Status Report

2010 LONG-TERM CARE PLAN FOR CONNECTICUT

Connecticut Long-Term Care Planning Committee

JUNE 2011

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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 Social Services (DSS) Money Follows the Person (MFP) initiative transitioned 530 persons who had been institutionalized six months or more. The first protocol for informed choice closure was designed and implemented. As of the end of SFY 2011, one nursing home closed utilizing this process and four are in process. As part of the plan to expand the MFP Rebalancing Initiative, DSS has been awarded funding to help nursing facilities diversify their existing business model by restructuring and reducing the number of skilled nursing beds. The Department of Mental Health and Addiction Services (DMHAS) has	**Public Act 11-6**: To reflect the expansion of MFP to 2,251 individuals by the end of SFY 2013 in coordination with a 'right-sizing initiative, funding is reduced by $13,036,123 in SFY 2012 and $24,646,730 in SFY 2013. **Public Act 11-6**: Increases funding for additional mental health Medicaid home and community based waiver slots. Provide funding of $489,000 in SFY 2012 and$1,026,000 in SFY 2013 to reflect a transfer from the DSS Medicaid account. Funding will support 30 waiver slots per year to divert individuals who frequent emergency rooms and shelters from nursing homes to appropriate services. This change also results in an increase of federal funding at a 50 percent

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	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. The NHDT Program is working with some Area Agencies on Aging around specific clients who have mental health and/or substance abuse problems. As of May 1, 2011, during SFY 2011, the NHDT Program has diverted approximately 44 individuals from nursing home admission and 81 nursing home residents have been transitioned back to the community. Under the Mental Health Waiver, at the end of the 3rd quarter of SFY 2011, 73 individuals have been enrolled and are living in the community.	reimbursement rate ($244,500 in SFY2012 and $513,000 in SFY 2013), due to an increase in Medicaid waiver expenditures. **(SB 6618): Sections 547 & 548**: Requires the Department of Social Services to develop a strategic plan, consistent with the state's long-term care plan, to rebalance Medicaid long-term care supports and services, including supports and services provided in-home, in a community-based setting, and in institutions. Providers from all three setting types must be included in the development of the plan. The bill also exempts from the general CON moratorium on new nursing home beds those beds that are relocated to a new facility to meet a priority need identified in the strategic plan. By law, the moratorium is due to expire on June 30, 2012.

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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 insurance represented 7.2 percent of long-term care spending in 2005.	Continued implementation of the Connecticut Partnership for Long-Term Care, including outreach and educational efforts.	
STRUCTURAL		
1. Create greater integration of State level long-term care administration and functions serving both older adults and people with disabilities and their families.		**Public Act 11-44, Sections 1-69**: Creation of a new Bureau of Rehabilitative Services by removing the current Bureau of Rehabilitative Services from DSS and merging it with both the Board of Education Services for the Blind (BESB) and the Commission on the Deaf and Hearing Impaired (CHDI).
a. Establish a consolidated, efficient all-ages human services approach to long-term care in Connecticut that maximizes the impact of Medicaid, Older	Since 2009 two additional Aging and Disability Resource Centers (ADRCs) opened in Connecticut. One in the	**Public Act 11-44, Section 145**: Postpones the establishment of the Department on Aging to July 1, 2013.

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Americans Act and Veterans Administration (VA) funds rather than divides them.	Western region and one in the North Central region serving people with disabilities and people of advanced age. In 2009, the State Unit on Aging (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. The SUA in cooperation with the Agency on Aging of South Central Connecticut and the VA Connecticut Health Care System are just completing the first year of implementation of a Veteran's Directed Home and Community Based Services Program (VDHCBS) in the south central region of Connecticut. VDHCBS provides veterans of all ages the opportunity to self-direct their HCBS, manage their budgets and hire Personal Care Assistants (PCAs) of their choice. In 2011 the SUA received approval from the federal VA and Administration	

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	on Aging to expand the VDHCBS program to Fairfield County and has begun expansion efforts in collaboration with the Southwestern Connecticut Area Agency on Aging and the VA Connecticut Medical Center. The program is expected to open enrollment in Fairfield County mid-June, 2011. Expansion statewide is expected over the next few years. DSS contracted with Mercer to conduct a study to analyze the MFP demonstration and the Elder, Katie Beckett, Personal Care Attendant and Acquired Brain Injury Home and Community-Based Services waivers, as well as the proposed HIV/AIDS waiver for 1) system efficiencies, 2) quality of care and 3) improvement in employment services. Draft recommendations were presented in October 2010 and stakeholder comments were solicited. DSS applied for and was awarded funding to demonstrate integration f funding sources, including Medicare and Medicaid, to develop an integrated care model for acute and long-term care services.	

