# VERMONT STATE PLAN ON AGING
## for
# Federal Fiscal Years 2015- 2017

October 1, 2014 through September 30, 2017

AS REQUIRED BY
THE OLDER AMERICANS ACT OF 1965
AMENDED THROUGH 2006

Department of Disabilities, Aging and Independent Living
(State Unit on Aging and Disabilities)
Vermont Agency of Human Services
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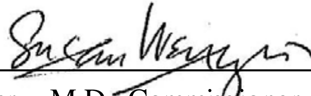
## A: VERIFICATION OF INTENT

The State Plan on Aging for the State of Vermont is hereby submitted for the three-year period October 1, 2014 through September 30, 2017.

The plan includes assurances and plans to be conducted by the Vermont Department of Disabilities, Aging and Independent Living (DAIL) under the relevant provisions of the Older Americans Act, as amended, during the period specified. DAIL has been given the authority to develop and administer the State Plan on Aging in accordance with all of the State activities related to the purposes of the Act, including the development of comprehensive and coordinated systems for the delivery of supportive services, such as multipurpose senior centers and nutrition services, and to serve as the effective and visible advocate for older adults and family caregivers in Vermont.

This plan is hereby approved by the Secretary of the Agency of Human Services, designee of the Governor, and constitutes authorization to proceed with activities under the Plan upon approval by the U.S. Assistant Secretary on Aging.

The State Plan on Aging hereby submitted has been developed in accordance with all federal statutory and regulatory requirements.

Authorized Signature: 

Susan Wehry, M.D., Commissioner,
Department of Disabilities, Aging and Independent Living
State of Vermont

Date: June 27, 2014

## Mission Statement

The Department of Disabilities, Aging and Independent Living's (DAIL) mission is to **make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence.**

To achieve this goal, the Department is committed to fostering the development of a comprehensive and coordinated approach to the provision of community-based systems of services for older adults and people with disabilities. Our goal is to enhance the ability of these Vermonters to live as independently as possible, actively participating in and contributing to their communities. As we approach this work, we are guided by the following core principles:

- ***Person-centered:*** the individual is at the core of all plans and services.
- ***Respect:*** individuals, families, providers and staff are treated with respect.
- ***Independence:*** the individual's personal and economic independence are promoted.
- ***Choice:*** individuals will have options for services and supports.
- ***Self-determination:*** individuals direct their own lives.
- ***Living well:*** the individual's services and supports promote health and well-being.
- ***Contributing to the community:*** individuals are able to work, volunteer and participate in local communities.
- ***Flexibility:*** individual needs guide our actions.
- ***Effective and efficient:*** individuals' needs are met in a timely and cost effective way.
- ***Collaboration:*** individuals benefit from our partnership with families, communities, providers, and other federal, state and local organizations.

# Purpose of The State Plan On Aging

In order to plan for the ongoing and future needs of older adults in Vermont and to meet the requirements of Section 307 of the Older Americans Act (OAA), the Department of Disabilities, Aging and Independent Living (DAIL), the designated State Unit on Aging and Disabilities (SUAD) for Vermont, has prepared this State Plan for submission to the federal Administration for Community Living (ACL). Vermont has opted to create a three year State Plan for the period October 1, 2014 (FFY15) through September 30, 2017(FFY17).

The State is required by federal regulation to:

a) Develop a State Plan for submission to the Assistant Secretary on Aging;
b) Administer the State Plan in accordance with Title III of the OAA, as amended;
c) Be responsible for planning, policy development, administration, coordination, priority setting and evaluation of all state activities related to the objectives of the OAA;
d) Serve as an effective and visible advocate for older individuals by reviewing, commenting on and recommending appropriate action for all State plans, budgets and policies which may impact older Vermonters; and,
e) Provide technical assistance and training to any agency, organization, association or individual representing the needs and interests of older individuals.

The State Plan aligns with the broader vision and goals of the Strategic Plan of the Department of Disabilities, Aging and Independent Living, assuring a focus on strategic priorities and outcomes, and fulfillment of OAA responsibilities. The State Plan offers a framework for the ongoing operations of programs funded through the Older Americans Act and describes the coordination and advocacy activities the state will undertake to meet the needs of older adults, including integrating health and social series delivery systems. In addition, this plan reflects the Vermont Agency of Human Services' vision that Vermonters are healthy, safe and achieve their greatest potential for well-being and personal independence in healthy, safe and supportive communities.

## Executive Summary

It is the mission of the Vermont Department of Disabilities, Aging and Independent Living (DAIL) to make Vermont the best state in which to grow old or to live with a disability – with dignity, respect and independence. The State Plan on Aging (SPA) is required under the Older Americans Act (OAA) and affords the opportunity for the State to articulate its priorities and strategies for improving the lives of older Vermonters, people with disabilities and caregivers. We will do this by working collaboratively with older Vermonters, family caregivers, Vermont's five Area Agencies on Aging (AAAs), the network of Vermont community agencies, and our federal and state government partners. In challenging fiscal times, and an era of reorganizing the delivery of health care and social services resulting from the Affordable Care Act (ACA), we are committed at all levels to optimize efforts and outcomes for the benefit of older Vermonters, people with disabilities, and caregivers.

It will come as no surprise on the heels of a national, slowly healing recession and a belt-tightening federal budget process led by sequestration cuts, that older Vermonters and those organizations committed to helping them, identify increasing poverty or financial insecurity as the number one concern for the future. In our 2014 statewide assessment of needs, the capacity to afford and access the most basic needs, housing and food, followed by access to health care and transportation dominate the list of concerns identified by older Vermonters and providers looking into the future.

Considering just housing and food security alone, in 2013 Vermont lost 11.4% of its Section 8 housing supports with another 9% cut looming in 2014. An estimated 69% of those reductions will impact older Vermonters and people with disabilities. Cuts in OAA nutrition services and in 3Square Vermont (SNAP) place the capacity to live healthy, productive lives at risk. In 2013, Vermont experienced a 5.2% cut in funding for Congregate Meals and Home Delivered Meals, while also experiencing a 3.9% cut in funding for Nutrition Services Incentive Program (NSIP) meals. This impact was somewhat mitigated by the state legislature's authorization of funds for Home Delivered Meals (HDM) and Congregate Meals to offset the loss in Federal nutrition funds due to sequestration.

The services supported by the OAA along with the complementary supports for housing, food assistance and supports for other needs in other federal and state programs, provides a foundation for helping older Vermonters.

These cuts are coming at exactly the beginning of a major demographic phenomenon. By 2020 the entire baby-boomer population will be between the ages of 55 and 75 resulting in a dramatic tilt in population and the aging of society and a matching increase in demand for supports and services. Vermont and all other states need to estimate and prepare for the impact of the aging of our population. In 2012, Vermont's total population of about 625,000 people was ranked fiftieth in the United States. The median age of 42.6 ranks Vermont the second oldest state in the nation. 15.9% of the Vermont population was over

the age of 65, ranking #4 in the US. By 2032, 23.8% of the Vermont population is predicted to be over the age of 65, ranking #1 in the US.

Accompanying these demographic phenomena and these blows to economic security and healthy living supports for millions of Americans and thousands of older Vermonters, is the shifting landscape in the delivery of healthcare and social services that now extends to traditional services for older Americans. The ACA along with the impetus toward performance based payment for services have created a demand for the integration of healthcare and social services systems including the call for integrating OAA Core Programs and discretionary programs of the Administration for Community Living (ACL). Vermont, along with most states, is engaged in a complex process of constructing public business structures that integrate health care, social services, and long-term care services and supports. Many parts of the aging services network will need re-tooling, improved business acumen, and improved staff and systems capacities to successfully integrate into the new models of delivering and paying for care. The goals of our SPA prioritize the mix of re-enforcing core services addressing fundamental needs of older Vermonters and modifying and enhancing the aging network's capacity, which includes DAIL, to deliver effective services.

A significant aspect of the approach articulated in our plan is maximizing the added values of partnerships and stimulating community ownership in the cause of improving the lives of older Vermonters in all communities. Principal amongst these partnerships is Vermont's Aging and Disabilities Resource Connection (ADRC) which is currently an operational partnership of 10 community organizations working statewide in conjunction with DAIL, Vermont's Department of Health Access (VDHA) and Vermont's Department for Children and Families (DCF). The ADRC exemplifies the type of partnership that is statewide; leverages community, state, and federal resources; is person-centered; simplifies and streamlines access to long term care services and supports enabling individuals to maintain independence and live in their chosen communities; and creates efficiencies that save time and money for individuals and the state. Other partnerships central to our approach include, amongst many others, the DAIL Advisory Board, Vermont's AAAs, the Agency of Human Services (AHS) Housing Task Force, the Alzheimer Disease and Related Disorders Commission, the Commission on Successful Aging, and the many valued partners comprising Vermont's Aging Services Network. Facing the future shoulder-to-shoulder with community partner organizations and community leadership offers opportunity to assuage the negative impacts of cuts and maximize involvement and choice in ensuring healthy communities and healthy, independent, older Vermonters.

Vermont's SPA is organized around four goals that reflect the needs and challenges identified in our needs assessment process along and aligns with the strategic priorities of DAIL and ACL's Strategic Action Plan.

The Goals and related Objectives of the State Unit on Aging and Disabilities' (SUAD) SPA are:

**Goal 1 –Decrease the impacts of poverty on older Vermonters and Vermonters with disabilities and support pathways out of poverty.**

Objective 1.1: Improve food security of older Vermonters and Vermonters with disabilities.
Objective 1.2: Improve employment supports and options for older Vermonters and Vermonters with disabilities.

**Goal 2 –Promote the health, wellbeing and safety of older Vermonters.**

Objective 2.1: Provide effective Adult Protective Services.
Objective 2.2: Provide effective guardianship and guardianship alternatives.
Objective 2.3: Reduce the negative consequences of self-neglect of older Vermonters.
Objective 2.4: Provide effective Long Term Care Ombudsman Program (LTCOP) services.
Objective 2.5: Reduce the incidence and negative consequences of falls for older Vermonters.
Objective 2.6: Expand options for long-term community housing with integrated supportive services and supports.
Objective 2.7: Promote increase in availability and accessibility of person-centered transportation.
Objective 2.8: Support expansion of “age-friendly” livable communities.
Objective 2.9: Support older Vermonters in the community by sustaining family caregivers.

**Goal 3 –Enhance the Vermont aging network’s focus on program effectiveness and accountability for outcomes.**

Objective 3.1: Improve DAIL’s capacity to plan, achieve and capture information related to program performance and meaningful improvements in the lives of people.
Objective 3.2: Improve partner organizations’ capacity to plan, achieve, and capture information related to program performance and client outcomes.
Objective 3.3: Improve DAIL’s communication with the public, partner organizations and people needing services and supports provided through DAIL.
Objective 3.4: Improve DAIL’s and the aging network’s planning capacity.
Objective 3.5: Promote support for person-centered long-term care services and supports in Vermont’s Health Care Integration Project.

**Goal 4 –Older Vermonters have access to high quality, person-centered, evidence-based or evidence-informed dementia care services, mental health and substance abuse services and health care.**

Objective 4.1: Expand access to person-centered, evidence-based or evidence-informed mental health services including substance abuse services and dementia care.

# B: NARRATIVE

## The Context
## The Aging Services Network

The following description of Vermont's Aging Network provides important contextual information regarding the pivotal role each component plays in addressing the needs of older Vermonters and in supporting their family caregivers, including the SUAD's role as part of this network. For the purposes of this document, the term, "Aging Network" refers to services and organizations across the full spectrum of long-term services and supports, from home-and community-based settings to nursing homes. Each component of the Aging Network serves a unique and important role in meeting the needs of older Vermonters and family caregivers. Each link in the broad and diverse Aging Network helps meet the needs of older Vermonters, wherever they may choose to live.

Vermont's Aging Network is comprised of a wide variety of community organizations, service providers, and government agencies. The SUAD works in concert with Vermont's Aging Network which includes, but is not limited to, the following:

- DAIL
- Five Area Agencies On Aging (AAA),
- Elder Care Clinicians,
- 14 Adult Day Services Providers (16 Adult Day Centers statewide),
- Senior Centers and community meals providers,
- Home Health Agencies (HHA),
- Private Home Care Agencies,
- Nursing Homes,
- Private Home Care Providers,
- Residential Care Homes (RCHs),
- Assisted Living Residences (ALRs),
- Homesharing Providers,
- Public Housing Authorities and Nonprofit Housing Providers,
- Public Transit Providers and private transportation agencies,
- Support and Services at Home (SASH),
- The Vermont Long-term Care Ombudsman Project (VLTCOP),
- The Elder Law Project of Vermont Legal Aid,
- The Community Of Vermont Elders (COVE),
- AARP Vermont,
- Volunteer and Community Service Programs, and
- University of Vermont Center on Aging

**Vermont's Department of Disabilities, Aging and Independent Living (DAIL)** is the State Unit on Aging and Disabilities and is the sole state agency responsible for the administration of the State Plan on Aging. DAIL is comprised of 5 divisions, each

responsible for different areas of service:

- **Adult Services Division (ASD):** The Adult Services Division is responsible for long-term services and supports for older Vermonters and adults with physical disabilities. ASD works with private organizations to provide a broad array of long-term services and supports including residential support, community supports, case management, family supports, respite, crisis services, clinical interventions, assistance with Activities of Daily Living, guardianship services, nursing home level of care, rehabilitation services, supports to live at home, integrated health care and personal care. The ASD oversees the core programs of the Area Agencies on Aging, including those funded by the OAA; the Long Term Care Ombudsman Program; Adult Day Services; Attendant Services; High Technology Home Care; Choices for Care, (VT's 1115b HCBS waiver); Money Follows the Person, Adult Family Care, the Aging and Disabilities Resource Connection (ADRC),
- **Developmental Disabilities Services Division (DDSD):** The DDSD is responsible for services to people with developmental disabilities, traumatic brain injuries and guardianship services to adults with developmental disabilities and older Vermonters. DDSD works with private organizations to provide a broad array of long term services and supports, including service coordination, family supports, community supports, employment supports, guardianship services, residential support, crises services, clinical interventions, respite, and rehabilitation services. The DDSD oversees a number of programs and services including: Developmental Disabilities Home and Community Based Services, Flexible Family Funding, Public Guardians, and the Traumatic Brain Injury Program.
- **Division of Licensing and Protection (DLP):** The DLP enforces federal and state statutes and regulations for providers of health care (Survey and Certification) and investigates cases of alleged abuse, neglect, and exploitation of vulnerable adults (APS). Programs and services of DLP include: Survey and Certification, Partnership to Improve Dementia Care, Elder Justice Task Force, Adult Protective Services, and the Adult Abuse Registry.
- **Division for the Blind and Visually Impaired (DBVI):** The DBVI is the designated state unit to provide vocational rehabilitation and independent living services to eligible Vermonters who are blind and visually impaired. Programs and services include: Transition Services, counseling and guidance, independent living services, homemaker services, assistive technology equipment, vocational training, job-seeking skills, employer assistance, and job-placement services.
- **Division of Vocational Rehabilitation (VR):** The mission of VR Vermont is to help Vermonters with disabilities prepare for, obtain, and maintain meaningful employment and to help employers recruit, train, and retain employees with disabilities. They have recently expanded their involvement with the mature worker through the Governor's Commission on Successful Aging.

