept of the small nursing home and compare to the current nursing facility model in terms of reducing acute care hospital admissions, complications and declines in health and function and assessing overall costs.		
c. As nursing facilities and other institutions close, or occupancy levels are reduced, Connecticut should continually conduct a needs analysis to: 1) determine if any of the beds are needed elsewhere in the system; and 2) de-license, reclassify, or hold in		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
abeyance the remaining beds. Distinctions should be made between beds serving long-term care needs and beds serving post-acute rehabilitation needs. Data and analysis is needed to guide both providers and policy makers. As this occurs, there is an opportunity to redirect the appropriate level of resources to enhance home and community-based services and supports.		
PROGRAM AND SERVICES		
12. Provide a broader range of community-based choices for long-term care supports, foster flexibility in home care delivery, and promote independence, aging in place and other community solutions.		
a. Develop increased flexibility in Connecticut's highly professionalized model of home care delivery without sacrificing quality of care and health and safety concerns. In the current model, both agencies and individual providers are sometimes subject to extensive and inflexible licensing requirements and regulations. ▪ Reduce restrictions on who can provide home and community-based services to foster personal		

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choice and independence, flexibility, aging in place, and the needs of caregivers. States such as Oregon and Washington can serve as useful models. ▪ Study, and implement where appropriate, scope of practice issues, such as delegation of specific tasks in specific settings, and use of lower cost alternatives (e.g. homemaker vs. home health care) while not compromising the quality of care. ▪ Review the current scope of practice definitions for the nursing professions, and develop options for refinement in order to promote flexibility. ▪ Consider allowing under Medicaid waivers and public funding an independent provider model in which providers are not required to work for an agency, a model that is more cost-effective and flexible. DDS currently employs such a model.		
b. Provide incentives to existing, experienced providers to transition or expand their services to provide more community-based options.		
c. Break down the barriers to community integration, such as the "not in my backyard" syndrome.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
d. Expand the Veterans directed home and community-based program being developed and piloted in the south central region of the state through the DSS State Unit on Aging, Area Agency of South Central Connecticut and the Veterans Administration Connecticut Health Care System, West Haven Office. Enhance partnerships between the aging and disability networks and the Veterans Administration to better serve veterans of all ages and disabilities.	The SUA in cooperation with the Agency on Aging of South Central Connecticut and the VA Connecticut Health Care System developed and is implementing a Veteran's Directed Home and Community Based Services Program (VDHCBS) in the south central region of Connecticut. This program will take its first clients June 2010. The expectation is that the model will be implemented statewide in the future.	
e. Enhance the availability of and access to community mental health services to support individuals at home. This includes improving access to Local Mental Health Authorities in addition to advocating for investment in the creation of a comprehensive system of community mental health services. Through collaboration with the Local Mental Health Authorities and other service providers, expand the capacity of the DMHAS Older Adult Services to educate the system about the aging process and develop services that meet the behavioral health needs of older adults, particularly services that provide interventions in homes and communities to promote aging in place over institutionalization.	During the Fall and Spring DMHAS Education and Training Division courses, Older Adult Services (OAS) provides education to Local Mental Health Authority and other agency staff on older adults with mental health and/or substance abuse problems. Additionally, OAS has met with the Connecticut Home Care Program for Elders Access Agencies to explore training needs and the development of new services to meet the needs of an exploding demographic. A Resource Guide has been developed outlining ways to access mental health resources for older adults and other Connecticut	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	citizens.	
f. Expand the number of slots, funding and case management in the various community-based State-funded and Medicaid waiver programs, including the Connecticut Home Care Program for Elders, Connecticut Home Care Program for People with Disabilities, Personal Care Assistance, Acquired Brain Injury, Katie Becket, Mental Health Waiver, the DDS Comprehensive Supports Waiver and the DDS Individual and Family Support Waiver. Some of these programs have a waiting list and this impedes the ability of persons with disabilities from transitioning into or remaining in the community.		