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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. MFP was funded to develop a web based system linking discharge planners and other to long-term supports and services. The system will be coordinated with DSS Modernization efforts, ASOs, SUA, and ADRCs.	
c. Provide for global budgeting with flexibility and authority to fund an array of long-term care services and supports, to be adjusted annually based on the projected needs of the population and for inflation.	The SUA has been overseeing several initiatives to provide flexible budgeting for long-term care services including: • Embedding a self-directed care option into the Older Americans Act National Family Caregiver Support Program (Title III-E) and the State funded Connecticut Statewide Respite Care Program. • Implementing cost-sharing for	

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	NFCSP recipients with incomes greater than 200 percent of the FPL to generate revenue for Title III-E respite and supplemental services effective 10/1/2011. The implementation of the Veteran's Directed Home and Community Base Services program in South Central Connecticut and planned 2011 expansion to Southwestern Connecticut 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.	Medicaid eligibility will be streamlined by the Modernization initiative within DSS.	**Public Act 10-126:** Requires DSS, whenever it sends its annual eligibility redetermination form to a person participating in the Connecticut Home Care Program (CHCP), 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 CHCP: Connecticut Community Care, Inc., (the access agency), South Central

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		AAA, and Southwestern AAA.
e. Ensure linkages with the CHOICES Program, ADRCs, Centers for Independent Living, and providers of mental health services for all ages.	DMHAS is represented on the ADRC Steering Committee and the NHDT Nurse Clinicians actively collaborate on community referrals. 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. MFP funds mental health services and independent living centers and ADRCs.	
f. Develop systems and technology to share long-term care data. ▪ Improve technology in state systems to implement electronic records and make valuable data readily retrievable. ▪ Assist all health care providers with the implementation of electronic records and the implementation of the statewide electronic data exchange.	MFP developed a web-based data system used by all MFP case managers including transition coordinators. The data system includes a critical incident reporting system. The system is currently under expansion. Applications for services will be stored on the server within six months.	

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▪ Build data capacity and systems integration that facilitates more efficient care management for people receiving services.		
2. Simplify Connecticut's Medicaid structure.		
a. If the federal government revises their rules to allow it, establish a universal Medicaid home and community-based services waiver based on function, not age or diagnosis. Allow for flexibility to address a variety of specific needs.		States may now apply for a combined 1915C waiver.
b. If it is determined that a universal Medicaid waiver is not feasible, every effort should be made to ensure that eligibility criteria and level of need reporting forms are consistent across waivers.		
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.		

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Require evaluation of all pilot programs after three years, including cost-effectiveness.		
e. Streamline Medicaid eligibility procedures, reduce response time to individuals and develop a web-based on-line application process for Medicaid services.	DSS plans to implement Modernization (web-based application process) to streamline Medicaid in SFY 2012 with the goal to reduce response time. MFP is demonstrating an expedited long-term care process for community placements in coordination with Modernization.	
f. Ensure interagency accessibility to eligibility application information to streamline the application process for many state programs.	During SFY 2012, agencies will have access to the web-based Medicaid application.	
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	MFP is developing an action plan in coordination with the DSS Dental program for implementation in SFY 2012. DDS hired a dental coordinator 3 ½ years ago. UConn dental department has	

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

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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.		**Public Act 11-6**: Eliminates the establishment of a long-term care reinvestment account. These funds will continue to be treated as General Fund revenue.
d. Maximize reimbursement of state long-term care expenditures through an ongoing review process.		
e. Consider setting Medicaid rates based on objective quality measures.	MFP strategic planning initiative includes a review of rates with respect to quality across all long-term care.	
4. Further reform and coordinate the nursing facility/ institutional admission prescreening process.		
a. Expand the current State commitment to prescreen all applicants to nursing facilities age 65 and older, regardless of their payer status, to include all nursing facility applicants, regardless of age or payer source. Similar prescreening for applicants of all institutions for individuals with disabilities should be developed.		
b. Implement a systematic, web-based, comprehensive	DMHAS continues to collaborate with	

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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.	the DSS Alternate Care Unit around the Ascend web-based Pre-Admission Screening Resident Review (PASRR) program. NHDT nurse clinicians track and monitor the nursing home length of stay of 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 with disabilities.	By June 30, 2010, DMHAS will have met with five institutional providers (hospitals including Connecticut Hospital Association utilization managers and nursing homes) and seven community providers, including the Elder Waiver access agencies, to educate them about PASRR and community options that may be accessed through the DMHAS NHDT Program and the Mental Health Waiver. A Resource Guide has been developed and distributed to participants. MFP conducts extensive training with hospital staff, nursing facility staff, physicians, and others regarding community services, screening, transition, etc.	
d. Identify people who have housing to return to and preserve its availability as part of the prescreening process.	MFP created a streamlined process for hospital discharge and admission to a nursing facility that will identify and	