Community Partners Comprising our Aging and Disabilities Network

**Vermont's five Area Agencies on Aging (AAAs):** The primary role of the five AAAs is to serve as the key planning and development agencies within the five service areas. The AAAs are responsible for comprehensively assessing the needs of older Vermonters and family caregivers and to facilitate the development of services to meet the identified needs. In addition to their planning and development function, AAAs provide assistance to many older Vermonters and family caregivers who have short term needs, or require help which is intermittent in nature. In fact, thousands of older Vermonters are able to retain their independence because of ongoing case management, nutrition services and other OAA services that are not crisis driven, but are more preventive in nature. AAAs contract with multiple providers for services such as nutrition, transportation, legal and mental health services. In recent years, emphasis has been placed on promoting the availability of evidence-based disease prevention and health promotion activities. Without such assistance, many people would eventually be at greater risk for deteriorating health and/or economic status, either of which can lead to a loss of independence or diminish the quality of life. In addition, many consumers of AAA services regain their independence after a stay in a hospital or nursing facility, as a result of case management support, nutrition services, transportation, supports for family caregivers and other interventions. AAAs sponsor programs such as Senior Companion Program, and RSVP, which add a significant contingent of volunteers who enhance AAA services. Volunteers lead a variety of healthy aging programs in communities all over the Vermont, including: performing in-home services, and providing regular friendly visits and assisting with food shopping. AAAs also provide regional outreach and assistance to Medicare beneficiaries about the full range of public and private health benefits through the State Health Insurance Assistance Program (SHIP) and help to prevent health care fraud through the SMP (formerly referred to as the Senior Medicare Patrol, administered by the Community of Vermont Elders).

The AAAs have also been core partners in Vermont's Aging and Disability Resource Connection (ADRC). They were in the formative group of organizations at the launch of Vermont's "No Wrong Door" ADRC model and are central players in the continuous improvement and expansion of Vermont's ADRC. They are fully engaged in delivering core ADRC services: (Information Referral/Assistance (IR/A), Options Counseling, Streamlining Access to services and piloting Care Transitions as well as Medicaid Reimbursement strategies.

**Elder Care Clinician Program :** The Elder Care Clinician program (ECCP) is a collaborative effort with the Vermont Department of Mental Health and Vermont's Area Agencies on Aging that provides mental health services to elders and caregivers. Elder care services are provided in both home and office settings. ECCP's work with elders and caregivers to address a broad range of challenges in daily living such as depression, stress, grief and loss, substance abuse, caregiving and anxiety. The ECC Program is a resource and working partner in addressing the needs of Vermont's elders and caregivers.

**Adult Day Services**: Vermont has 14 adult day service providers operating 16 adult day centers around the state. Adult day services provide an array of services to help older Vermonters and adults with disabilities to remain as independent as possible in their own homes. Adult day services are provided in community-based, non-residential day centers creating a safe, supportive environment in which people can access both health and social

services. Services include: professional nursing services, respite, personal care, therapeutic activities, nutritious meals, social opportunities, activities to foster independence and support and education to families and caregivers.

**Senior Centers**: Senior centers serve as focal points within communities for information, referrals and opportunities for volunteering. They are dispersal sites for important information pertaining to the abuse, neglect and exploitation of older Vermonters, as well as information to increase awareness and prevent fraud. Senior centers play an important role in helping to prevent social isolation and provide opportunities for people of all ages to connect and contribute to their community. For example, Vermont's senior centers are places older Vermonters can obtain information about area services and resources, participate in health promotion programs, practice yoga, play Wii bowling, email grandchildren, share meals and learn a new language, or learn English as a second language. The SUAD provided competitive funding in 2013 to senior centers supporting the development of plans to improve outreach and services at the centers. Many centers also provide meal programs and receive Older American Act (OAA) funding and other support through Vermont's network of area agencies on aging.

**Home Health Agencies:** Home health agencies (HHA) provide high-quality, medically-necessary home health and hospice care. Vermont has 12 designated home health agencies. The agencies promote the general welfare of Vermonters with health promotion and long term care services. In addition to their acute care services, HHA programs provide person-centered care for older Vermonters and people with disabilities of any age. HHA provide assistance with the activities of daily living and encourage independence for individuals, enabling them to live safely and comfortably at home. HHA programs and services may include homemaker assistance, assistance with personal care, adult day services, and case management services, in which home and community long term care services are available as an alternative to nursing homes.

**Private Home Care Agencies:** Private home care agencies specialize in providing non-medical home care to support independent living and aging in place. Services range from assistance with personal care, companionship services, help with shopping and transportation, homemaking services, meal preparation and much more. In recent years, Vermont has seen growth in the number of home care providers, with providers reporting increasing demand for their services.

**Residential Care Homes:** Vermont's 111 residential care homes are state licensed group living arrangements designed to meet the needs of people who cannot live independently and usually do not require the type of care provided in a nursing home. When needed, help is provided with daily activities such as eating, walking, toileting, bathing, and dressing. Residential care homes may provide nursing home level of care to residents, known as enhanced residential care (ERC). ERC services include personal care, housekeeping, meals, activities, nursing oversight and medication management.

**Assisted Living Facilities:** There are currently 8 state licensed assisted living residences that combine housing, health and supportive services to promote resident's independence and aging in place. Assisted living residences offer, within a homelike setting, a private bedroom, private bath, living space, kitchen capacity, and a lockable door. Assisted living

promotes resident self- direction and active participation in decision-making while emphasizing individuality, privacy and dignity.

**Nursing Homes:** Vermont's 37 nursing homes are licensed facilities providing 24-hour nursing care, supervision, therapies, personal care, meals, nutrition services, activities and social services. Nursing facilities are an important component of Vermont's Aging Network. They provide long-term care for individuals who require and want 24-hour nursing care and supervision as well as short-term rehabilitation for many Vermonters who need support after an illness or injury.

**Public Housing Authorities and Nonprofit Housing Providers:** Vermont's non-profit housing organizations and public housing authorities serve the lowest income older Vermonters, providing many of the homes essential to Medicaid participants to remain at home under the Choices for Care program.

**Public Transit Providers and Private Transportation Agencies:** Vermont's 11 public transit providers, along with numerous private transportation providers, play an important role in helping older Vermonters get to essential medical services, social services, senior centers and community meals programs, grocery stores, drug stores and shopping. Key players include the Vermont Transportation Agency which administers the Elderly and Disabled (E&D) Transportation funds in all designated regions in Vermont and the Vermont Department for Health Access (VDHA) which administers Medicaid transportation services. Transportation services help older Vermonters stay connected with and participate in community events.

**Homesharing:** Vermont's two homeshare providers help to match people who need some assistance to remain in their home with other Vermonters who seek affordable housing. In some cases, caregiving services are also arranged. This expansion to caregiving services has been threatened by the US Department of Labor's recently published rules regarding the companionship exemption to the Fair Labor Standards Act. With additional funding provided with the assistance of DAIL in 2012, Homesharing services were expanded to serve about half of the state. (Chittenden, Addison, Grand Isle, Washington, Lamoille and Orange counties) Homesharing is viewed as a promising model for alleviating housing challenges for some older Vermonters. It promotes aging in place while providing affordable housing for many.

**Supports and Services at Home (SASH):** SASH is a demonstration project partially funded by CMS and supported by DAIL and other State agencies. SASH explores the effectiveness of integrating the provision of coordinated services at home—in both congregate housing sites and individual community homes. SASH members participate in SASH as team members along with their primary care practitioner and other providers to develop person-centered Individual Healthy Aging Plans. The plans reflect each individual's personal preferences and priorities. The SASH staff develops a Community Healthy Aging Plan (CHAP) by aggregating the needs identified in individual plans, such as medication management, falls prevention, nutrition programs, homemaker services, or personal care services. Conceiving housing as the platform or foundation for the delivery of services, SASH has been developing regional planning and services teams called Designated Regional Housing Organizations (DRHO) that have brought together

representation from the AAAs, the local housing authorities and organizations, Home Health Agencies and others. Operating in 93 affordable housing sites in Vermont SASH has been developing capacity to reach individual neighborhoods and homes to make the support and services available to all seniors.

**Vermont Ombudsman Project:** The SUAD contracts with Vermont Legal Aid, Inc. to operate the Vermont Long-term Care Ombudsman Project (VLTCOP) – a statewide long-term care ombudsman program that fulfills all of the advocacy requirements of Title VII, Chapter 2 of the Older Americans Act. Currently, there is one full-time State Long Term Care Ombudsman who supervises 4.6 FTE regional ombudsmen. In addition to paid staff, the project utilizes 15 certified volunteers. In 2005, the Vermont Legislature expanded the LTC ombudsmen's responsibilities. In addition to advocating for residents of nursing facilities, residential care homes and assisted living residences, the legislature gave ombudsmen the authority to respond to complaints on behalf of individuals receiving home-based services through the 1115 Long Term Care Medicaid Waiver Choices for Care Program.

**Elder Law Project: (ELP)** The Elder Law Project consists of the Senior Law Project (SLP) and Medicare Advocacy Project (MAP), and focuses on the legal needs and problems of seniors. ELP provides a full range of legal services including advice, assistance with documents, and representation. It represents seniors on legal and policy matters with the State government and with the Legislature. ELP attorneys work closely with case managers to provide professional legal advice, consultation and representation to seniors. In addition, MAP represents Medicaid beneficiaries in Medicare appeals after referral by the State of Vermont.

**Community of Vermont Elders (COVE):** COVE's mission is to promote and protect a high quality of life for Vermont's seniors, through advocacy and education. It works with and for older Vermonters and the organizations that serve them to identify, interpret, and respond to critical issues that impact the dignity, security and well-being of seniors. COVE researches and educates the public and policymakers, and advocates for or against the adoption or revision of laws, rules, regulations or policies. COVE also sponsors SMP, funded through the Administration for Community Living with the goal of empowering older Vermonters "to prevent health care fraud through outreach and education."

**AARP Vermont:** The Association for the Advancement of Retired Persons promotes the welfare of older Vermonters. AARP is a nonprofit, nonpartisan membership organization that helps people age 50 and over improve the quality of their lives. It is comprised of different legal entities. In collaboration with aging network members, the Vermont AARP has been a state leader in promoting understanding and adoption of livable communities projects like Complete Streets and Age Friendly Communities and is an active lobbyist for senior health care issues in Vermont state government.

**Volunteer and Community Service Programs:** In addition to the programs described above, Vermont has many volunteer and community service programs, such as RSVP, Foster Grandparents, the Senior Companion Program, and Vermont Kin as Parents, to name a few. These programs provide valuable opportunities for older Vermonters and people of all ages to contribute to their community, and to benefit from the services

provided. The range of services and benefits provided through these programs is extensive, from mentoring young children, to delivering health promotion and disease prevention programs, to companionship and assistance with heavy chores.

**University of Vermont Center on Aging:** Officially established in 2008, the University of Vermont Center (UVM) Center on Aging aims to forge on-going collaboration among faculty, students, staff and programs within the UVM, Fletcher Allen Health Care, and broader Vermont community to promote a sense of well-being and a high quality of life for older adults. The Center on Aging focuses on coordinating and supporting gerontological and geriatric research at UVM, providing educational opportunities in gerontology and geriatrics and translating research outcomes and educational activities into policy and excellent practice in the fields of medicine and human services.

## Vermont's Older Population

**Demographics:**

Vermont's population is small. In 2012, Vermont's total population of about 625,000 people was ranked fiftieth in the United States. However, Vermont is also an 'old' state. The median age is 42.6, making Vermont the 2nd oldest state in the nation. In 2012, 15.9% of the Vermont population was over the age of 65, ranking #4 in the US. By 2032, 23.8% of the Vermont population is predicted to be over the age of 65, ranking #1 in the US.

Vermont's 'oldest' population is relatively large, and growing larger. In 2012, 2.3% of the population was aged 85 and over, ranking #10. This age group is estimated to increase to 3.5% of the population in 2032 (rank #3) and to 5.8% of the population in 2050 (rank #2). The increase in this age group is noteworthy, due to the increased prevalence of dementia in this age group, as high as 40%. We can expect many more Vermonters to survive past age 85, which means that we can expect about three times as many people with dementia and their family caregivers to need housing and support services in the future. **Figure 1** illustrates projected population growth by age group:

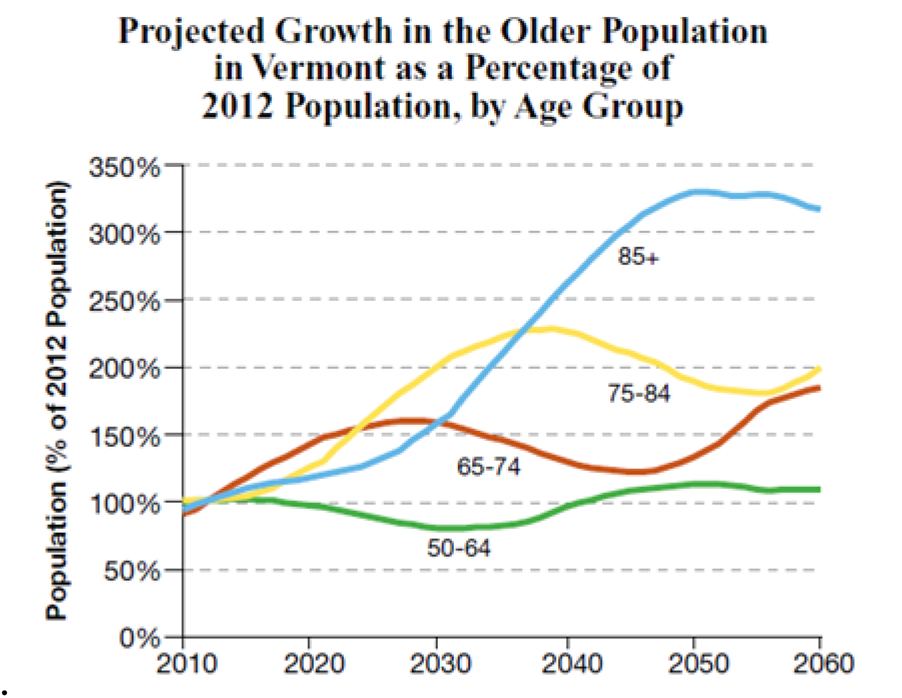



**Figure 1:**

*Source: Across the States: Profiles of Long-Term Services and Supports, Vermont (Ninth Edition). A. Houser, W. Fox-Grage, K. Ujvari. AARP, 2012.*
*http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-vermont-AARP-ppi-ltc.pdf*

**Figure 2** below provides Vermont population projections for several age groups: 50 to 64; 65+; 65 to 74; 75 to 84; and 85+. Projections for 2032 and 2050 are compared to 2012, producing percentages of change from 2012. The table also compares Vermont's projected future population with the projected future populations of other states.

The table depicts the aging of the baby-boomers which, combined with the fact that people are generally living longer, contributes to the growth in the older population. Just as society needed to adjust school capacities in communities from the 50s to the 80s, society needs to adjust capacities to meet the needs of older people from 2013 to 2050.