g. Continue to advocate for changes to federal Medicaid law that will facilitate an expansion of home and community-based options. In the past, Connecticut submitted a proposal to the federal Centers for Medicare and Medicaid Services (CMS) to expand the medically needy income formula allowing individuals with incomes in excess of 300 percent of Supplemental Security Income to be eligible under the Medicaid portion of the Connecticut Home Care Program for Elders (CHCPE). This proposal would have allowed individuals the same access to home and community-based care as they have for nursing facility care. Unfortunately, Connecticut's proposal		

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was rejected by CMS. Connecticut should resubmit this proposal and continue its efforts in this regard. If successful in its effort to expand the income requirements under the CHCPE rules, Connecticut should also examine the feasibility of utilizing similar income requirements under its other Medicaid home and community-based services waiver programs, resulting in equal access to home and community-based care and nursing facility care for individuals of all ages and disabilities.		
h. Current Medicaid law prohibits the reimbursement of room and board charges for those living in the community, including in assisted living communities. Connecticut should continue its efforts to remove this prohibition or expand other State and federal programs such as Section 8 housing vouchers, allowing more aggressive development of community living options.		
i. Enhance rates and grants to home and community-based service providers in order to develop and maintain an adequate network of services.		
j. Allow reimbursement for adult day care for residents of subsidized assisted living facilities.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
k. Enhance interagency efforts to offer community-based service options to dually diagnosed individuals.		
l. Explore Aging in Place models of community living, such as the Beacon Hill Village in Massachusetts (www.beaconhillvillage.org), that are designed to enable people to stay in their neighborhoods as they age, by organizing and delivering programs and services that allow them to lead safe, healthy productive lives in their own homes.	Funding for the Community Renewal Team's Grandfamilies Housing Development, Generations, was provided through the Department of Housing and Urban Development (HUD), Department of Economic and Community Development (DECD), the City of Hartford and DSS Aging Services Division. Services for seniors and/or grandparents raising their grandchildren have been established allowing for comprehensive on-site support services in a community setting.	
13. Increase availability of readily accessible, affordable and inclusive transportation.		
a. Increase the availability and affordability of transportation options available to aging individuals and those with disabilities that provide transport not only for medically-related purposes, but also	Connect-Ability, in partnership with the Connecticut Department of Transportation and RideShare, developed the Getting On Board	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
employment, social and recreational activities through utilization of models such as the Independent Transportation Network (ITN - http://itnamerica.org), expansion of the Municipal Matching Grant program funded through DOT, and volunteer programs such as Interfaith Caregivers and RSVP.	accessible transportation guide for the Eastern, North Central Northwestern, South Central and Southwestern regions of the state. Guides are available through transit districts, state agencies, libraries, schools, para-transit providers, hospital, colleges Chambers of Commerce and other organizations. A web-based Trip Planner has been developed in partnership with CTTRANSIT and the Connecticut Department of Transportation. Trip information is available for the Hartford, New Britain, New Haven and Stamford bus routes at http://www.cttransit.com/tripplanner. The state's first wheelchair accessible cab became available in October 2009, jointly developed by the City of New Haven's Department of Persons with Disabilities and MetroTaxi, the state's largest full-service taxi company.	
b. Encourage municipalities to work together to form regional plans that meet local and regional needs.	ITN model expanded to include program in Westport this past year.	
c. Consider the formation of a broadly representative task force, led by a state-wide liaison from DOT, to		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
fully investigate alternative approaches and resource needs to improve transportation options. Coordinate with the Medicaid Infrastructure Grant (Connect-Ability) team which has identified transportation as a priority area.		
d. Give priority to the availability of public transportation resources whenever new housing resources are being developed for individuals with disabilities or the general public.	DECD encourages its housing developers to undertake responsible development strategies for state and federally funded projects. These strategies include the development of mixed-use properties located in regional or rural community centers where there is access to public transportation, and an existing ADA compliant infrastructure within walking distance to shopping, education, recreational and municipal and social services.	