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	transition persons for whom there are no barriers to community living.	
INFORMATION/ ACCESS		
5. Provide true individual choice and self-direction to all users of long-term care.		
a. Expand self-directed care options under home and community-based services programs. ▪ Allow individuals and family members to choose their own care providers, including individuals from within their own informal care network, particularly family members, and allow individuals to control their own budgets. ▪ Operate programs with as much flexibility as possible, including the ability to arrange for as 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	The SUA has added a permanent self-directed care option to the Connecticut Statewide Respite Care Program for all five AAA regions, increasing accessibility to clients living in regions outside the existing piloted areas of South Central and Western Connecticut covered in the Nursing Home Diversion grant that ended in 9/30/10. This statewide option offered clients in this program the option to hire and supervise their own caregiver rather than utilizing an employee of an agency to provide services. It was implemented January 1, 2011. It was renamed the "Self Directed Care" option, rather than "Cash and Counseling" to better describe its scope of flexibility to	

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home care services.	clients. This option is expected to be offered statewide through the National Family Caregiver program effective 10/1/11. The implementation of the Veteran's Directed Home and Community Base Services program in South Central Connecticut and planned 2011 expansion to Southwestern Connecticut provides veterans of all ages the opportunity to self-direct their HCBS, manage individual budgets and hire PCAs of their choice. All Medicaid waiver programs now have self-direction (hiring staff) as an option.	
b. Offer where feasible a self-directed care option for programs, including but not limited to the DSS National Family Caregiver Support Program (for those caring for relatives age 60 and older) and the Connecticut State Respite Care Program (for individuals with Alzheimer's disease) using the existing model being piloted under the Nursing Home Diversion Modernization Grants. Also, investigate funding options to support Fiscal Intermediary Services under these and other programs to allow individuals the flexibility to	The SUA has been overseeing an initiative to provide flexible budgeting for long-term care services by embedding a Cash and Counseling option into the Older Americans Act National Family Caregiver Support Program (Title III-E) and the State funded Connecticut Statewide Respite Care program. The SUA is expanding these services statewide. This option has been made available to recipients of	

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choose and hire their own personal care workers and control their budgets, similar to what are allowed under the current DDS Medicaid waivers.	the Connecticut Statewide Respite Care program effective 1/1/2011 and effective 10/1/2011 will be available to National Family Caregiver Support Program recipients as well.	
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.	Legislation approved permitting DSS to apply for an 1915K state plan option.
d. Increase public and professional understanding of individual choice, recovery, independence and self-determination.	DSS and DPH collaborated on the state's first 'informed choice' conference. DPH clarified regulation supporting informed choice and risk for licensed providers. MFP created and implemented the first informed risk agreement. The informed risk protocol was supported by the legislature as a best practice. DHMAS Older Adult Services staff have presented several times to professional and consumer groups on individual choice, recovery, etc. (e.g. DSS access agencies, Connecticut Hospital Association, nursing facilitates,	

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	National Association of State Mental Health Program Directors Older Persons Division). SUA and AAA staff have done several presentations to professional and consumer groups regarding individual choice, self-direction etc., including presenting on the Veteran's Directed Home and Community Based Services Program at venues such as the C4A Aging and Mental Health Conference.	
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.	After the statewide 'informed choice' conference referenced above, regional training will be hosed in September 2011 regarding informed choice and the supportive interpretation of regulation. MFP conducts extensive training to professionals.	

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▪ There should be training on Social Roles Valorization that would help human service workers better understand the value of social roles and the do's and don'ts of supporting people in the community. Social role valorization starts with the assumption that it is important for people who need long-term care to live in valued residential situations and take on valued roles in the community. This relates both to a person's individual competencies and social image in the community.		
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 10/1/10 and 5/30/11. Approximately 400 consumers were educated. As of 12/31/10, over 40,000 Connecticut residents owned Partnership for Long-Term Care insurance policies and the Partnership has saved Connecticut's Medicaid	

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	program over $11 million to date.	
b. Coordinate efforts of the Connecticut Partnership for Long-Term Care with the long-term care support options counseling efforts of the ADRCs.	The 5 AAA's continue to take on a larger role with the Connecticut Partnership for Long-Term Care in the form of information & referral and coordination of the public forums as the part of their CHOICES and ADRC program activities. Additional 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.	
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	MFP currently conducts targeted outreach and plans to develop web-based tools over the next 12 months.	