**Figure 2:**

| Vermont Population & Projections | Year | State Pop. (1,000s) | % of Total Population | Rank | U.S. | % Change from 2012 | Rank | U.S. |
|---|---|---|---|---|---|---|---|---|
| All ages | 2012 | 620 | | 50 | 315,311 | | | |
| | 2032 | 722 | | 51 | 376,660 | +16% | 36 | +19% |
| | 2050 | 803 | | 51 | 434,447 | +29% | 38 | +38% |
| Age 50-64 | 2012 | 144 | 23.2% | 1 | 19.2% | | | |
| | 2032 | 114 | 15.8% | 36 | 16.4% | -21% | 50 | +2% |
| | 2050 | 161 | 20.0% | 2 | 16.6% | +12% | 39 | +19% |
| Age 65+ | 2012 | 99 | 15.9% | 4 | 13.6% | | | |
| | 2032 | 172 | 23.8% | 1 | 19.8% | +74% | 18 | +74% |
| | 2050 | 175 | 21.8% | 5 | 20.4% | +77% | 44 | +107% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Age 65-74 | 2012 | 55 | 8.9% | 4 | 7.4% | | | |
| | 2032 | 85 | 11.8% | 2 | 10.1% | +53% | 31 | +64% |
| | 2050 | 73 | 9.1% | 26 | 9.1% | +32% | 49 | +69% |
| Age 75-84 | 2012 | 29 | 4.7% | 7 | 4.2% | | | |
| | 2032 | 62 | 8.6% | 1 | 6.8% | +111% | 13 | +94% |
| | 2050 | 55 | 6.9% | 7 | 6.6% | +89% | 31 | +116% |
| Age 85+ | 2012 | 14 | 2.3% | 10 | 2.0% | | | |
| | 2032 | 25 | 3.5% | 3 | 2.9% | +77% | 19 | +69% |
| | 2050 | 47 | 5.8% | 2 | 4.8% | +230% | 20 | +224% |

*Data source: Across the States: Profiles of Long-Term Services and Supports, Vermont (Ninth Edition). A. Houser, W. Fox-Grage, K. Ujvari. AARP, 2012. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-vermont-AARP-ppi-ltc.pdf*

Vermont currently provides a high percentage of long term support services (LTSS) in the community. For older people and adults with physical disabilities, 41% of Vermont LTSS spending is in home and community based settings, ranking #14 in the US. For all populations, 65% of Vermont LTSS spending is in home and community based settings, ranking #5 in the US. The people who want services in the community also need housing in the community, which means that the demand for combinations of housing and support services in the community is higher than the national average, and can be expected to continue to grow. Vermont's increasingly 'old' population, coupled with people's general desire to 'age in place' and Vermont's efforts to provide home and community based services, is expected to increase future demand for both affordable, accessible housing and support services in HCBS settings.

**Figure 3** below shows current estimates of disability rates in the 65+ population and the 18 to 64 population in Vermont. If current prevalence and incidence rates continue, as the proportions and numbers of population 65 and older, 75 and older, and 85 and older increases, then the numbers of individuals with self-care and cognitive disabilities will also increase.

- Applying the Self-Care Difficulty rate of 6.9% in Table 3 to the 2012 and 2032 populations in Table 1 the numbers of individuals with Self-Care Difficulties in 2012 were 6,831. In 2032 these numbers would increase to 11,868.
- Applying the Cognitive Difficulty rate of 8.9% to the 2012 and 2032 populations in Table 1, the numbers of individuals with Cognitive Difficulties in 2012 were 8,811. In 2032 these numbers would increase to 15,308.

**Figure 3:**

| Disability Rates | Number (1,000s) | Percent | Rank | U.S. |
|---|---|---|---|---|
| People age 65+ with disabilities, 2010 | | | | |
| Self-care difficulty | 6 | 6.9% | 37 | 8.8% |
| Cognitive difficulty | 8 | 8.9% | 26 | 9.5% |
| Any disability | 30 | 34% | 35 | 37% |
| People age 18-64 with disabilities, 2010 | | | | |
| Self-care difficulty | 7 | 1.8% | 21 | 1.8% |
| Cognitive difficulty | 22 | 5.5% | 11 | 4.2% |
| Any disability | 45 | 11.2% | 17 | 10.0% |

*Data source: Across the States: Profiles of Long-Term Services and Supports, Vermont (Ninth Edition). A. Houser, W. Fox-Grage, K. Ujvari. AARP, 2012.*
*http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-vermont-AARP-ppi-ltc.pdf*

Unfortunately, these population projections do not directly answer the question of future demand for publicly funded long term care services, which will be directly affected by future levels of disability, income and assets, and any policies that impact family caregivers. Combined projections of age, disability, income and assets are not currently available. Included in our strategies is contracting for such a projection report. Estimates of future demographics (including age, disability, income, and assets) will significantly increase the planning capacity of the state and help all members of the aging network.

According to the U.S. Census Bureau's "Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months, 2008-2012 American Community Survey 5-year Estimates" in Vermont, 13% of individuals 65 and older were at less than 125% of the federal poverty level. The following indicates the number and percentage of those age 60+ below 100% of the federal poverty level by County:

**Estimated Number and Percentage of Vermonters Age 60+ Below Federal Poverty Level (FPL) by County**

| | n | total population | % |
|---|---|---|---|
| Vermont | 9,400 | 125,045 | 7.5% |
| Addison County | 480 | 7,280 | 6.6% |
| Bennington County | 575 | 8,950 | 6.4% |
| Caledonia County | 715 | 6,630 | 10.8% |
| Chittenden County | 1465 | 24,750 | 5.9% |
| Essex County | 225 | 1,735 | 13.0% |
| Franklin County | 645 | 8,035 | 8.0% |
| Grand Isle County | 40 | 1,585 | 2.5% |

| | | | |
|---|---|---|---|
| Lamoille County | 435 | 4,390 | 9.9% |
| Orange County | 475 | 6,305 | 7.5% |
| Orleans County | 775 | 6,230 | 12.4% |
| Rutland County | 1,105 | 14,120 | 7.8% |
| Washington County | 740 | 11,565 | 6.4% |
| Windham County | 790 | 10,090 | 7.8% |
| Windsor County | 885 | 13,375 | 6.6% |

*Data source: 2007-2011 American Community Survey, Special Tabulation on Aging – Population Characteristics prepared by the U.S. Census Bureau, 2013.*
*Note: Estimates may include significant margins of error due to sampling methodology.*

The rural nature of the state adds its challenges to aging and poverty. The entire state of Vermont is considered to meet the federal OAA definition of "rural." Generally, older adults living in rural areas have less access to health care, including specialized health care, and the services tend to be more costly than those provided in metropolitan areas. Rural older adults usually have to travel farther to access these key resources, and yet at the same time, they have less access to transportation.

Vermont continues to have one of the lowest percentages of minorities in the nation. According to the 2010 Census it ranks second smallest percentage in the nation at 5.7%. Despite that, according to the 2010 census, 72% of Vermont's total population growth from 2000 to 2010 was from an increase in minority population. The 2010 Census reports 2,430 minority individuals age 60 or older. The greatest proportion of minority population can be found in Chittenden County. Of Vermont's 35,518 total minority population of all ages, 13,697 (38.6%) reside in Chittenden County. The majority of Vermont's minority older adults also reside in Chittenden County. It is also the case that the vast majority of Vermont's refugee population resides in Chittenden County. As of May 2012 Vermont had 128 older refugees, 74% of whom are Bhutanese of Nepali origin. A 2012 needs assessment conducted by the Vermont State Refugee Coordinator revealed that almost none of the elderly refugees know of, or access mainstream elderly services. This fact led to the development of the *Vermont Refugee Elders Collaborative* which created a deliberate connection to the Area Agency on Aging and focused programing and resources for elderly refugees.

## Needs Assessment:

DAIL conducted an internal and external assessment of needs. In meetings with each of DAIL's Divisions, the *2011 - 2014 State Plan on Aging* was reviewed and discussed to evaluate status of goals and objectives and to identify current and projected issues/needs with respect to accomplishing the mission of DAIL and fulfilling the obligations of the Older Americans Act. In the several meetings, priorities coalesced around three areas needing attention in the coming years to best accomplish the mission of the DAIL: 1) the

need for a greater access to affordable housing and a greater variety of housing model options for people served by DAIL; 2) the need to improve access and quality of mental health, substance abuse and dementia services for people served by DAIL and 3) the need to improve the methods and approach to accountability by improving focus on policies and practices that produce measureable benefits to people served by DAIL. The State of Vermont and its Agency of Human Services has committed to implementing the Results Based Accountability (RBA) approach in planning, contracting, delivery, monitoring, and evaluation of programs and services. The DAIL Divisions assessment meetings produced agreement in prioritizing implementation of the Results Based Accountability (RBA) planning and continuous quality improvement processes within the Department as RBA was being fully embraced by the Vermont Agency of Human Services (AHS) and the State Legislature.

In 2013 DAIL contracted with the University of Vermont to conduct a statewide assessment to identify the needs of older Vermonters and family caregivers, available resources and their effectiveness, and gaps in the service delivery system. The assessment utilized separate, non-experimental surveys of service providers, community members and caregivers. Also, interviews were conducted with 36 key stakeholders, and a focus group was conducted of seniors. There were 137 provider survey respondents and participation was proportionally distributed between the five AAA Planning Service Areas. In addition to a consolidated State-wide Report, individual reports for each AAA service area were produced detailing responses particular to each service area. Providers represented people from aging services, government, healthcare, housing, mental health, and protective services. Unfortunately, the response rates for the community member and caregiver surveys were low (n=30 for community members survey and n=23 for caregiver survey). Despite extending deadlines for responding and repeating requests and postings, the response rate remained low.

The five top priorities identified by providers, out of a possible 17 categories, were:

- Financial Security
- Housing
- Transportation
- Health Care
- Long-Term Care

Top Issues of Concern for Vermont's Aging Services Providers

| | #1 | #2 | #3 | Overall |
|---|---|---|---|---|
| *Financial Security* | 36% | 12% | 6% | **54%** |
| *Housing* | 25% | 15% | 7% | **47%** |
| *Health Care* | 22% | 10% | 7% | **39%** |
| *Transportation* | 20% | 10% | 16% | **46%** |
| Maintaining Independence and Dignity | 19% | 10% | 9% | 38% |
| Family and Caregiver Support | 17% | 9% | 5% | 31% |
| Food and Nutrition | 15% | 9% | 7% | 31% |
| *Long-Term Care* | 15% | 13% | 11% | **39%** |
| Mental Health | 12% | 10% | 7% | 29% |
| Employment | 9% | 5% | 4% | 18% |
| Safety and Security | 8% | 5% | 4% | 17% |
| Physical Activity, Fitness, Fall Prevention | 6% | 9% | 1% | 16% |
| Spirituality | 4% | 3% | 5% | 12% |
| Education and Learning Opportunities | 2% | 5% | 4% | 11% |
| Legal Assistance | 2% | 8% | 2% | 12% |
| Leisure and Recreational Activities | 2% | 7% | 5% | 14% |
| Volunteer Opportunities | 1% | 5% | 5% | 11% |

- The majority of the provider survey respondents (62%) rated the quality of their area of the state "good" or "excellent" as a place to live for older adults.
- 33% rated the quality as "fair" and 3% rated the quality as poor.
- 65% "agreed" or "strongly agreed" that "services provided in Vermont promote healthy aging and independent living."
- The strongest concerns related to "access" to services and "access to well-coordinated services."
- 53% "disagreed" or "strongly disagreed" that "older adults and individuals with disabilities have easy access to well-coordinated services."

- Nearly every provider respondent highlighted transportation as a challenge though transportation was not the sole contributor to the access challenges.
- Not knowing where to turn to and the complexity of the service system and application processes were also identified as barriers to accessing care. These findings imply the importance of a fully developed Aging and Disability Resource Connection capacity in the state.

Top issues for consumers, as in the coming years (2015-2020) as indicated in the surveys and focus group, were 1) financial security, 2) health care, and 3) maintaining independence and dignity. Caregivers highlighted 1) how to prepare for long-term care, 2) help paying for care, and 3) balancing work and caregiving responsibilities.

## Trends, Challenges and Opportunities

**Trends and Challenges:**

Several trends, challenges and opportunities influence this State Plan. Major trends and challenges include:

- Understanding and responding to the implications of the aging of Vermont society;
- Responding to cuts in federal funding and the impacts of the recession and what might be the new reality for federal and other resources;
- Participating in the complex process of restructuring the delivery and payment of medical services, social services and long-term-care and support services.

In addition to these challenges, DAIL is in the midst of planning and responding to important events and studies that took place in 2013 - 2014:

- Vermont's 1115 Long Term Care Demonstration waiver program, **Choices for Care** (CFC) program was evaluated by the University of Massachusetts Medical School resulting in action steps to address the effectiveness of the Moderate Needs program and increase funding to address applicants waiting for Moderate Needs services.
- CFC reinvestments supported a Statewide Self-Neglect Needs Assessment that articulated steps to improve care for services for people who are self-neglecting, as well as supplementing Home Delivered Meals (HDM) and Congregate Meals due to a loss in Federal nutrition funds to the AAAs from sequestration. CFC reinvestment funds also provided funds for AAAs to utilize in their service areas to increase mental health services for older adults, and through funds to SASH supported the development and implementation of dementia care training for elder care workers across agencies and throughout the state.
- The **Vermont Long-term Care Consumer Satisfaction Survey Report** conducted by Thoroughbred Research Group indicated that "the large majority of

consumers are satisfied with DAIL programs", while providing an analysis of areas that have the highest "potential" for improving satisfaction, such as ensuring that people receiving Choices for Care services are receiving services when and how they are needed, and ensuring that services provided help them achieve their personal goals.

- The Program for All-Inclusive Care for the Elderly (PACE) closed its doors and created a challenging service gap for 140 participants. Fortunately, the local Area on Aging Agencies, Home health agencies and others in the aging network stepped in and successfully created alternative services and supports for the former PACE participants. In an effort to learn from the closure of PACE Vermont, DAIL conducted a study to evaluate the successes and challenges of the PACE model in Vermont.
- The state successfully resolved litigation brought by Vermont Legal Aid against the Adult Protective Services program and instituted an independent review panel as part of its continuous quality improvement plan.
- The statewide assessment highlighted priority needs identified by seniors, caregivers and providers along with identifying gaps in mental health, dementia and substance abuse services. The study also indicated a strong need to increase capacity to coordinate services.

Accompanying this growth is the well-established trend to home and community based services to match the documented desire of older Vermonters to age-in-place and received long-term-care services at home. In a *2010 Survey of AARP Vermont Members Age 50+ on Health and Livable Community Issues,* 65% of AARP Vermonters said they would prefer to receive long-term care services in their own homes, 18% would like to receive care in an assisted living facility and only 3% would like to receive care in a nursing home setting. The goal of Choices for Care (CFC, Vermont's 1115 Long-term Care Demonstration Waiver program) is to give people choice and control over where and how their needs are met. One of the program goals is to "shift the balance," serving a lower percentage of people in nursing homes and a higher percentage of people in alternative settings, according to their expressed desires. CFC has achieved progress since 2005, with enrollment in HCBS exceeding enrollment in nursing homes in 2013. How does CFC continue its success with a growing senior population, particularly a growing 85+ population that will have a high prevalence of Alzheimer's disease and related disorders?