e. Provide transportation options beyond the limitations of the existing Medicaid medical transportation contracts to participants of Medicaid home and community-based services waiver programs. A recurring problem is the lack of same day transportation to unanticipated medical appointments. Another obstacle is that social service provider organizations willing to provide transportation to their customers receive no specific reimbursement for this expense.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
f. Persons with disabilities who want to access public transportation may not be able to get to and from the public transportation lines. Explore solutions to this barrier to transportation, such as reconfiguring vans funded under the federal Capital Assistance Program for Elderly Persons and Persons with Disabilities (Section 5310C) into a feeder-system so these vans can take people with disabilities to and from public transportation lines. Also address the need for para-transit services in rural areas due to the limited availability of public transportation.		
g. Provide adequate funding for the Dial-a-Ride Program (municipal match for demand-responsive transportation).		
h. Enhance sidewalks, cross-signals, crosswalks, and curb cuts to ensure pedestrian access.		
14. Preserve and expand affordable and accessible housing for older adults and individuals with disabilities.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
a. Promote universal design and "Visit-ability" in new building projects and with architects and housing developers. Require Visit-ability standards as part of tax credits to builders for affordable housing.	SUA student intern worked with Independence Unlimited to lend administrative support to work on Public Act 10-56.	Public Act 10-56: Authorizes the Department of Economic and Community Development (DECD), in consultation with the Connecticut Housing Finance Authority (CHFA), to establish a program that encourages Connecticut developers to build residential homes that are easy for people with disabilities to visit (commonly known as visitable housing). The bill also exempts developers from a requirement to obtain a State Building Code variance or exemption to construct visitable homes. And, it authorizes municipal legislative bodies to adopt ordinances giving these developers a property tax abatement. Within available appropriations, the bill requires DECD to establish an informational webpage in a conspicuous place on its Internet website that provides links to available visitable housing resources.
b. Increase outreach to landlords and homeowners about resources and financing to make their units and homes accessible.		
c. Provide funding for home modifications that would	Funding received by the SUA for the	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
either allow individuals to remain in their own homes or return to their own home following institutionalization.	Administration on Aging Community Living Program grants allowed for an increase in the cap for National Family Caregiver Support Program Supplemental Services. Home modifications have been provided to numerous consumers, enabling them to remain in their own homes, avoiding costly nursing home placement. A no-cost extension is in place until 9/30/2010.	
d. Encourage all State agencies, cities, and towns to update their ADA Transition Plans to ensure that necessary accessibility modifications are made when rehabilitating or updating public facilities, including public housing, or their programs, policies, and services.	DECD encourages cities and town to update their ADA Transition Plans by including it in its annual competitive Community Development Block Grant Small Cities Application. Towns are awarded bonus points if Transition Plans are submitted with the application and are updated every three years.	
e. Preserve and expand the stock of affordable housing and link residents with existing community-based services. Explore a range of different housing options to maximize the number of units available with supports, including Supportive Housing, with an emphasis on truly integrated community housing. Make alternative low income housing and rental assistance available for older adults and people with disabilities. Models of community living used by	DECD continuously provides gap financing to fund a broad range of affordable housing options including HUD Sec. 202 and 811 projects and other supportive housing options. DMHAS currently operates over 1500 units of supportive housing and that number increases every year. We are	**Public Act 10-179: Section 1:** Adds $1 million for Next Steps Supportive Housing in SFY 2011. **P.A. 10-3, Section 4:** Transfers $380,000 for the DECD HomeCT program t the General Fund. **Public Act 10-179: Section 14:**

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
DDS, generally no larger than one to four people per single dwelling, should serve as a model of true community integration.	currently in the process of developing an additional 266 units of supportive housing. This past year, DMHAS has also initiated two Supportive Housing PILOT programs. The first is called Frequent User Service Enhancement (FUSE). This program seeks to provide supportive housing to individuals that cycle between the homeless shelter system and the corrections system. It is believed that providing permanent supportive housing to this population not only provides individuals with the least restrictive living situation, but also saves the government money by providing a less expensive solution to the problems of this population. The other PILOT program, called Housing First, seeks to have the same outcomes but for a different population, those individuals being discharged from a psychiatric facility that has no stable housing options to be discharged to. DMHAS continues to explore relationships with the Department of Correction (DOC) and the Court Services support Division (CSSD) of the Judicial Branch to create supportive housing options for DMHAS clients that	Carries forward to SFY 2011 the unspent balance as of June 30, 2010 of funds appropriated to DECD for Home CT. This program provides grants to towns that choose to zone land for developing housing mainly where transit facilities, infrastructure and complementary uses already exist or have been planned.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	are under criminal justice jurisdiction. Many of these units of supportive housing are the scattered site model, which creates total integration into the community since the individuals sign their own lease with a private landlord in the community.	