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provided to those who are the most frequent sources of long-term care information and advice, such as social workers and heath care providers, as well as Probate Court officials and conservators.		
d. Initiate a campaign of cultural change around long-term care, especially targeting health care professionals (physicians, nurses, social workers, occupational therapists, physical therapists, etc.). These professions often influence consumer choices.	MFP has initiated a campaign of cultural change.	
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.	Four federal grants were awarded to DSS under the Affordable Care Act as of October 1, 2010. Connecticut was one of only four states to receive all four ADRC funding opportunities. 1. The formula funded opportunity, Medicare Improvement for Patients and Providers Act, made funding available to AAAs State Health Insurance Programs, and ADRCs through states for outreach/ assistance on additional programs	

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	for low-income Medicare beneficiaries including preventative benefits. $442,003 2. The competitive funding opportunity, ADRC Options Counseling Grant, strengthens options counseling in existing ADRCs. $500,000 3. The competitive funding opportunity, ADRC Evidence-Based Care Transition Grant, strengthens Connecticut's existing care transition intervention model in the North Central ADRC with the Hospital of Central Connecticut. The purpose of the funds is to prevent unnecessary hospital readmissions. $193,418 for one year and potential for funding in 2nd year. 4. The competitive funding opportunity, ADRC Nursing Home Transition and Diversion Programs Grant, provides supplemental administrative funds through MFP to strengthen the capacity of existing ADRCs. The purpose of the funds is to assist with the implementation	

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	of nursing home Minimum Date Set 3.0 Section Q. $448,500	
b. Implement new ADRCs in the remaining three areas of the state: eastern, southwestern, and north central. Base further development of the model upon evaluation of the existing ADRCs and tracking of their quality and efficiency.	In May 2010, a third ADRC was established in the North Central region. A statewide ADRC Five Year Plan was submitted to the Administration on Aging in April 2011 and includes expansion plans for the eastern and southwestern regions of the state.	
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. ADRC staff will have access to the comprehensive resource database developed under the MFP iniative.	

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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		
8. Address the long-term care workforce shortage.		
a. Enhance public perception of long-term care jobs and professionalize paraprofessional positions.	MFP workforce development workgroup developed a strategic plan to support expansion of 9,000 additional long-term care workers by 2016. $300,000 per year is available to fund the plan.	
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.		

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e. Develop, coordinate and expand education and training programs targeted to areas of workforce shortages. ▪ Attract students into the field with scholarships and grants. Education and training curricula should be considered beginning in high school. ▪ Provide re-training for individuals who lose their job in such sectors as manufacturing and institutional care for new careers in long-term care, especially home and community-based care. ▪ Expand efforts at collaboration among the Connecticut Department of Labor, the Workforce Investment Boards and the Older Workers program to address the needs of workers who have lost their jobs and need to be retrained in order to support themselves. ▪ Promote distance learning as an option for workforce shortage areas. ▪ 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.	**Public Act 10-3, Section 29:** By January 1, 2011, the education commissioner and the vocational-technical school system superintendent must establish and administer licensed practical nurse programs at six vocational-technical schools. The school locations must be distributed on an equitable geographic basis throughout the state. The requirement applies unless the education commissioner notifies the Education Committee by November 1, 2010 that he will not establish the programs and the reasons why. If the appropriation for the programs is too little to cover their costs, the bill allows program tuition to be increased to cover the shortfall. **Public Act 10-8:** Specifically authorizes the 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

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		career programs at the bachelors, masters, and sixth year level.
f. Inventory existing direct care workforce initiatives to identify duplication and gaps.	MFP workforce development workgroup led a mapping initiative funded by the federal Centers for Medicare and Medicaid to identity duplication and gaps.	
g. Review the current licensing certification statutes for formal caregivers to be sure that appropriate skills, training and roles are required as the system of formal caregiving evolves.		
h. Engage Workforce Investment Boards to develop approaches to increase the size of the formal long-term care workforce, including training, education and incentives. The wage gaps, including benefits, between public and private frontline workers and across those workers who care for different populations should be addressed. Transportation issues must also be addressed.	The MFP workforce development workgroup has developed a partnership with the Workforce Incentive Boards.	
i. Allow individuals to choose their own care-providers and increase flexibility in Connecticut's self-direction model to increase availability of workers and help to address the workforce shortage. (See Recommendation #5)	Participants in all Medicaid waivers now have the option to choose their own staff. The SUA has implemented two self-directed care models that allow	