Health reform in Vermont is well underway. Vermont was successful in securing federal funding for a large and significant payment and delivery system reform demonstration grant, the Vermont Health Care Integration Project, VHCIP. DAIL is engaged in the project at several levels and is a key player with respect to inclusion of long-term support services. Planning includes the challenge of integrating aging network services performed by DAIL partners like the Area Agencies on Aging, the Home Health Agencies, Supports and Services at Home (SASH), and others.

**Opportunities:**

Every challenge presents an opportunity. The several challenges mentioned above present opportunities for improving the lives of older Vermonters and for enhancing the services provided by the Title III and Title VII programs. Each of the efforts below enhances and expands the capacity to deliver Title III and Title VII services.

Some of the many promising and productive opportunities for DAIL and partners include:

1. **Shaping the Future:** As indicated above, part of the planning challenge is related to not currently possessing sharp projections regarding future demographics, family caregivers needs, disability data, poverty and assets data and projections related to forecasted needs of the generation entering older age in the next 5 to 20 years. DAIL is researching study possibilities to contract for and conduct research that would provide deeper and richer projections to assist in planning by DAIL and the aging network.
2. **ADRC:** Critical to facing the future is the development of a highly functional Aging and Disabilities Resource Connection initiative. The ADRC is a continuously evolving and strengthening initiative at the core of efforts to improve access to long-term care services and supports for all Vermonters. The initiative illustrates the value and strategy of creating well-coordinated partnerships that leverage and integrate local resources, state resources and federal resources in creating statewide efficiencies and improved services for Vermonters. The ADRC initiative focuses on ensuring people of all ages, disabilities and incomes have access to the information and support needed in order to make informed decisions about long-term services and supports.

   Vermont's ADRC builds on the existing infrastructures of community organizations that are already recognized as key "front doors" to long term services and supports and information and assistance. In the last year the ADRC expanded to 10 "core partners" that include the five Area Agencies on Aging, the Vermont Center for Independent Living, the Brain Injury Association of Vermont, Vermont 211, the Vermont Family Network, and Green Mountain Self Advocates. A key partnership also exists with the Veterans Administration Medical Center (VAMC) in White River Junction in serving Vermont veterans.

   In September 2012 DAIL was awarded a three year Enhanced Options Counseling Program grant—a highly competitive grant awarded to only 8 states. Together with 7 other states, Vermont is helping shape the future of the ADRC and No Wrong Door initiative for the nation. As part of this work, DAIL and its ADRC partners are involved in several key areas that show promise for significantly improving access to care. A sample of ADRC efforts include:

   - **National Options Counseling Training and Certification**: Collaborating on development of national drafts of core job duties and competencies, online curricula, catalog of courses, and options

counseling standards that will be the foundation for the rest of the country.

- **Medicaid Reimbursement for Options Counseling and ADRC Functions**: In partnership with the Vermont Department for Children and Families, the Department of Vermont Health Access, the Central Vermont Council on Aging, and the Area Agency on Aging for Northeastern Vermont (two of Vermont's ADRC core partners), the ADRC is piloting a Medicaid reimbursement project to determine the effectiveness and value of Options Counselors' roles in streamlining individuals access to long-term care Medicaid. The goal is to identify a sustainable Medicaid funding stream for Options Counseling and ADRC functions overall.
- **Evidence-based Care Transitions**: In partnership with the Southwestern Vermont Medical Center, the Vermont Center for Independent Living, Brain Injury Association of Vermont, and the Council on Aging of Southwestern Vermont (three of Vermont's core ADRC partners) the ADRC is piloting a care transitions project to measure the effectiveness of a hybrid evidence-based care transitions program based on Project BOOST and the Naylor Model (Transitional Care Model) in partnership with ADRC Options Counselors. The goal is to determine how the ADRC partners can augment and improve care transitions from hospital to home, reducing unnecessary readmissions and emergency room utilization.
- **Veterans Independence Program**: The VIP expands the Veteran-Directed Home and Community Based Program to serve more Veterans across the state in partnership with the five Area Agencies on Aging and the VAMC by leveraging ADRC partners and I/&A database.
- **State Health Reform**: Exploring expansion through relationship with the State health reform initiatives, particularly Vermont's Blueprint for Health and SASH.
- **ADRC Marketing and Outreach**: Implement ADRC marketing and outreach efforts that include a marketing campaign across partners built on common branding, logo and ADRC messaging.

These efforts relate to the achievement of several objectives articulated in ADRC's Five-Year Strategic Plan. The Goal of the ADRC is to build a "statewide, robust, fully-functioning, consumer-centered, and sustainable Aging and Disability Resource Connection." There are several objectives and subsequent strategies related to the achievement of this goal. The objectives include:

a. Evolve a unified and shared voice on ADRC;
b. Commit to and support development of an IT/MIS infrastructure that addresses fragmentation across the ADRC partner agencies;
c. Develop State level "outreach and education" plan for ADRC;
d. Build and sustain relationship with the Department for Children and Families to enhance streamlined eligibility for Medicaid and other publicly-funded programs;
e. Support the ADRC partner agencies in continued capacity-building

and refinement;

f. Build and sustain systems for quality improvement;
g. Sustain State-level coordination and project management;
h. Identification of necessary resources (staff/money/other) to support and sustain a fully-functional ADRC;
i. Commit to ongoing cross training across all ADRC partner agencies, including necessary community partners who serve populations in common (e.g. mental health, developmental disabilities, substance abuse);
j. Formalize protocols among ADRC partner agencies in support of Core Functions as outlined in the ADRC Strategic Plan;
k. Foster outreach and awareness of partner agencies' roles as community focal points for information and access to LTSS;
l. Implement Options Counseling across all ADRC partner agencies;
m. Build capacity to develop Transition Support activities across ADRC partner agencies.

3. **Choices for Care and Money Follows the Person:** *Choices for Care*—1115 Long-term Care Demonstration Waiver is a Medicaid funded program that pays for care and support for older Vermonters and adults with physical disabilities. The overall goal of CFC is to give people more choice and control over where and how they meet their needs. For people who need "nursing home level of care," the program provides person-centered services in their own home, in Residential Care/Assisted Living Home or in a nursing facility. For people who choose to receive their services at home, CFC offers a variety of self-directed options for people who are able and willing to manage their own services or have a surrogate who is able to manage services on their behalf. For people who are not able or do not wish to direct his or her own services, local certified Home Health Agencies provide the in-home services.

   In 2011 DAIL was awarded a five year, $17.9 million grant from the Centers for Medicare and Medicaid Services (CMS) for *Money Follows the Person* (MFP). The goal of MFP is to work in concert with Choices for Care to help people living in nursing facilities overcome the barriers that have prevented them from moving to their preferred community-based setting.

   Together with stakeholders, MFP spearheaded the design and implementation of the Adult Family Care model. Adult Family Care is a 24-hour Home and Community Based Service option for participants in Vermont's Long-Term Care Medicaid Choices for Care Program. This option became available through CFC to participants in the Highest and High needs groups in September, 2013and will continue to roll out in 2014 and 2015. Adult Family Care provides participants with person-centered supports in a home environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity. Adult Family Care is provided in a residence of the home provider who provides the care and support to no more than two people unrelated to the home

provider.

Building upon our current quality management plan, an overarching goal during this state plan period is to expand and align quality management of the CFC program with emerging Home and Community Based Services regulations.

4. **SASH, Support and Services at Home:** SASH is a Medicare demonstration program that is fully integrated with Vermont's health care reform Blueprint for Health. SASH brings care management and preventive services to peoples' homes through direct involvement with non-profit housing programs and the neighborhoods surrounding housing programs. SASH expanded from one pilot site in 2010 to 93 sites across Vermont, including most local public housing authorities and non-profit housing organizations. SASH is built on the premise that three elements are essential to achieving better health, better care and lower costs: Transitions Planning; Chronic Care Self-Management; and Care Coordination. When an individual decides to participate in the SASH program staff conduct a complete functional assessment, cognitive screen, depression scale, nutritional assessment, universal Substance Abuse Screen (The Audit) and falls assessment. SASH provides daily check-ins, medication management, communication with family, and transportation assistance. SASH has developed formal, collaborative relationships with 55 organizations including Visiting Nurse Associations, AAAs, Community mental health agencies, hospitals, Public Housing Authorities, and non-profit housing providers. SASH was designed to be scalable across rural and urban areas, and to be replicable. SASH is a promising model for delivering preventive and chronic care services to vulnerable adults in home settings.
5. **Vermont Health Care Integration Project** (VHCIP)**:** DAIL is actively involved in the VHCIP providing significant leadership and technical assistance for each major area for engagement. This includes: produce alignment of VHCIP with the goals of the DUAL Eligible Planning Grant; support for inclusion of LTSS care models and the Employee Assistance Program (EAP) in the development of related VHCIP Care Models; lead in promoting person-centered and other LTSS performance measures in all VHCIP activities; and exploring inclusion of LTSS among new VHCIP payment models to be tested.
6. **Mental Health, Dementia and Substance Abuse:** DAIL staff and providers made the strong recommendation to increase coordination and capacity to provide mental health services, substance abuse services and improved services for people with dementia and for their unpaid family caregivers. DAIL recently created a LTSS Health Integration Team which combines staff focus on health care reform, mental health, dementia, substance abuse, health promotion and disease prevention, and nutrition services. A goal of the team is to improve outcomes and quality of life for older Vermonters with mental health needs, including those with substance abuse needs, and people with dementia and their unpaid family caregivers. Explicit efforts will be developed and implemented to increase the number of older Vermonters with these needs who access evidence-based and

evidence-informed services. Efforts include an initial inventory of mental health, substance abuse, and cognitive capacity screening and assessment tools utilized by community partners. Following this inventory, a work plan will be developed that assures the delivery of two quarters of data showing utilization of tools and referrals based on the results. Several deliberate collaborative efforts have begun which offer promise for building service bridges between mental health, substance abuse and dementia services which are often segregated to the detriment of people with multiple needs. Examples include: (1) DAIL and the Department of Mental Health are holding high level discussions about use of peer counselors or specialists, better coordinating aging and disability services with mental health services and access to ElderCare Clinicians; each department has designated point staff for engineering the bridges between often segregated services; (2) DAIL and the Vermont Department of Alcohol and Drug Abuse Programs recently co-hired a substance abuse coordinator who is charged with bringing substance abuse resources and aging resources together to improve services for old Vermonters; (3) partners in the Governor's Commission on Alzheimer's Disease and Related Disorders are collaborating with DAIL in developing a grant proposal to produce a dementia capable system of care in Vermont.

7. **Self-Neglect Project:** In 2012, DAIL supported a "Self-Neglect Task Force" which identified the current status of understanding and response to people who are identified as self-neglecting and made recommendations for improving care. This work led to the issuance of grants to the 5 AAA agencies in 2013 that required them to produce a report on the nature and scope of self-neglect in their service areas; collaborate on the development of Self-neglect Risk Tool and utilize the tool with 15 individuals in each service area to determine effectiveness of their interventions; and to develop a plan for a "coordinated community response" in their respective communities for addressing self-neglect. DAIL has committed to advancing the capacity and effectiveness of services for people who are self-neglecting and will be supporting interventions that demonstrate positive results in improving the safety of people who are self-neglecting.
8. **Mature Worker Initiatives:** DAIL has been instrumental, in collaboration with community partners including the Vermont League of Cities and Towns, the Vermont Associates In Training and Development, the Community of Vermont Elders, the Vermont Center on Aging, AARP, the Vermont Department of Labor, the Vermont Workforce Investment Council, and the Vermont Agency for Commerce and Community Development, in developing a set of mature worker recommendations which have been endorsed by the Governor. Vermont will initiate a multi-pronged effort to improve involvement of older Vermonters in the Vermont workforce: 1) "Mature Worker Initiative" spearheaded by the Vermont Department of Labor that will promote the recruitment, hiring, and retention of mature workers; 2) an Employer Recognition Program that recognizes employers who exemplify best practice in recruiting, hiring, and retaining mature workers; 3) a focus on the skill-set offered by mature workers in efforts to recruit new employers to Vermont. This work will involve close

collaboration with Vermont's *Senior Community Service Employment Program* (SCSEP) and will strengthen the job placement potential of the SCSEP program.

## Adult Protective Services

**Adult Protective Services (APS):** APS is the primary unit of State government responsible for investigating allegations of abuse, neglect and exploitation of vulnerable adults under Title 33 of the Vermont Statutes. It has taken significant steps forward to work towards improved management of the program and adapting to new challenges facing Vermont's vulnerable adults.

- The financial exploitation of elders has been an increased problem nationwide. To combat this trend, the Financial Abuse Specialist Team (FAST) was formed by the APS Financial Exploitation Unit in January 2013 and is a collaborative effort including banks/credit unions, the Attorney General's Office, law enforcement, state agencies and non-profit human services providers. It achieves its mission by taking a holistic and multi-disciplinary approach to the problem of financial exploitation. The partnerships established with the FAST will be critical for APS in meeting this growing problem during the period of this strategic plan.
- APS began implementing new case management software in 2012. Since that time, it has continued to develop this product to allow for better management of the program and increased reporting options.

## State Long-term Care Ombudsman Program

**State Long-term Care Ombudsman Program:** DAIL contracts with Vermont Legal Aid to operate the Vermont Long –Term Care Ombudsman Program (SLTCOP). The STLCOP is charged with protecting the safety, welfare and rights of older Vermonters receiving long-term care in nursing homes and residential care homes and all Choices for Care recipients in home and community-based settings. 79.9% of all complaints closed during SFY 13 were resolved to the satisfaction of the complainants or the person acting on their behalf. The addition of meeting with people in their home-settings expanded the scope of STLCOP services beyond nursing facilities and residential care homes and increased the workload for the program which has received state funding for that purpose. In SFY13, 97 individuals received information and consultation in their homes.

**Vermont State Unit on Aging and Disabilities**
**State Plan on Aging**
**Goals, Objectives, Strategies**
**Performance Measures and Population Indicators**
**For FFY 2015 through FFY 2017**

(Please note: Consistent with Vermont's result based accountability initiative DAIL will continue work to collect and report baseline data for population indicators and refine performance measures. Unless otherwise specified, DAIL will carry out strategies in collaboration with community partners.)

**Goal 1 –Decrease the impacts of poverty on older Vermonters and Vermonters with disabilities and support pathways out of poverty.**

OBJECTIVE 1.1: Improve food security of older Vermonters and Vermonters with disabilities

Population Indicator: Access to nutritionally balanced, affordable food for older Vermonters and Vermonters with disabilities.

Performance Measures:

- Increase the participation rate among Vermonters age 60+ enrolled in *3Squares Vermont* so that 45% of those eligible for assistance actually receive assistance by January 2016. (Baseline: 35%)
- Increase the number of people receiving information from AAA's about *3Squares Vermont*.