f. Increase the utilization of housing vouchers in communities throughout Connecticut so additional vouchers may be requested from HUD.	DMHAS has begun to cultivate relationships with the Public Housing Authorities (PHA), including the Department of Social Services, throughout the state in an attempt to match rental subsidy vouchers with support services. This collaboration would work well since DMHAS clients need housing and the PHA's need assistance in providing services to their housed population. If this model is shown successful, excess units could be filled with DMHAS clients and theoretically, the PHA's could ask HUD for more vouchers.	
g. Over the next biennium, support the efforts of DECD regarding the *CTHousingSearch.org* website to identify accessible units and increase their utilization. Ensure that all State agencies that construct or rehabilitate housing or provide rental assistance, report the accessible units to the website.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
h. Ensure that persons with disabilities and older adults are accessing foreclosure assistance programs when needed including special assistance if forced to move.	The Connecticut Supreme Court has ruled that there can be no reasonable accommodations made on foreclosures because the statutes do not apply to lending institutions. However, the Connecticut Fair Housing Center (FHC) through funding from the state of Connecticut (general funds-DECD), assists with part of the cost of a foreclosure attorney, works with housing counselors, and represents people in foreclosure. The FHC recommends the aged or disabled to request what are known as "long law days." That is the time span until transfer of ownership takes place. This gives occupants the longest time possible to find a replacement dwelling and is particularly helpful if the dwelling must have accessibility features or requires modifications. The DMHAS housing unit has knowledge of particular eviction prevention and foreclosure prevention programs funded both by the federal and state governments and can make proper referrals to these programs when	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	necessary.	
i. Expand affordable assisted living options. Strategies could include making assisted living available to individuals under the age of 55 and combining HUD and other housing programs to cover housing costs for those whose assisted living services are covered by Medicaid. Direct systematic attention toward expanding available slots in pilot programs for assisted living and other supportive community-based residence settings, and making these programs permanent. Remove obstacles in state laws that prevent full maximization of federal funds under the Assisted Living Conversion Program.		**P.A. 09-5 Sept. Special Session**: Eliminates the limit of four projects under the Assisted Living Conversion Program.
j. Establish a Resident Services Coordinator in every State-funded Elderly Housing facility. Currently, there is one Resident Services Coordinator in every three facilities. Training is also needed to equip Resident Service Coordinators to serve both older adults and people with disabilities.		**Public Act 10-179: Section 1:** Eliminates funding for Residential Service Coordinators in SFY 2011. However, this funding remains in place. It was switched to General. Fund line item entitled "Elderly Rental Registry and Counseling."
k. Create incentives for underutilized institutions to convert their facilities to adult day care services, assisted living, residential care homes, independent living communities, or other community housing options in order to offer settings that reflect the more		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
home-like features that people generally prefer.		
l. Develop new housing alternatives for persons with persistent mental illness who do not need nursing facility level of care. Consider Supportive Housing as one strategy to pursue.		
m. Raise public awareness about reverse mortgage options.		