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	individuals to select the caregiver of their choice: 1) A self directed care option through the Older Americans Act National Family Caregiver Support Program (Title III-E) and 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 which has wrapped up its first year of program implementation with 27 veterans served and an expansion effort underway to offer the program in the southwestern region of the state by mid-June 2011.	
j. Expand the use of the non-traditional workforce, such as personal care assistants (PCAs) and personal care managers, to help address the increased number of individuals desiring home and community-based care. To make the positions competitive and a viable career, these types of jobs must provide the necessary worker benefits and supports, including health insurance. Low cost opportunities for health insurance for PCAs should also be explored.	Several times a year, DMHAS offers two-day trainings for recovery assistants (RAs) who work with Mental Health Waiver Program clients. Thus far, over 200 RAs have been trained. Generally, RAs are employed by community home care agencies.	
k. Support the creation and availability of PCA registries such as *rewardingwork.com*.		

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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, 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.	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 Family Caregiver Support Program and the state funded Connecticut Statewide Respite Care program. This option has been made available to recipients of the Statewide Respite Care program effective 1/1/2011 and will be available in the National Family Caregiver Support Program as well.	**Public Act 10-179: Section 1:** Increase appropriation for Alzheimer's Respite Program from $2,294,338 to $2,794,338 in SFY 2011. **June Special Session, Public Act 10-2: 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	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.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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.		
c. Explore the potential for supporting overnight respite care in settings other than institutions, such as evening or overnight adult day care. This should include consideration of licensing and Medicaid reimbursement issues.		
d. Build on and expand current efforts supported under the National Family Caregiver Support Program, enhancing the basic information, training and respite services that are already provided.		
e. Support partnerships across State agencies to share information on age and disease specific programming for caregivers and develop coordinated sources for caregivers to obtain information on available respite services, utilizing ADRCs.		
f. Expand and support caregiver respite service options through the availability of flexible respite services, including respite services provided in an individual's or caregiver's home. (See Recommendation # 5)		
g. Explore informal peer support training as a means to	Coordination with the Chronic Disease	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
meeting needs without increasing the cost associated with licensed or other professional personnel.	Self-Management Program and the National Family Caregiver Support Program is taking place in order to provide training to caregivers and consumers on how to manage chronic 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.	UConn Research Project continues to evaluate the outcomes of the DMHAS Mental Health Waiver Program. MFP operates under a continuous quality improvement process.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
c. Increase the quality of care in the various long-term care settings by including educational programs, identification of mechanisms that encourage longevity of employment, team building concepts and education of the public regarding the continuum of care. Include education about evidenced-based programs such as fall prevention, Gatekeeper Program, Healthy IDEAS (Identify Depression, Empowering Activities for Seniors), and Chronic Disease Self- Management.		
d. Incorporate the needs of older adults and persons with disabilities in all state emergency planning.	DDS public and private congregate day and residential service sites have emergency response plans that include identified sites for relocation in the event of an emergency. DDS has identified personnel who participate in the State Emergency Operations Center, should the governor activate the Center in the event of an emergency. DDS, on a monthly basis, sends to the Connecticut Department of Emergency Management and Homeland Security (DEMHS) data about the number, location, and contact information regarding congregate day and residential service sites located in each of the 169	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	towns in Connecticut. This information in turn is sent by DEMHS to each of the towns' Emergency Management Directors to be used in their emergency planning and response efforts. DDS personnel, in conjunction with other people representing an array of citizens with disabilities, has trained close to 2,000 first responders in the 41 town Capital Region regarding the functional needs of people with disabilities in emergency circumstances such as needs during evacuation, shelter, and relocation situations. DDS participates on a quarterly basis with local, state and federal officials from Emergency Planning Zone towns in and around the Millstone Nuclear Power Plant to design, exercise and evaluate emergency planning and response protocols in the event of a radiological incident at the Millstone Nuclear power Plant. DDS regularly and actively participates in State and federally sponsored emergency management drills.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	DDS personnel participated in the Connecticut Inter-Agency Supportive Care Shelter Workgroup. This workgroup was tasked to develop a standardized, comprehensive statewide and regional approach for support services and temporary shelters for vulnerable populations during disasters and public health emergencies.	
e. Employ a state disability coordinator who can organize and coordinate emergency preparedness trainings with people with disabilities for fire responders, emergency medical technicians (EMT), police and community teams.		