Strategies:

- Active participation in *3Squares Vermont* workgroup chaired by Hunger Free VT attended by a variety of community stakeholders including all of the AAAs.
- Active participation and promoting focus on food security with the *Farm to Plate Food Access Cross-cutting Team.*
- Promote activities under the "Farm to Plate" legislation including strengthening the relationships between OAA meal providers and the various players with the food system (farmers, processors, distributors, cooks) who can assist in the achievement of the "Farm to Plate" primary goals of improving access to healthy, local foods and the goals of the OAA Nutrition Program.
- Advocate for *Behavioral Risk Factor Surveillance System (BRFSS)* question with the Vermont Department of Health (VDH) regarding access to nutritional food to develop a performance measure.

OBJECTIVE 1.2: Improve employment supports and options for older Vermonters and Vermonters with disabilities.

Population Indicator: 1) By January 2016, demonstrated increase in employment for persons age 65-74 from 2011 rates of 29.2% (US rate was 23.2%), and for age 75+ from 7.1% (US rate was 5.5%); 2) Demonstrated increase in the estimated 2011

employment rate of all working-age people with disabilities in Vermont which was 39.8%.

Performance Measures:

- Meet annual continuous improvement goals of the *Senior Community Service Employment Program* (SCSEP).
- Establish and meet performance measures related to the recruitment, hiring and retention of mature workers in Vermont's *Mature Worker Initiative.*
- Of all individuals who exit the Division of Vocational Rehabilitation (DVR) program after receiving services, the percentages who are determined to have achieved employment outcome was 58% in 2012. Attain 60% by January 2016.
- Number/percentage of people employed at the time of graduation from the Traumatic Brain Injury (TBI) rehabilitation program.

Strategies:

- In collaboration with the Vermont Department of Labor (VDOL), the Vermont Agency for Commerce and Community Development (VACCD), the Vermont Associates in Training and Development implement a statewide *Mature Worker Initiative.*
- In collaboration with VDOL, the VACCD, the Vermont Associates in Training and Development, the Vermont Center on Aging and the Vermont Chapter of AARP implement an *Annual Mature Worker Employer Recognition Program.*
- Promote the goal and related activities associated with making the State of Vermont a model mature worker employer.
- In collaboration with VACCD foster recruitment of new employers whose employee needs match skill sets of mature workers seeking employment.
- DVR will implement a coordinated approach to employment services across the Vermont Agency of Human Services (AHS) under Creative Workforce Solutions (CWS).
- DVR will implement activities designed to reduce the number of individuals who are closed in a "not employed" status.
- Explore enhancing and expanding the *Silver Linings Program.* The Silver Linings Group was designed as a vocational preparation group for individuals aged 50 and older who had been experiencing difficulty finding employment or transitioning from one field of work to another.

**Goal 2 –Promote the health, wellbeing and safety of older Vermonters.**

OBJECTIVE 2.1: Provide effective Adult Protective Services.

Population Indicator: Substantiation rates for victims over 60 and victims with a disability with census data on these populations.

Performance Measures:

- Establish a baseline measure of abuse, neglect, and exploitation of vulnerable adults in Vermont,.
- APS will screen and investigate all reports of alleged abuse, neglect, and exploitation according to established policies. For each quarter:
  - # of intakes.

- #/% of intakes referred to Survey and Certification (S&C) without APS investigation.
- #/% of intakes closed without S&C referral or APS investigation.
- #/% of intakes investigated.
- #/% of investigations substantiated.
- #/% abuse/neglect investigations closed within 60 days.
- #/% exploitation investigations closed within 90 days.
- Average # open cases per quarter.
- Average # open cases per investigator per quarter.
- # of community education events.
- # of participants in community education events.
- # and distribution of referrals to other service providers.

Strategies:

- Enhance data management and reporting, to include continuous work to improve APS performance measures.
- APS Field Supervisors will review unsubstantiated reports for content and to ensure investigative policies and procedures are followed.
- APS Program Chief will review and approve substantiated reports for content and to ensure investigative policies and procedures are followed.
- APS Program Chief will review intakes not investigated for content and to ensure policies and procedures are followed.
- External review panel will meet quarterly to review APS reports and investigations, and related performance measures.
- Continue work with the Financial Abuse Specialist Team (FAST), and work to identify other potential partnerships to expand APS' ability to protect older Vermonters.

OBJECTIVE 2.2: Provide effective guardianship and guardianship alternatives.

Population Indicator: Improve access to health care; according to the 2012 BRFSS, 88% of Vermont adults report having a primary health care provider.

Performance Measures:

- Increase the percentage of individuals served by OPG under medical guardianship who report having a primary healthcare provider.
- Increase the percentage of individuals served by OPG under medical guardianship who have had at least an annual visit with their primary healthcare provider.

Strategies:

- Develop performance measure baselines by end of FY' 15.
- Involve individuals in choosing their healthcare provider.
- Ensure that healthcare providers are provided with adequate information about the individual to maximize the value of the patient-provider relationship.
- Document information about contact between individual and healthcare provider.

Population Indicator: Maintain or reduce the rate of public guardianship for

Vermonters who are 60 or older. The rate in 2012 was approximately 7.5 per 10,000.

Performance Measure: Increase community awareness about guardianship and alternatives guardianship.

Strategies:

- Provide at least 6 trainings or presentations about guardianship and alternatives to guardianship to community partners and stakeholders during FY' 15.
- Participate in at least 10 individual diversions from public guardianship during FY'15.
- Institute rules, as allowed in statute, which allow the Commissioner to limit the number of people under public guardianship.

OBJECTIVE 2.3: Reduce the negative consequences of self-neglect of older Vermonters.

Population Indicator: # of people who are referred by APS to other agencies for self-neglect each quarter.

Performance Measures:

- #s people >60 identified as self-neglecting that receive services.
- Demonstrated improvement in "Self-neglect Severity Scale" for people receiving services for self-neglect.

Strategies:

- AAA staff utilize "Self-neglect Severity Scale" embedded in SAMS along with relevant self-neglect case data features.
- AAA implement Coordinated Community Response Plans developed to address self-neglect in their service areas.

OBJECTIVE 2.4: Provide effective Long Term Care Ombudsman Program (LTCOP) services.

Population Indicator: Demonstrate the percentage of increased awareness of the LTC Ombudsman Program.

Performance Measure:

- The percentage of people in the DAIL Long Term Care Consumer Survey who report that they are familiar with the Long Term Care Ombudsman program will increase each year from 41% to 75% by FFY 2017.
- VTLTCOP will maintain a satisfaction rate of at least 75%.

Strategies:

- VTLTCOP will publish a quarterly e-newsletter for individuals, providers and the public in general.
- VTLTCOP will make a non-complaint related visit to every nursing facility at least once a quarter.
- VTLTCOP will submit quarterly data describing complaints received from individuals receiving home and community based services and the resolution of such complaints.

OBJECTIVE 2.5: Reduce the incidence and negative consequences of falls for older Vermonters

Population Indicators: Vermonters aged 65+: 32% fell in the last 12 months; of those

that fell at least once, 34% were injured. Vermonters age 85+: 36% fell in the last 12 months; of those that fell at least once 43% were injured (VDH *BRFSS, 2012*). Vermont death rate from falls: 210 deaths per 100,000 (US rate 73).

Performance Measures:

- Increase the number of older Vermonters who participate in evidence-based and evidence-informed healthy aging and falls prevention activities through AAAs.
- Vermont ACL State Program Report (SPR) report for FFY2012 indicates 1,383 people participated in health promotion activities.
- Increase the number of nursing homes and residential care homes that have evidence-base/evidence-informed falls prevention strategies in place via Vermont's Division of Rate Setting (DRS) quality award incentives.

Strategies:

- Work in collaboration with the Fall Free Coalition and Agency of Human Services (AHS) partners to identify a small set of successful interventions with proven results for use in Vermont as a tool kit; explore increased funding to expand evidence-based activities.
- Explore incentives for evidence-based or evidence-informed falls risk screening efforts in nursing homes and other care providers through DAIL Quality Awards.

OBJECTIVE 2.6: Expand options for long-term community housing with integrated supported services and supports.

Population Indicator: Number of persons receiving HCBS; DAIL supports approximately 2,600 people with individualized HCBS, including approximately 1,800 people who receive a combination of housing and support services.

Performance Measures:

- *Adult Family Care* model is fully implemented and will serve 25 people by January 2016.
- Increase the number of *Money Follows the Person* transitions by 20 people by January 2016.
- Increase number of Homeshare placements by 5% by January 2016.
- Expand *Support and Services At Home* (SASH) according to contractual agreements.
- Enroll all eligible Moderate Needs wait list applicants who applied before January 1, 2014 by December 2014.
- Create flexibility by implementing a new Moderate Needs Flexible Funds service April 2014, allowing people to flexibly purchase goods and services that contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.
- Maximize use of funds by spending 90% of new CFC Moderate Needs allocation by June 30, 2015.

Strategies:

- Add *Adult Family Care* model to the CY15 consumer survey.
- Create incentives for more effective person-centered practices for people with dementia.
- Support feasibility study for expansion of Homeshare model to other parts of

the state.

- In collaboration with the Vermont Housing Finance Agency (VHFA) and partners in the Agency of Human Services, (AHS) apply for and implement HUD 811 housing supports.
- Explore funding opportunities to increase evidence based/evidence informed caregiver support.
- Promote universal design principals.
- Explore funding opportunities that support home modifications, allowing seniors to age-in-place.
- Build and support statewide Designated Regional Housing Organizations (DRHO) and Community partner structure with SASH.
- Provide technical assistance in the execution of SASH operating agreements.
- Provide technical assistance in the development and execution of Memoranda of Understanding (MOU) with SASH team partners.

OBJECTIVE 2.7: Promote increase in availability and accessibility of person-centered transportation.

Population Indicator: Relevant data and sources will be developed in partnership with the VT Department of Transportation and other transportation providers.

Performance Measures:

- Report from the Vermont Association of Adult Day Centers that transportation capacities have improved for Adult Day Centers.
- Demonstrated increase in utilization of *Neighbor Rides.*

Strategies:

- Review and consider transportation improvement strategies suggested by the study currently underway at the University of Vermont to enhance transportation for people 60+.
- Identify and implement specific solutions to challenges that Vermonters face in securing responsive, person-centered transportation to and from Adult Day services.
- Promote the inclusion of person-centered transportation strategies in the Vermont Comprehensive Human Services Transportation Plan.
- Explore support for expansion of *Neighbor Rides.*
- Explore implementing a Transportation Summit with providers of transportation services, older Vermonters and Vermonters with disabilities, as well as other stakeholders, to identify options and strategies for meeting gaps in transportation services.

OBJECTIVE 2.8: Support expansion of "age-friendly" livable communities.

Population Indicator: Seniors in "age-friendly" communities display greater engagement in their communities; planning and policy regarding land-use, social and civic activities, mobility and housing issues reflect the desires and needs of local seniors.

Performance Measures:

- Number of Vermont communities implementing "complete streets" planning.
- Adoption of "age-friendly" policies in local communities.

Strategies:

- Participation in Governor's Commission on Successful Aging "Livable Communities" Subcommittee.
- Promote identification and adoption of local policy planning statements that articulate "age-friendly" principals.
- Promote support for dedicated focus on "complete streets" planning activities at the Vermont Department of Transportation.

OBJECTIVE 2.9: Support older Vermonters in the community by sustaining family caregivers.

Population Indicator: Caregivers receive needed support; stress and health effects of caregiving on caregivers is reduced; delay in admissions to nursing homes of people with dementia; Explore addition of Vermont *BRFSS* with the Vermont Department of Health, (VDOH). Consider implementing a general population survey in partnership with AARP or the Vermont Center on Aging.

Performance Measure:

- Increase the number of caregivers who receive evidence-based or evidence-informed caregiver support services.
- Increase in number of caregivers who receive evidence-based or evidence-informed care-giver training.

Strategies:

- Explore funding opportunities to increase AAA caregiver support (also mitigate impact of sequestration on AAA Title IIIE caregiver support).
- Ensure that AAA caregiver support services are evidence-based or evidence-informed and target caregivers of people with dementia.
- Explore new, "out-of-the-box" ideas and models to support family caregivers in accordance with the Results Based Accountability (RBA) method for demonstrating quality and performance.
- Develop methods for AAAs to track individuals, services and outcomes in SAMS.
- Identify policies and action strategies for caregiver support within the Governor's Commission on Alzheimer's Disease and Related Disorders.

**Goal 3 –Enhance the Vermont aging network's focus on program effectiveness and accountability for outcomes.**

OBJECTIVE 3.1: Improve DAIL's capacity to plan, achieve and capture information related to program performance and outcomes for people.

Population Indicators: Vermonters experience demonstrated improved outcomes, e.g. health status, access to services including LTSS.

Performance Measures:

- 100% of DAIL's contracts with service providers reflect Results Based Accountability (RBA) concepts by July 2016.
- Relevant AAA activity data is merged with Vermont Blueprint data system.

Strategies:

- DAIL develop and implement plan to employ RBA in services planning and services contracting processes.
- DAIL collaborate with Vermont Blueprint to 'flag' people who receive AAA

case management and other relevant AAA services to evaluate connections to health care outcomes.

OBJECTIVE 3.2: Improve partner organizations' capacity to plan, achieve, and capture information related to program performance and client outcomes.

Population Indicators: Vermonters experience demonstrated improved outcomes, e.g. health status, access to services including LTSS.

Performance Measures:

- ADRC's ten partner agencies, including the five AAAs, complete Results Based Accountability training by January 2015 and adopt and implement RBA planning and reporting practices by January 2016.
- Relevant AAA activity data is merged with Vermont Blueprint data system.

Strategies:

- By January 2015 implement RBA training with ADRC core partners including AAAs, VCIL, Brain Injury Association, Vermont Family Network, and Green Mountain Self Advocates.
- Improve active use of SAMS data by AAAs for measuring performance including consumer outcomes.
- Collaborate with Blueprint data staff to incorporate relevant AAA service activity in Blueprint data system.

OBJECTIVE 3.3: Improve DAIL's communication with the public, partner organizations and people needing services and supports.

Performance Measures:

- Google Analytics and Alexis Analytics indicate improved traffic and utilization of DAIL Websites.
- Implementation of a Website User Satisfaction Survey to determine level of satisfaction, ease of use and areas for improvement completed on an annual basis beginning June 2015.

Strategies:

- Complete web design and content revision for all DAIL Websites.
- Identify dedicated website manager to assure thorough implementation of Website revisions.
- Define roles for and appoint Website Content and Technical Staff for each Division Website and the DAIL portal site.
- Implement Website User Satisfaction Survey at annual intervals and modify sites as indicated by survey results.

OBJECTIVE 3.4: Improve DAIL's and the aging network's planning capacity.

Population Indicator: Vermonters experience improved outcomes in service area planned by DAIL.

Performance Measures:

- Projections of future needs/services of older Vermonter are professionally identified relating age, poverty, disability and relevant variables.

Strategies:

- Contract for and conduct a study similar to past *Shaping the Future* studies designed to obtain relevant projections regarding demographics, assets,

disability, and other variables.