15. Support programs that divert or transition individuals from nursing facilities or other institutions.		
a. Support current nursing facility diversion and transition programs, such as Money Follows the Person (MFP), the home and community-based Medicaid waiver programs, the Pre-Admission Screening Resident Review (PASRR), Aging and Disability Resource Centers (ADRCs), cash and counseling options under existing respite programs, and the DMHAS Nursing Home Diversion and Transition Program.	By the end of SFY010, the DMHAS Nursing Home Diversion and Transition Program will add four new staff for a total of eight nurses and two case managers.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
b. Identify individuals at risk of institutionalization, including people determined to be ineligible for Medicaid, and develop a long-term care service system that is able to sustain community living and significantly delay or avoid institutionalization. ▪ Establish and fund ADRCs statewide. (See Recommendation #7) ▪ Refer identified individuals who are at risk of spend-down to Medicaid and at risk of institutionalization to the ADRC for comprehensive long-term care needs assessments so that a home and community-based services plan can be developed. ▪ Emphasize diversion at the point of hospital admission and discharge. Information on the availability of community services and Medicaid home and community-based waivers should be provided to discharge nurses and updated periodically. ▪ For people residing in institutions, provide additional transition discussions after three months, six months and annually thereafter. Discharge planning should be an active part of every person's plan of care. ▪ Support and expand the DMHAS Nursing Home	An Assessment and Priority Tool for cash and counseling has been developed in the south central and western regions to identify individuals at risk of spend-down to Medicaid and at highest risk for institutionalization. Protocol for ADRC referrals have also been established to link consumers to community-based services as appropriate. For DMHAS-operated institutions and agencies who are working with a client who may need nursing home level of care, a pre-OBRA screen is utilized in order to determine eligibility and whether other less restrictive options are more appropriate. DMHAS has aggressively been educating hospitals and community providers about the NHDT Program. A Resource Guide has been developed for these entities to assist in locating community mental health services for clients at risk for institutionalization. Currently six DMHAS NHDT Program Nurse Clinicians track and monitor admissions of persons with MI to nursing homes. They collaborate with	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Diversion and Transition program to avoid continued institutionalization of individuals with mental illness at the point of hospital discharge. ▪ Expand the number of Medicaid eligibility service workers stationed at ADRCs, hospitals, community health centers and local mental health authorities to expedite the Medicaid eligibility screening process. ▪ Simplify the Medicaid application process and develop a web-based on-line application system, making both a paper-based and computer based application process equally available. Also, develop and implement an expedited eligibility process for state programs that support services in the community such as the Connecticut Home Care Program for Elders (CHCPE) and other Medicaid home and community-based services waiver programs. (See Recommendation #2) ▪ Support and promote the availability and development of adequate housing such as Supportive Housing, services and in-home respite in efforts to divert people from initial institutionalization.	MFP Transition Coordinators and the facility social services department around discharge planning as appropriate. By 7/1/10, there will be a total of eight NHDT Nurse Clinicians working on client transitions from nursing homes. In areas of the state not covered by the program, Local Mental Health Authorities and DMHAS-funded providers assist with transitions.	
16. Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
and older adults.		
a. Increase expectations and opportunities for people with disabilities in achieving career potential. Educate the public and professionals about career potential for persons with disabilities.		
b. Improve the transition process for young adults moving from school to post-secondary education or employment.		
c. Increase the recruitment, employment and retention of individuals with disabilities and older adults into Connecticut businesses.		
d. Increase access to transportation to and from work for individuals with disabilities and older adults. (See Recommendation #13)		
e. Create a statewide technical assistance center for job seekers with disabilities and employers.		
f. State government, as the largest employer in		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Connecticut should adopt older worker friendly initiatives that provide flexibility for workers, while ensuring that their work is completed on time and with high quality. Options include: voluntary schedule reductions, flexible work hours, phased-in retirement programs and telecommuting options.		

Acronyms:

AAA - Area Agency on Aging
ADRC – Aging and Disability Resource Centers
ARRA - American Recovery and Reinvestment Act of 2009
CMS – Center for Medicare and Medicaid Services
DMHAS – Department of Mental Health and Addiction Services
DPH – Department of Public Health
DSS – Department of Social Services
DECD – Department of Economic and Community Development
HCBS – Home and Community Based Services
HUD - Department of Housing and Urban Development (HUD), Department of Economic and Community Development
MFP – Money Follows the Person
NHDT - Nursing Home Diversion and Transition
PASRR - Pre-Admission Screening Resident Review
PCA – Personal Care Assistant
SUA – State Unit on Aging
VA – Veteran's Administration
VDHCBS - Veteran's Directed Home and Community Based Services Program