f. Support the purchase and maintenance of assistive technology. More emphasis should also be placed on the use of robotics in the home to assist with activities of daily living. Expenditures for assistive technology can be minor when compared to the extended cost of human services for personal assistance. This technology can allow an individual to maintain or regain independence and reduce their reliance on paid services.	Assistive technology devices are an available service through the National Family Caregiver Support Program as a supplemental service item. Veterans on the Veteran's Directed Home and Community Based Services Program may use their flexible service budgets to purchase assistive technology devices when not covered under traditional VA programs and funding sources. DSS/BRS also administers the	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Connecticut Tech Act Project, which helps to increase access to assistive technology devices through a variety of services, information and referral, and the provision of low interest loans for the purchase of assistive technology. Assistive technology is a primary focus of the MFP demonstration.	
g. Utilize federal and state health promotion resources through adoption of Evidence-Based Programs.	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	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.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	Administration on Aging to systematically embed the Chronic 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.	The Connecticut Collaboration for Fall Prevention through Yale has been expanding their fall prevention assessment, training and outreach initiative statewide utilizing state funds through the SUA. The SUA received a grant continuation for the 2007 Evidence-Based Program Federal Grant to introduce the Tai Chi: Movement for Better Balance evidence-based program in the Western and South Central Regions. This Tai Chi intervention focuses on fall prevention and is a partnership between the SUA and DPH. This Tai Chi project started in 2010 and will continue into 2012.	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).		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
j. Address the isolation and segregation of older adults and people with disabilities by emphasizing connection to natural supports and community as well as social and recreational opportunities. This should include strategies to link individuals with informal, non-paid networks. Support for transportation options to aid and encourage participation is also important.	Data is collected on all MFP participants to identify persons who have transitioned from a nursing facility to the community and feels isolated. Interventions to address isolation are implemented if needed.	
11. Address the scope and quality of institutional care.		
a. Develop a plan to modernize the physical plants of existing nursing facilities when feasible and appropriate. Modernized and high quality skilled nursing facilities are needed as an available option for consumers of long-term care.		
b. Explore the concept of the small nursing home and compare to the current nursing facility model in terms of reducing acute care hospital admissions, complications and declines in health and function and assessing overall costs.		**Public Act 11-6**: Reduced funding by $750,000 in SFY 2013 to reflect capping any further development of small house nursing home beds at 280.
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	DSS is developing a right-sizing plan scheduled for implementation in SFY 2012. The plan will guide future workforce development, community	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
system; and 2) de-license, reclassify, or hold in abeyance the remaining beds. Distinctions should be made between beds serving long-term care needs and beds serving post-acute rehabilitation needs. Data and analysis is needed to guide both providers and policy makers. As this occurs, there is an opportunity to redirect the appropriate level of resources to enhance home and community-based services and supports.	housing, nursing facility closure or down-sizing – or addition of beds if merited, at a community level.	
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	DSS developed a white paper on nurse delegation and its importance in rebalancing.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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.	MFP right-sizing initiative is funded to provide options for institutional providers to diversify their business model to provide community long-term care services.	
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 concluded the first year of implementation of the Veteran's Directed Home and Community Based Services Program in the south central region of Connecticut serving the maximum allowable number of veterans (27). In FY 2011 efforts to expand the program have been underway with implementation expected in mid-June 2011. 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	On an ongoing basis, DMHAS Older Adult Services provides education to Local Mental Health Authorities and other community providers on older adults with mental health and/or substance abuse problems. A Resource Guide has been developed outlining ways to access mental health resources. DMHAS initiated a request for proposal in February 2011 to fund a Gatekeeper Program statewide. The program should be implemented by the Fall of 2011.	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
promote aging in place over institutionalization.		
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.	MFP increase capacity, funding and, if necessary, slots for each MFP participant after 365 days.	
g. Continue to advocate for changes to federal Medicaid law that will facilitate an expansion of home and community-based options. In the past, Connecticut submitted a proposal to the federal Centers for Medicare and Medicaid Services (CMS) to expand the medically needy income formula allowing individuals with incomes in excess of 300 percent of Supplemental Security Income to be eligible under the Medicaid portion of the Connecticut Home Care Program for Elders (CHCPE). This proposal would have allowed individuals the same access to home and community-based care as they have for nursing facility care. Unfortunately, Connecticut's proposal was rejected by CMS. Connecticut should resubmit		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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.		
k. Enhance interagency efforts to offer community-based service options to dually diagnosed individuals.		