OBJECTIVE 3.5: Promote support for person centered long-term care services and supports in Vermont's Health Care Integration Project (VHCIP).

Performance Measure:

- VHCIP will articulate and include relevant support for planning and investment in long-term care services and supports and include roles for principal players in the aging network in the production of health care and long-term services and support integration.

Strategies:

- Active participation in relevant planning teams of the VHCIP.
- Advocate for inclusion of relevant aging network partners in the integration design that emerges from the planning process.
- Advocate for person-centered LTSS processes for inclusion in final project design.

**Goal 4 –Older Vermonters have access to high quality, person-centered, evidence-based or evidence-informed dementia care services, mental health and substance abuse services and health care.**

OBJECTIVE 4.1: Expand access to person-centered, evidence-based or evidence-informed mental health services, substance abuse services, and dementia care services.

Population Indicator: Relevant data and sources will include: BRFSS 30-Day Binge Drinking among older Vermonters; BRFSS Vermonters Ages 50 and Older Reporting Frequent Mental Distress; BRFSS cognitive impairment question.

Performance Indicators:

- Number of individuals receiving screening and/or assessment utilizing effective screening/assessment tools for substance abuse, cognitive impairment, and depression by AAAs, Community Health Teams, SASH and the Vermont Chronic Care Initiative.
- By January 2015, complete formulation of an Integrated Action Plan in collaboration with the Vermont Department of Health (VDH), the Vermont Department of Mental Health (DMH), and key DAIL and community partners including AAAs, home health, and SASH that specifies methods to support the identification, assessment, and referral to appropriate services for people over age 60 with dementia, mental health and substance abuse needs.
- Information reflecting the completion and quality of evidence-based, person-centered elder mental health training, including dementia care training meeting specifications of contract between DAIL and SASH.

Strategies:

- Create comprehensive inventory of screening and assessment tools being utilized to screen and assess for dementia, substance abuse, depression by key elder service organizations including AAAs, Community Health Teams, SASH, Elder Care Clinicians and the Vermont Chronic Care Initiative.
- Develop processes to collect data related to the utilization of recommended screening and assessment tools for dementia, depression and substance abuse including nature of referral based on results of screening and assessment.

- Develop strategies to improve access and integration of mental and substance abuse services for helping older persons and persons affected by dementia
- Increase access to home based mental health and support services.
- Support development of a comprehensive plan to create and sustain a dementia-capable HCBS system that includes Single Point Entry/No Wrong Door access for people with dementia and their caregivers by utilizing ADRC resources and infrastructure.
- Coordinate utilization of SBRT screening and brief intervention and referral for treatment approach with the Agency of Human Services (AHS) effort.

## Emergency Preparedness

DAIL, as part of the Vermont Agency of Human Services (AHS), is contracted with BOLDplanning, Inc., has constructed and implemented a Continuity of Operations Plan (COOP) in preparation for emergency events. Under the direction of BOLDplanning, Inc. and leadership at AHS, the plan is reviewed annually with necessary revisions. BOLDplanning, Inc. conducts periodic "Tabletop" exercises to test the effectiveness and efficiency of the plan's elements. BOLDplanning , Inc. provides state-of-the-art consultation regarding COOP efforts and DAIL's plan encompasses all of the essential planning elements to effectively respond to emergencies and disasters.

DAIL requires AAAs to have Emergency Preparedness Plans in their Area Plans that are updated on an annual basis as needed, and approved by DAIL. AAA Emergency Preparedness Plans address critical functions, outreach to vulnerable individuals, and coordination efforts with local and State emergency response agencies. In the event of an emergency i.e. Tropical Storm Irene, DAIL staff reached out to each of Vermont's AAAs to offer support, insure critical functions were possible and that AAAs were able to contact the most vulnerable older Vermonters and adults with disabilities they worked with. AAAs in turn least affected by the impact of Tropical Storm Irene offered support and case management staff to AAAs most impacted.

## Quality Management

The Department of Disabilities, Aging and Independent Living (DAIL) uses the CMS Home and Community-based Services Quality Framework to organize quality initiatives and monitoring as part of our relationship with the aging network and more specifically, with the Area Agencies on Aging (AAAs).

Data collection is done on both an annual and quarterly basis. The State Unit on Aging and Disabilities (SUAD) provides instruction and oversight to the AAAs for annual State Plan Reporting (SPR) of data to the Administration for Community Living (ACL). Each year AAAs are provided with Area Plan (AP) Instructions to assist them in completing their regional APs. Throughout Federal Fiscal Years (FFY) 15-18, AAA APs will align with the Vermont State Plan on Aging (SPA), FFY 15-18, outlining regional goals, objectives,

strategies and measurable outcomes in the Results Based Accountability (RBA) format.

Vermont is currently moving to a Results Based Accountability (RBA) model for performance measurement and continuous improvement. RBA is a disciplined method of thinking that frames interdisciplinary initiatives that support mutually agreed upon population and performance based goals. RBA starts at the end by describing the outcomes desired and works back to establish the strategies that will lead to the outcome in the most straightforward method possible. Common sense data collection methods are agreed upon as anecdotal evidence does not adequately inform the process.

AAAs four year APs are updated, reviewed, and approved each year. DAIL currently requires the AAAs to submit quarterly Area Plan updates on goals, objectives, strategies and outcomes outlined in the plans. The AAAs are required to send quarterly reports to demonstrate progress and obstacles presented in the previous three months. During FFY 15-18, AAAs will report on their regional goals in an RBA score-card format on a semi-annual basis. DAIL/ASD staff are making site visits to each AAA as they develop their FFY 15-18 APs to hear what they have learned from their regional Needs Assessments about gaps in services, their thoughts towards goals, objectives, strategies and outcomes, along with providing technical assistance. DAIL/ASD staff plan to visit each AAA annually to discuss progress and challenges. Additionally, DAIL/ASD staff meet with the AAA Executive Directors on a monthly basis to review different program areas and provide technical assistance. Specific discussion takes place on; access of services, coordination of services among local agencies and providers, outcomes of services, program standards and procedures, and data collection and reporting requirements.

DAIL/ASD also provides quality oversight via annual monitoring visits by the Quality and Program Participant Specialist. This staff person reviews the agency through the lens of case management using an approved standard for AAAs against an established review grid that follows the standard requirements. At each site, a random selection of charts are pulled with representation from as many case managers as possible to assure across the board timely and appropriate care through review of assessments, plans of care, goals, strategies, needs, and follow up as needs change. Great care is taken to ensure that the participants and/or family caregivers have in-put into the plan such that opportunities for choice/flexibility are emphasized in the process. For each record, the reviewer looks at the initial documents, and then follows case notes, team conference notes, progress, barriers, changing strategies, utilization of community resources, vocational rehab and other applicable interventions. Reviewers also check for on-going supervisory interface and evaluations, training, orientation, tracking lists, and updated background checks. All applicable AAA policies and procedures are also reviewed. If an AAA has standards and/or policies and procedures that are "unmet", there is a written request for a plan of correction which must be submitted within an allotted timeline. If the plan of correction is deemed acceptable, a letter stating such is sent. If a plan is not acceptable, a further request is made with follow-up technical

assistance. Once the plan of correction is accepted, the Specialist will conduct a follow up visit to assure that the corrective action has been operationalized.

## Summary of Public Hearing And Comment Process

A public hearing on the Vermont Draft State Plan on Aging was held on May 8, 2014 at the Comfort Inn in Berlin, Vermont in conjunction with the Department of Disabilities, Aging and Independent Living (DAIL) Advisory Board Meeting. Many members of the DAIL Advisory Board and interested parties attended the public hearing as well as DAIL staff. The hearing was structured around the DAIL Advisory Board to encourage broad input, feedback and suggestions on the Draft. We are pleased this effort was as successful this year as it was in the development of Vermont's current State Plan on Aging for Federal Fiscal Years 2011-2014.

In addition to the public hearing written comments were received from The VNAs of Vermont, Central Vermont Council on Aging and The Elder Care Clinician Program. We are appreciative of the interest and time taken by members of the DAIL Advisory Board, interested parties and those representatives who provided written feedback on behalf of older Vermonters and family caregivers.

The following comments were received from the public hearing. Our response follows in italics.

- Transportation and accessibility to homes, particularly in regards to Adult Family Care Homes is challenging for people with disabilities.
- It was noted that transportation is a challenging issue even for older Vermonters and adults with disabilities who have Medicaid. At times it is difficult to get to doctor appointments and to activities in the community.

*DAIL agrees and acknowledges the importance of transportation and accessibility to homes, including Adult Family Care Homes. Goal 1, Objective 2.6 addresses expanding options for long-term community housing with integrated supported services and supports. Goal 2, Objective 2.7 addresses promoting an increase in availability and accessibility of person-centered transportation.*

- The need for sustainable funding to address older adults with self-neglecting behaviors.

*DAIL duly notes. Ongoing funding is dependent upon legislative action. The area of Self-Neglect is addressed on page 25, #7 and in Goal 2, Objective 2.3.*

- Objective 3.1 and 3.2: It is not enough to incorporate AAA Data with Blueprint data. The AAA data system needs an overhaul so data is better managed and results can be demonstrated. AAAs need to have unduplicated counts of individuals receiving services. This needs to be a priority for DAIL if DAIL wants AAAs to have RBA compliant data.

*The Harmony/SAMS system is capable of supporting all the uses described. The Harmony/SAMS system is able to produce unduplicated counts of individuals and ways to incorporate results. The AAAs may want to revise their procedures and uses of SAMS to achieve these ends. RBA is a legislative mandate for all organizations. If improvements in the use of SAMS is a priority for AAAs, DAIL encourages them to work together through V4A.*

- There should be a strong emphasis on housing, particularly Homeshare and Section 8.

*Duly noted. Goal, 2 Objective 2.6 focuses on expanding options for long-term community housing with integrated supported services and supports.*

- Congregate meal sites are very important.

*DAIL agrees. All important areas cannot be addressed in the State Plan on Aging for a given timeframe. DAIL, with legislative approval utilized CFC reinvestment savings in FFY 2013 to offset a loss of Federal funds to the AAA's for Congregate and Home Delivered Meals due to sequestration.*

- PTSD (in light of recent Vermont news) and other Veterans issues should be addressed in the State Plan on Aging.

*DAIL acknowledges the importance of Veterans issues and challenges some Veterans face with PTSD. The State Plan on Aging is not designed to address all areas in a given timeframe. On page 22 under Opportunities, the Veterans Independence Program (VIP) is included. VIP is an important initiative to expand Veteran-Directed Home and Community Based services to serve more Veterans across the state. While not specific to PTSD, Goal 4, Objective 4.1 addresses expanding access to person-centered, evidence-based or evidence-informed mental health services. This includes the Elder Care Clinician Program.*

- Concern was expressed that while Goal 2, Objective 2.4 is very good concerning the Long Term Care Ombudsman Program there is concern with decreased staffing and the ability of the program to meet these and other goals. The quality of life for the most vulnerable in facilities must be maintained and addressed.

*DAIL duly notes. The 2014 Vermont Legislature has committed an additional $57,458 to the Long Term Care Ombudsman Program for home and community based services through*

*Global Commitment.*

- Respite for family caregivers and evidence-based Dementia training across providers should be supported as much as possible.
- ER physicians/acute care need more training and responsiveness to people with dementia.

*DAIL duly notes. Supporting older Vermonters in the community by sustaining family caregivers is addressed under Goal 2, Objective 2.9. Goal 4 addresses older Vermonters having access to high quality, person-centered, evidence-based or evidence-informed dementia care services.*

- Related to health care reform: The acute care medical world doesn't understand the importance of LTSS integration. They are locked into a medical model. Try to get more people involved from the long term care world, not just on planning and workgroups, but in the decision making arena.

*DAIL duly notes.*

- An Acronym sheet would be helpful.

*DAIL duly notes and has added.*

- The benefits of senior centers and the importance of socialization and nutrition and all the programs offered there aid in a healthier senior.

*DAIL duly notes.*

- Alcohol and drug abuse by elders is a serious concern. Some elders are selling drugs.

*DAIL duly notes. Please note Goal 4, Objective 4.1.*

- Comment regarding Goal 3, Objective 3.3: Improve DAIL's communication with the public, partner organizations and people needing services and supports. The performance measures and strategies included under this Objective are helpful and positive. This topic was discussed at the Advisory meeting today. Currently our partners don't get information from the board as they did in the past. The board could play an important role in getting this information out to them. A written Commissioner's report would give them an opportunity to review material, and let them know what was going on with the Board. This may encourage more participation at Board meetings.

*DAIL duly notes.*

- It is not always clear who is implementing strategies. It would be helpful to clarify if it is DAIL or a partner organization.

*DAIL duly notes.*

- Several comments were given regarding the development of the State Plan on Aging and the public hearing process:
  - It might improve the process to have a question/answer session prior to the public hearing. While the public hearing provides an opportunity to comment, it is not intended to be a question/answer session. When the System of Care Plan was developed for Developmental Services some of us had many questions and did not understand sections of it.
  - It would be helpful to view the entire draft sooner and not just the Goal section.
  - It would be helpful to receive paper copies in advance of the public hearing.
  - The Advisory Board would appreciate being involved more in the development of the State Plan on Aging.

*DAIL duly notes.*

- Staff representing the Elder Care Clinician Program (ECCP) noted the Program had not been mentioned under the Aging Services Network. Several areas of the draft were indicated where it was felt the Elder Care Clinician Program should be addressed. ECCs play a fairly significant role in mental health, dementia and substance misuse with VT elders and could be instrumental in helping that move forward. ECC's indicated they would love to see something about their ability to be a resource, support, collaborator and working partner in addressing the needs of elders in VT.

*DAIL duly notes and agrees with the significance of the Elder Care Clinician Program. A description of the ECCP was added to the Aging Services Network. Under Opportunities, #6 pertinent information was added.*

- I appreciate the Executive Summary and the acknowledgement that funding and services are decreasing just as the demand for these services is increasing.

*DAIL duly notes.*

- I would recommend including a statement within the AAA Section that indicates that AAAs contract with multiple providers for services such as nutrition, transportation, legal services, and mental health services. This is about half of our budget, and is not incidental.

*Sentence has been added.*

- I appreciate the demographic information, thank you.

*DAIL duly notes.*

- Page 19 and 20 discussed the investments in self-neglect and nutrition through CFC reinvestments. I need to point out that while these are appreciated, it is challenging to plan for the future when funding is one time (nutrition and mental health) and fragmented (self-neglect). DAIL needs to strongly consider making rolling, multi-year contracts so that providers can have some sort of assurance that funding will be ongoing and not dependent upon RFPs and grants which don't get sent out in a timely manner.

The recommendation for rolling, multi-year contracts is duly noted; ongoing funding is dependent upon legislative action. CFC reinvestments are subject to availability and legislative action.

- I applaud the intent to revisit the Shaping the Future document. It was very helpful in the past and will be more so as we face increasing challenges.

*Duly noted, subject to funding.*

- Objective 1:1 I would encourage DAIL to include a focus or a mention of the role that senior centers and meal sites play, especially in nutritional status for elders. Working on increasing funding for congregate and home delivered meals would support this goal. At this time, senior centers operate on the edge of solvency and constant uncertainty. Additional state financial support that was consistent and ongoing would help dramatically.