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

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	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 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	DECD encourages its housing developers to undertake responsible	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
resources are being developed for individuals with disabilities or the general public.	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.		
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		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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.		
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. In accordance with Public Act 10-56: DECD established an informational webpage on its Internet website that provides links to available visit-able housing resources at http://www.ct.gov/ecd/cwp/view.asp?a=1098&q=466356&ecdNav=|.	**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

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	In its 2010 design standards the Connecticut Housing Finance Authority (CHFA) added that all newly constructed ground floor residential spaces shall be designed as visit-able for guests.	or exemption to construct visitable homes. And, it authorizes municipal legislative bodies to adopt ordinances giving these developers a property tax abatement. Within available appropriations, the bill requires DECD to establish an informational webpage in a conspicuous place on its Internet website that provides links to available visitable housing resources.
b. Increase outreach to landlords and homeowners about resources and financing to make their units and homes accessible.	MFP has leased up over 400 units over the past two years; over 100 homes were modified.	
c. Provide funding for home modifications that would either allow individuals to remain in their own homes or return to their own home following institutionalization.	MFP funds modifications on homes allowing the individual to transition from an institution to the community. DECD partners with MFP providing $1 million in additional funding for modifications costing in excess of $10,000. Some funding for home modifications is available to consumers through the National Family Caregiver Support Program as Supplemental Services enabling individuals to remain in their own homes, avoiding costly nursing	DECD has approved an additional $500,000 in Housing Trust Fund program funds for Centers for Independent Living to continue the Money Follows the Person Transition program which provides grants for accessibility modifications to both homeownership and rental units for those persons leaving long term care institutions.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	facility placement.	
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 DDS, generally no larger than one to four people per single dwelling, should serve as a model of true community integration.	DECD continuously provides gap financing to fund a broad range of affordable housing options including HUD Section 202 and 811 projects and supportive housing options. MFP partners on grant applications submitted to HUD. TO date, five assisted living units were creased as a result of the partnership. MFP also partners with developers. To date, three new accessible two bedroom partners were built.	**Public Act 10-179: Section 1:** Adds $1 million for Next Steps Supportive Housing in SFY 2011. **Public Act 10-3, Section 4:** Transfers $380,000 for the DECD HomeCT program to the General Fund. **Public Act 10-179: Section 14:** Carries forward to SFY 2011 the unspent balance as of June 30, 2010 of funds appropriated to DECD for Home CT. This program provides grants to towns that choose to zone land for developing housing mainly where transit facilities, infrastructure and complementary uses already exist or have been planned.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		Public Act 11-6: Expands supportive housing by providing DSS half-year funding of $775,850 in SFY 2013 to cover Rental Assistance program (RAP) certification for 150 units. The proposed capital budget for the upcoming biennium includes $30 million in SFY 2012 for supportive housing under DECD. The current administration intends to provide $50 M in SFY 2012 and SFY 2013 ($100 M total) for the development of affordable housing. This will add more accessible housing to the stock because in accordance with the state building code, all newly constructed or substantially rehabilitated buildings with an elevator must be fully accessible housing; without an elevator 100 percent of the ground floor units must be 100 percent accessible. In addition, 2 percent of all units must be designed for the hearing or vision impaired. All other rehabilitation must be made accessible to the maximum extent feasible. The current administration has

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		requested and anticipates providing the following for Supportive Housing: • $30M in bond financing for development of 150 units • $1.5M in general fund dollars for rental assistance for 150 units • $1.1M in general fund dollars for service subsidies for 150 units
f. Increase the utilization of housing vouchers in communities throughout Connecticut so additional vouchers may be requested from HUD.		
g. Over the next biennium, support the efforts of DECD regarding the *CTHousingSearch.org* website to identify accessible units and increase their utilization. Ensure that all State agencies that construct or rehabilitate housing or provide rental assistance, report the accessible units to the website.		This program continues to be funded.
h. Ensure that persons with disabilities and older adults are accessing foreclosure assistance programs when needed including special assistance if forced to move.	The 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	

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	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.	
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.	Within the past year, MFP partnered on four applications to HUD.	**Public Act 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		**Public Act 10-179: Section 1:** Eliminates funding for Residential Service Coordinators in SFY 2011. However, this funding remains in

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Resident Service Coordinators to serve both older adults and people with disabilities.		place. It was switched to General. Fund line item entitled "Elderly Rental Registry and Counseling." The proposed funding level for the Resident Service Coordinator Program is $1,021,000 for FY 2012. The level is essentially the same as the previous year therefore no new service coordinator positions can be funded.
k. Create incentives for underutilized institutions to convert their facilities to adult day care services, assisted living, residential care homes, independent living communities, or other community housing options in order to offer settings that reflect the more home-like features that people generally prefer.	The MFP right-sizing initiative includes funding for this activity.	
l. Develop new housing alternatives for persons with persistent mental illness who do not need nursing facility level of care. Consider Supportive Housing as one strategy to pursue.		See comments on supportive housing.
m. Raise public awareness about reverse mortgage options.		
15. Support programs that divert or transition individuals from nursing facilities or other institutions.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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.	During SFY 2012, MFP will fund 21 central office staff and 75 fully dedicated field staff to support the transition of 1,000 people per year from institutions to the community. As of May 1, 2011, the DMHAS Nursing Home Diversion and Transition (NHDT) Program is comprised of seven nurse clinicians (three of who are cross-trained in the NHDT Program) and two bi-lingual case managers. Another nurse will join the group by summer of 2011. Two additional staff have joined the NHDT Program for a total of six clinicians, plus housing coordinators. The North Central ADRC began piloting a Care Transition Intervention Initiative with the Hospital of Central Connecticut in July 2010 for the purpose of reducing unnecessary hospital readmissions.	
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	An Assessment and Priority Tool for cash and counseling (aka self-directed care) was developed to identify individuals at risk of spend-down to	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
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 Diversion and Transition program to avoid continued institutionalization of individuals with mental illness at the point of hospital discharge.	Medicaid and at highest risk for institutionalization under the CLP Grant received by the SUA. Protocol for ADRC referrals have also been established to link consumers to community-based services as appropriate. Currently seven DMHAS NHDT Program Nurse Clinicians focus on diverting clients from nursing facilities admission, as well as track and monitor nursing facility admissions that do occur. They collaborate with MFP Transition Coordinators and the facility social services department around discharge planning as appropriate. In SFY 2012, an expedited eligibility process will be implemented supporting community discharges; seven dedicated eligibility staff will be located at DSS central office coordinating with hospital and nursing home staff. An additional seven positions are funded in the community to support persons applying for Medicaid with collection of necessary documentation. DSS continues to fund a transition program for anyone not eligible for MFP	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
▪ 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.	demonstration services. Discharge planners will have access to a new web based resource data based. MDS Section Q requires that all individuals in nursing facilities are asked quarterly if they would like to return home. Facilities are required to submit names to MFP within 10 days.	
16. Expand and improve employment opportunities and vocational rehabilitation for persons with disabilities and older adults.	MFP is coordinating with BRS to ensure work is integrated into all transition planning.	
a. Increase expectations and opportunities for people with disabilities in achieving career potential.	Connect-Ability continues to implement its comprehensive marketing campaign,	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
Educate the public and professionals about career potential for persons with disabilities.	designed to increase expectations and develop opportunities for partnership between people with disabilities and business.	
b. Improve the transition process for young adults moving from school to post-secondary education or employment.	Connect-Ability and its partner agencies have focused on the transition process for young adults. The partners have created a transition toolkit with resources for many key stakeholders. The Bureau of Rehabilitation Services has just entered into a contract with the State Education Resource Center to implement a statewide Transition Initiative, using the expertise of the Regional Education Service Centers. The initiative will provide information to school systems, students and families about employment resources, including services available through the adult service system. Connect-Ability has developed a searchable online database of community rehabilitation providers. This searchable database is available on the Connect-Ability website and allows all stakeholders to search for providers by location, services and youth or adult	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	categories.	
c. Increase the recruitment, employment and retention of individuals with disabilities and older adults into Connecticut businesses.	Connect-Ability continues to staff the technical assistance center in a way that maximizes opportunities for relationship building with businesses. Connect-Ability also continues to fund the Business Leadership Network, a coalition formed to provide peer to peer support for businesses looking to diversify their work environment by including people with disabilities in their diversity efforts. The Bureau of Rehabilitation Services is in its second year of implementing its Employment Division, staffed by a Director of Employer Development and nine Employment Consultants. ADRCs are working with the Bureau of Rehabilitation Services on the Medicaid Infrastructure Grant so that ADRC staff can educate and connect persons with disabilities to employment.	
d. Increase access to transportation to and from work for individuals with disabilities and older adults. (See Recommendation #13)	Connect-Ability initiatives were described in the Transportation section above. In addition, staff within two	

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	Connect-Ability funded local level pilots were able to secure funding for accessible taxis. Federal New Freedom Initiative will also provide funding to implement a voucher system and Mobility Ombudsman position. Connect-Ability will continue collaborative efforts with Department of Transportation and the Kennedy Center to standardize the statewide ADA paratransit application for people with disabilities.	
e. Create a statewide technical assistance center for job seekers with disabilities and employers.	Connect-Ability has created a comprehensive website and a toll-free line, staffed with individuals who can help job seekers, businesses, advocates, and other stakeholders find the appropriate resources related to employment.	
f. State government, as the largest employer in Connecticut should adopt older worker friendly initiatives that provide flexibility for workers, while ensuring that their work is completed on time and with high quality. Options include: voluntary schedule reductions, flexible work hours, phased-in retirement programs and telecommuting options.	Connect-Ability has developed a Model Employer toolkit that provides information for businesses and state government entities about diversifying their workforce.	

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
CHCPE - Connecticut Home Care Program for Elders
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