*State financial support depends upon legislative action.*

- Objective 1.2 Improving employment supports is an admirable goal. However, the state needs to look at and reduce some of the barriers inherent in our employment system, including legal discrimination against older workers. For example, many insurance companies will not include drivers over 75 on their liability policies. This leaves agencies who employ these older workers vulnerable to large claims should a worker have an accident while driving for work. Additionally, worker's compensation practices punish companies whenever an employee has an accident or injury on the job. Because accidents involving older workers may cost more, companies who employ older workers may have increased worker's comp rates and get pressured by the companies to not hire older workers and/or to not retain them. Any focus on employing mature workers must also recognize the challenges while trying to overcome them.

*This concern has been forwarded to the Mature Worker Initiative.*

- Objective 2.6 The moderate needs flexible choice program is a new and creative initiative to support this goal. The state will need to carefully monitor the implementation, to make sure it is not too cumbersome to administer and that reimbursement is adequate to the community partners (AAAs) who are administering this.

*Monitoring is included in the program work plan protocols.*

- Objective 2.9 We welcome the exploration of additional funding to support AAA caregiver services. We'd like the state to recognize that "thinking outside the box" may sometimes mean that our services and programs are not always "evidence-based." We welcome the development of better ways to track our services through SAMS. We encourage the state to seriously consider supporting the development of a single data base for AAAs so that all our services can be tracked and monitored in a cohesive manner, rather than through multiple separate data bases that don't communicate with each other.

*The SPA recognizes the importance of an evidence-based foundation. "Out of the box" is included in the RBA framework. DAIL has created a single, integrated database in SAMS. All services can be tracked and monitored within SAMS, as evidenced by such use in numerous other states. If AAA's choose to use multiple databases, DAIL recommends AAAs consider shifting all activities to SAMS.*

- Goal 4 – Access to evidence based dementia and mental health care.

  While I applaud the intent of this goal, I need to caution that the over-reliance on AAA Case Managers to do every assessment for every possible elder need dilutes their effectiveness overall. Certainly, AAA Case Managers should be a part of this; however, there cannot be an expectation that they will do comprehensive assessments on every client who comes in for assistance with public benefits etc.

*Tools will be available to case managers. Their utilization is contingent upon individual's needs.*

- Goal 2, Objective 2.5: Home health should be prominently mentioned in this goal and in the strategies to achieve the goal as the agencies are essential providers for services related to this objective. All home care agencies have aggressive falls prevention programs which as evaluated through the OASIS assessments.

*This Objective has not been changed. The focus is on what DAIL funds; DAIL does not fund the VNA's. The VNA's are included in the Fall Free Coalition. The SPA is not intended to include all efforts underway.*

- Goal 2, Objective 2.6: OASIS is the assessment tool used by home health agencies and is geared toward care provided in private homes. Nursing homes use the MDS

assessment. Is DAIL considering having nursing homes use OASIS for all patients or just for their dementia programs?

*DAIL is referring to the OASIS curriculum for nursing home staff, not to the Home Health OASIS tool.*

- Goal 2, Objective 2.6, Strategies: "Revise CFC payment to nursing homes and ERCs to create incentives for more effective person-centered practices for people with dementia."
  Home health should be included in this section as a significant percentage of our 22,000+ patients suffer from Alzheimer's or other dementia related illness.

*This strategy is specific to improving staffing practices in facilities.*

- Goal 2, Objective 2.6, Strategies: "Explore additional funding (e.g. through CFC reinvestments) to AAAs to increase evidence based/evidence informed caregiver support."
  We are curious AAA is the only provider listed as home care and others would benefit from additional funding.

*Language has been added to address this concern.*

- Goal 2, Objective 2.6, Strategies: "Provide technical assistance in the development and execution of Memoranda of Understanding (MOU) with SASH team partners, which at a minimum must include AAAs, Home Health agencies and Community Mental Health."
  VNAVT members believe this strategy is wrongly focused and should read: "Support negotiations and execution of Memoranda of Understanding (MOU) among all community providers including SASH teams, AAAs, Home Health agencies and Community Mental Health."

*This is an established goal within an existing grant.*

- Goal 3, Objective 3.2, Performance Measures: Is home care among ADRC's ten partners?

*Home care is not a core partner agency. Core partner agencies perform specific ADRC grant related functions. Home care is connected to ADRC in that home care is a valued community resource and ADRC may refer individuals to home care.*

- Goal 3, Objective 3.2, Strategy related to RBA: Does DAIL intend to include home-care in results-based accountability?

*As recently legislated, DAIL encourages all community partners to pursue RBA training opportunities that improve their service delivery operations.*

- Goal 3, Objective 3.2, Strategy related to collaboration with Blueprint data staff: Home care should be included here also and the agencies that work closely with Blueprint staff.

DAIL encourages home care agencies to collaborate with the Blueprint.

- Goal 4, Objective 4.1, Performance Indicators: "Number of individuals receiving screening and/or assessment utilizing effective screening/assessment tools for substance abuse, cognitive impairment, and depression by AAAs, Community Health Teams, SASH and the Vermont Chronic Care Initiative." Home health should be included here also as home care agencies serve several thousand people with these concerns.

This indicator is focused on providers who currently perform screenings/assessments. If home care has implemented screening/assessments, or would like to, DAIL will include that data in this indicator.

## Minimum Proportion of Title IIIB

Each AAA shall expend at least 65% of Part B funds for Access to Services, 1% of Part B funds for In-home Services, and 5% of Part B funds for Legal Assistance. DAIL includes this requirement in AAA Area Plan Instructions.

## C: INTRASTATE FUNDING FORMULA

## Method of Distribution For Title III, Title VII and State Funding

### FFY 14 Intrastate Funding Formula

In June 2013 DAIL submitted a request to amend the Intrastate Funding Formula. The proposed amendment below was approved by ACL in July 2013.

The proposed FFY 14 OAA Intrastate Funding Formula was developed in consultation with Vermont's five AAAs. Formula adjustments were discussed in three meetings between September and December of 2012 along with numerous e-mail and phone communications about possible restructuring of the IFF. DAIL reviewed 28 formula options before settling on a draft proposal in December. On December 5th 2012 DAIL sent a draft amended intrastate funding formula for FFY 14 to the five AAAs and encouraged them to review and "pursue a consensus recommendation knowing that this is an opportunity to forge agreement on a formula that affects all of the AAAs." On January 4th, 2013 DAIL received a collaborative response proposal from four of the five AAAs which included the following message:

"The attached document represents collaborative comments by 4 Area Agencies on Aging (CVAA, CVCOA, SOASEV/SS, and SVCOA) on DAIL's proposal for a new Intrastate Funding Formula. While we had hoped for agreement by all 5 AAAs, we are happy that 4

of us could come to an agreement. Our proposal is not vastly different from DAIL's but does make some changes, which we believe will strengthen and improve the formula process for this formula change, and look forward to DAIL's response and/or future opportunities to give input over the next several months."

The version offered by the four AAAs was reviewed by DAIL in detail including exploration of further adjustment to the formula. After due consideration and study of the comments offered by the fifth AAA, NEVAAA, DAIL decided to proceed with the version of the IFF presented by the four AAAs. The Formula was posted for public review and comment on the DAIL website.

**The Formula:**

***The dollars represented in the following presentation are based on the pre-sequestration FFY 13 projections. At the time of the writing of this explanation of the FFY 14 IFF, the final sequestration affected grant projections were not available.***

**Principles:**

- **Use "best available data" which is understood to be the most recent Administration for Community Living Special Tabulation of the American Community Survey 5-year Survey estimates. Data is updated annually and available at the Planning Service Area level (equivalent to AAA service areas in Vermont) or town level, producing information by AAA region.**
- **Pursue stability: avoid distributing large number of dollars associated with a small number of people**

**Funding Factors:**

1. **Service Base** distribution of $531,000, representing 10% of Federal funds available for distribution, is divided equally among the five AAAs ($106,200 per AAA).
2. **Area Plan Administration** distribution of $531,000 representing 10% of Federal funds available for distribution, is divided equally among the five AAAs ($106,200 per AAA).
3. **Distribution by Age:**
    - 15% of the *remaining* funds are distributed based on the 60 – 74 population in each Planning Service Area (PSA) (equivalent to the area served by each AAA)
    - 15% of the *remaining* funds are distributed based on the 75 – 84 population in each PSA
    - 27% of the *remaining* funds are distributed based on the 85+ population in each PSA
4. **Distribution according to age and greatest economic need:** 40% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and at or below 100% of the Federal Poverty Level.

5. **Distribution according to age and social need related to limited English:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and with limited English proficiency.
6. **Distribution according to age and social need related to minority status:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and minority.
7. **Distribution according to age and social need related to living alone:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and living alone.

Weightings emphasize supporting old-old (85+) and poverty.

The following two Tables provide information regarding the target populations in the five PSAs, the funding factors, and the resultant projections for distribution of funds.

Table 1: **Population Data by Planning Services Area and by Funding Factor.** Displays total populations related to funding factor categories and percentages of total populations by PSA. Data is derived from the most recently published ACL Special Tabulation of the American Community Survey 5-Year Survey estimates, 2005 – 2009.

| | | | | | | **low #s** | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Cohort Factors:** | | *total = 79715* | *total = 40925* | *total = 10730* | *total = 9685* | *total = 726* | *total = 1586* | *total= 27605* | |
| PSA | AAA | age 60-74 | age 75-84 | age 85+ | age 60+ <100% fpl | age 60+ w limited english | age 60+ minority | age 60+ living alone | **current $ %** |
| A | CVAA | 32.14% | 30.00% | 31.17% | 29.01% | 55.79% | 49.12% | 31.14% | **29.8%** |
| B | CVCOA | 20.04% | 20.83% | 17.57% | 20.08% | 16.53% | 17.02% | 21.55% | **19.0%** |
| C | NEVAA | 11.57% | 10.78% | 14.68% | 18.17% | 14.46% | 12.36% | 11.27% | **17.1%** |
| D | SWVCOA | 18.13% | 20.48% | 18.59% | 16.78% | 5.79% | 9.33% | 17.19% | **17.3%** |
| E | COASEV/ | 18.12% | 17.90% | 17.99% | 15.95% | 7.44% | 12.17% | 18.86% | **16.8%** |
| | TOTAL | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.0%** |

Table 2: **Funding Data by AAA and by Funding Factor.**

***N.B. The dollars represented in the following presentation are based on the pre-sequestration FFY 13 projections. At the time of the writing of this explanation of the FFY 14 Intrastate Formula, the final sequestration affected grant projections were not available.***

Displays the funding factors, the weighted percentages related to the factors, and the impact on fund distribution to the five Area Agencies on Aging.

| A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|
| **AAA Intrastate funding formula** | | | | | | | | | |
| **FFY 2014** | | | | | | | | | |
| | | | Total | CVAA | CVCOA | NEVAA | SWVCOA | COASEV/SS | Total |
| Area Plan Administration | **10%** | *of total* | $531,000 | $106,200 | $106,200 | $106,200 | $106,200 | $106,200 | $531,000 |
| Service base | **10%** | *of total* | $531,000 | $106,200 | $106,200 | $106,200 | $106,200 | $106,200 | $531,000 |
| age 60-74 | **15%** | *of balance* | $637,200 | $204,793 | $127,696 | $73,740 | $115,506 | $115,466 | $637,200 |
| age 75-84 | **15%** | *of balance* | $637,200 | $191,192 | $132,737 | $68,690 | $130,521 | $114,061 | $637,200 |
| age 85+ | **27%** | *of balance* | $1,146,961 | $357,557 | $201,493 | $168,356 | $213,251 | $206,303 | $1,146,961 |
| age 60+ poverty | **40%** | *of balance* | $1,699,201 | $493,005 | $341,244 | $308,786 | $285,101 | $271,065 | $1,699,201 |
| age 60+ limited english | **1%** | *of balance* | $42,480 | $23,698 | $7,021 | $6,144 | $2,458 | $3,160 | $42,480 |
| age 60+ minority | **1%** | *of balance* | $42,480 | $20,865 | $7,232 | $5,250 | $3,964 | $5,169 | $42,480 |
| age 60+ live alone | **1%** | *of balance* | $42,480 | $13,226 | $9,156 | $4,786 | $7,302 | $8,010 | $42,480 |
| **Proposed Total Title III & VII** | *4,248,003* | | $5,310,004 | $1,516,736 | $1,038,979 | $848,152 | $970,503 | $935,634 | $5,310,004 |
| | 100% | | | | | | | $5,310,004 | |

RESOURCE PROJECTIONS FOR 2015 BASED ON AWARDS DATED 03/06/2014

| | CENTRAL | CHAMPLAIN | NORTHEAST | SOUTHEAST | SOUTHWEST | TOTAL |
|---|---|---|---|---|---|---|
| TITLE III and VII | | | | | | |
| SERVICE BASE | 103,220 | 103,220 | 103,220 | 103,220 | 103,220 | 516,100 |
| SUPPORTIVE SERVICES | 761,246 | 1,294,127 | 606,325 | 728,249 | 738,844 | 4,128,791 |
| SUB-TOTAL SERVICES | 864,466 | 1,397,347 | 709,545 | 831,469 | 842,064 | 4,644,891 |
| AREA PLAN ADMINISTRATION | 103,220 | 103,220 | 103,220 | 103,220 | 103,220 | 516,100 |
| NET TITLE III and VII | **967,686** | **1,500,567** | **812,765** | **934,689** | **945,284** | **5,160,991** |
| STATE GENERAL FUND | 775,779 | 1,318,835 | 617,901 | 742,155 | 752,946 | 4,207,616 |
| LONG TERM CARE FLEX FUNDS | 17,700 | 30,090 | 14,098 | 16,933 | 17,179 | 96,000 |
| SPECIAL SERVICES FUND | 4,360 | 7,412 | 3,472 | 4,171 | 4,231 | 23,646 |
| ALZHEIMER FUND | 46,094 | 78,360 | 36,713 | 44,096 | 44,737 | 250,000 |
| NUTRITION SERVICE - MEALS | 9,218 | 15,672 | 7,343 | 8,819 | 8,948 | 50,000 |
| VOLUNTEEER OUTREACH FUNDS (FORMER N2N) | 22,125 | 37,613 | 17,622 | 21,166 | 21,474 | 120,000 |
| ST GEN FUND MATCH FOR 3SVT OR TRANS TO DCF ' | 38,475 | 65,408 | 30,645 | 36,806 | 37,344 | 208,678 |
| ST GEN FUND TRANS TO DMH | 43,407 | 73,791 | 34,571 | 41,525 | 42,129 | 235,423 |
| NUTRITION SERVICES INCENTIVE PROG. | 139,602 | 231,544 | 114,832 | 158,424 | 143,594 | 787,996 |
| TOTAL | 2,064,446 | 3,359,292 | 1,689,962 | 2,008,784 | 2,017,866 | 11,140,350 |

Using Funding Formula Approved by ACL

Title III and VII funds are based upon the March 6, 2014 Title III and VII FY14 awards to the State.

Former Neighbor to Neighbor Funds, now called Volunteer Outreach Funds, are distributed based on the FY15 cohort factors. The funds are to continue to build the volunteer base.
Title III and related resources are based on: Age 60+
Age Universe: Total Population: ages <55, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+ Table S21003 Age 75+
Age Universe: Total Population: ages <55, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+
Table S21003
Age 60+ at 100% FPL
Sex by poverty status in previous year by household type (including living alone) and relationship for the population 60 years and over: age 60+; includes people living in 'group quarters' Table S21042
Age 60+ with Limited English Proficiency
Age by ability to speak English for the population 60 years and over
Table S21014A
Age 60+ Minority Status
Age by race for the population 60 years and over Table S21006
Age 60+ Living Alone (i.e. household of one)
Age by sex by living alone for the population 60 years and over
Table S21004
Nutrition Services Incentive Program (NSIP) uses FY14 award dated April 9, 2014 and is allocated using NSIP meals served for FY13.
* The General Fund match for the 3 Squares VT (3SVT) outreach is to be transferred by the Department of Disabilites, Aging and Independent Living (DAIL) to the Department for Children and Families (DCF) based on agreement between DAIL and DCF and distributed to the AAAs in accordance with the DCF-AAA 3SVT outreach grants. The difference of $3,822 (FY11 $212,500 - FY12 $208,678) remains in the General Fund allocation.

# D: Attachments

## Attachment A: Assurances

*By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances, required activities and information requirements as stipulated in the Older Americans Act, as amended in 2006.*

**ASSURANCES**

**Sec. 305(a) - (c), ORGANIZATION**

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. **States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.**

**Sec. 306(a), AREA PLANS**

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain

dysfunction; and
(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.
(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall--
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).
(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and (VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.
(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older

individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non- governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships. (13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-
(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and
(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

**Sec. 307, STATE PLANS**
(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.
(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.
(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.
(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.
(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.
(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services. (11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older

individuals;
(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.
(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.
(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.
(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and (ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.
(16) The plan shall provide assurances that the State agency will require outreach efforts that will—
(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;
(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.
(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.
(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.
(19) The plan shall include the assurances and description required by section 705(a).
(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.
(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.
(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).
(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.
(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.
(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.
(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

**Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS**

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

**Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)**

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order

**REQUIRED ACTIVITIES**

**Sec. 307(a) STATE PLANS**

(1)(A)The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

*Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.*

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). *Note: "Periodic" (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.*

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

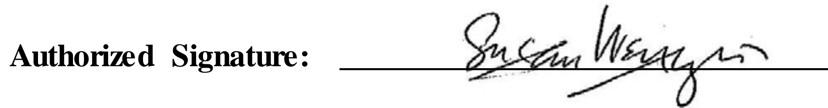
(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

**Authorized Signature:** 

**Date: June 27, 2014**

## Attachment B
### INFORMATION REQUIREMENTS

**Section 102(19)(G) – (required only if the State funds in-home services not already defined in Sec. 102(19))**
The term "in-home services" includes other in-home services as defined by the State agency in the State plan submitted in accordance with Sec. 307.

**Section 305(a)(2)(E)**
provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

**Section 306(a)(17)**
Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

**Section 307(a)**
(2) The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) *(Note: those categories are access, in-home, and legal assistance).*

**Section (307(a)(3)**
The plan shall:
(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning distribution of funds); *(Note: the "statement and demonstration" are the numerical statement of the intrastate funding formula, and a demonstration of the allocation of funds to each planning and service area)*
(B) with respect to services for older individuals residing in rural areas:
(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

**Section 307(a)(8)) (Include in plan if applicable)**
(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

**Section 307(a)(10)**
The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

**Section 307(a)(21)**
The plan shall:
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title *(title III),* if applicable, and specify the ways in which the State agency intends to implement the activities .

**Section 307(a)(28)**
(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.
(B) Such assessment may include—
(i) the projected change in the number of older individuals in the State;
(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;
(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and
(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

**Section 307(a)(29)**
The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery

**Section 307(a)(30)**
The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

**Section 705(a)(7)**
In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:
(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6). *(Note: Paragraphs (1) of through*

*(6) of this section are listed below)*
*In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:*
*(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;*
*(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;*
*(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;*
*(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;*
*(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);*
*(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--*
*(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for: (i) public education to identify and prevent elder abuse;*
*(ii) receipt of reports of elder abuse;*
*(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and*
*(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;*
*(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and*
*(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except:*
*(i) if all parties to such complaint consent in writing to the release of such information;*
*(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*
*(iii) upon court order.*

Authorized Signature: [signature]
Date: 07/22/2014

# Attachment C

## Intrastate Funding Formula

DAIL submitted a request to amend the Intrastate Funding Formula (IFF) in June 2013 and the following proposed IFF was approved in July 2013.

**Rationale and Process:**

The Vermont Department of Disabilities, Aging and Independent Living (DAIL), the State Unit on Aging and Disability, is requesting a change in its Intrastate Funding Formula (IFF) for FFY 14. The motive for making this request derives from what was a dramatic shift in the distribution of Older Americans Act (OAA) funding in FFY 13 with the use of the formula then in place. The formula in place in FFY 13 resulted in the following dramatic changes in funding to Vermont's five Area Agencies on Aging (AAA) compared to FFY 12 funding:

1. Champlain Valley Area Agency on Aging (CVAA), **plus** $82,952
2. Central Vermont Council on Aging (CVCOA), **minus** $70,600
3. Northeastern Vermont Area Agency on Aging (NEVAAA), **plus** $201,516
4. Southwest Council on Aging (SVCOA), **minus** $174,832
5. Council on Aging of Southeastern Vermont, Senior Solutions (COASEV), **minus** $61,953

The dimension of these shifts for the three agencies that experienced a loss was a genuine threat to their capacity to carry out their missions.

These dramatic shifts in funding triggered intense conversations between DAIL and all of the AAAs to generate a formula that fulfilled the goals of the OAA and diminished the possibility of dramatic, incapacitating shifts in funding. An analysis of the funding change revealed that a relatively small shift in the population of individuals who were 75+ and at or below 100% of the federal poverty level resulted in a large shift in funding. This cohort was weighted in the distribution formula at 80% of two-thirds of funds to be distributed by funding factor. Discussion with all of the AAA Directors produced agreement on two guiding thoughts for generation of the funding distribution:

1. Avoid distributing large funds associated with a small number of people.
2. Utilize the Special Tabulation completed by the Administration for Community Living (ACL) of the American Community Survey (ACS) 5-year estimates. This survey is completed annually and provides population estimates based on averages of a recent 5-year period. The "Special Tabulation" completed by ACL provides data divided by the "Planning Service Areas" which are identical to the service areas of the AAAs and provides best available data about populations in each distinct AAA service area. The ACS 5-year Survey is described by the U.S. Census Bureau (in *Guidance for Data Users*) as providing more precision than other data sources when surveying small populations. As most population cohorts in Vermont are small, the Special Tabulation of the ACS 5-year Survey is utilized as "best available data" for the purpose of the IFF.

The proposed FFY 14 OAA Intrastate Funding Formula was developed in consultation with Vermont's five AAAs. Formula adjustments were discussed in three meetings between September and December of 2012 along with numerous e-mail and phone communications about possible restructuring of the IFF. DAIL reviewed 28 formula options before settling on a draft proposal in December. On December 5th 2012 DAIL sent a draft amended intrastate funding formula for FFY 14 to the five AAAs and encouraged them to review and "pursue a consensus recommendation knowing that this is an opportunity to forge agreement on a formula that affects all of the AAAs." On January 4th, 2013 DAIL received a collaborative response proposal from four of the five AAAs which included the following message:

"The attached document represents collaborative comments by 4 Area Agencies on Aging (CVAA, CVCOA, SOASEV/SS, and SVCOA) on DAIL's proposal for a new Intrastate Funding Formula. While we had hoped for agreement by all 5 AAAs, we are happy that 4 of us could come to an agreement. Our proposal is not vastly different from DAIL's but does make some changes, which we believe will strengthen and improve the formula process for this formula change, and look forward to DAIL's response and/or future opportunities to give input over the next several months."

The version offered by the four AAAs was reviewed by DAIL in detail including exploration of further adjustment to the formula. After due consideration and study of the comments offered by the fifth AAA, NEVAAA, DAIL decided to proceed with the version of the IFF presented by the four AAAs. The Formula was posted for public review and comment on the DAIL website.

**The Formula:**

***The dollars represented in the following presentation are based on the pre-sequestration FFY 13 projections. At the time of the writing of this explanation of the FFY 14 IFF, the final sequestration affected grant projections were not available.***

**Principles:**

- **Use "best available data" which is understood to be the most recent Administration for Community Living Special Tabulation of the American Community Survey 5-year Survey estimates. Data is updated annually and available at the Planning Service Area level (equivalent to AAA service areas in Vermont) or town level, producing information by AAA region.**
- **Pursue stability: avoid distributing large number of dollars associated with a small number of people**

**Funding Factors:**

1. **Service Base** distribution of $531,000, representing 10% of total funds available for distribution, is divided equally among the five AAAs ($106,200 per AAA).
2. **Are Plan Administration** distribution of $531,000 representing 10% of total funds available for distribution, is divided equally among the five AAAs ($106,200 per AAA).

3. **Distribution by Age:**
    - 15% of the *remaining* funds are distributed based on the 60 – 74 population in each Planning Service Area (PSA) (equivalent to the area served by each AAA)
    - 15% of the *remaining* funds are distributed based on the 75 – 84 population in each PSA
    - 27% of the *remaining* funds are distributed based on the 85+ population in each PSA
4. **Distribution according to age and greatest economic need:** 40% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and at or below 100% of the Federal Poverty Level.
5. **Distribution according to age and social need related to limited English:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and with limited English proficiency.
6. **Distribution according to age and social need related to minority status:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and minority.
7. **Distribution according to age and social need related to living alone:** 1% of the *remaining* funds are distributed based on the population in each PSA that is 60+ and living alone.

Weightings emphasize supporting old-old (85+) and poverty.

The following two Tables provide information regarding the target populations in the five PSAs, the funding factors, and the resultant projections for distribution of funds

Table 1: **Population Data by Planning Services Area and by Funding Factor.**
Displays total populations related to funding factor categories and percentages of total populations by PSA. Data is derived from the most recently published ACL Special Tabulation of the American Community Survey 5-Year Survey estimates, 2005 – 2009.

| | | | | | | low #s | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Cohort Factors:** | | total = 79715 | total = 40925 | total = 10730 | total = 9685 | total = 726 | total = 1586 | total= 27605 | |
| PSA | AAA | age 60-74 | age 75-84 | age 85+ | age 60+ <100% fpl | age 60+ w limited englist | age 60+ minority | age 60+ living alon | **current $ %** |
| A | CVAA | 32.14% | 30.00% | 31.17% | 29.01% | 55.79% | 49.12% | 31.14% | **29.8%** |
| B | CVCOA | 20.04% | 20.83% | 17.57% | 20.08% | 16.53% | 17.02% | 21.55% | **19.0%** |
| C | NEVAA | 11.57% | 10.78% | 14.68% | 18.17% | 14.46% | 12.36% | 11.27% | **17.1%** |
| D | SWVCOA | 18.13% | 20.48% | 18.59% | 16.78% | 5.79% | 9.33% | 17.19% | **17.3%** |
| E | COASEV/ | 18.12% | 17.90% | 17.99% | 15.95% | 7.44% | 12.17% | 18.86% | **16.8%** |
| | TOTAL | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | **100.0%** |

TABLE 2: **Funding Data by AAA and by Funding Factor.**
***N.B. The dollars represented in the following presentation are based on the pre-sequestration FFY 13 projections. At the time of the writing of this explanation of the FFY 14 Intrastate Formula, the final sequestration affected grant projections were not available.***

Displays the funding factors, the weighted percentages related to the factors, and the impact on fund distribution to the five Area Agencies on Aging.

| A | B | C | D | E | F | G | H | I | J |
|---|---|---|---|---|---|---|---|---|---|
| **AAA Intrastate funding formula** | | | | | | | | | |
| **FFY 2014** | | | | | | | | | |
| | | | Total | CVAA | CVCOA | NEVAA | SWVCOA | COASEV/SS | Total |
| Area Plan Administration | **10%** | *of total* | $531,000 | $106,200 | $106,200 | $106,200 | $106,200 | $106,200 | $531,000 |
| Service base | **10%** | *of total* | $531,000 | $106,200 | $106,200 | $106,200 | $106,200 | $106,200 | $531,000 |
| age 60-74 | **15%** | *of balance* | $637,200 | $204,793 | $127,696 | $73,740 | $115,506 | $115,466 | $637,200 |
| age 75-84 | **15%** | *of balance* | $637,200 | $191,192 | $132,737 | $68,690 | $130,521 | $114,061 | $637,200 |
| age 85+ | **27%** | *of balance* | $1,146,961 | $357,557 | $201,493 | $168,356 | $213,251 | $206,303 | $1,146,961 |
| age 60+ poverty | **40%** | *of balance* | $1,699,201 | $493,005 | $341,244 | $308,786 | $285,101 | $271,065 | $1,699,201 |
| age 60+ limited english | **1%** | *of balance* | $42,480 | $23,698 | $7,021 | $6,144 | $2,458 | $3,160 | $42,480 |
| age 60+ minority | **1%** | *of balance* | $42,480 | $20,865 | $7,232 | $5,250 | $3,964 | $5,169 | $42,480 |
| age 60+ live alone | **1%** | *of balance* | $42,480 | $13,226 | $9,156 | $4,786 | $7,302 | $8,010 | $42,480 |
| **Proposed Total Title III & VII** | *4,248,003* | | $5,310,004 | $1,516,736 | $1,038,979 | $848,152 | $970,503 | $935,634 | $5,310,004 |
| | 100% | | | | | | | $5,310,004 | |

# Attachment D

## Guide To State Plan On Aging Acronyms

| Acronym | Description |
|---|---|
| AAA | Area Agency on Aging |
| AARP | Association for Advancement of Retired Persons |
| ACA | Affordable Care Act |
| ACL | Administration for Community Living |
| ACS | American community Survey |
| ADDGS | Alzheimer's Disease Demonstration Grants to States Program |
| ADP | Adult Day Program |
| ADRC | Aging And Disability Resource Connections |
| ADRD | Alzheimer's Disease and Related Disorders |
| AHS | Vermont Agency of Human Services |
| ALRs | Assisted Living Residences |
| AoA | Administration on Aging |
| AP | Area Plan |
| APS | Adult Protective Services |
| ASD | Adult Services Division |
| BRFSS | Behavioral Risk Factor Surveillance System |
| CFC | Choices for Care |
| CHAP | Community Healthy Aging Plan |
| CMS | Centers For Medicare and Medicaid Services |
| COASEV | Council on Aging for Southeastern Vermont |
| COVE | Community of Vermont Elders |
| CVAA | Champlain Valley Agency on Aging |
| CVCOA | Central Vermont Council on Aging |
| CWA | Creative Workforce Solutions |
| DAIL | Department of Disabilities, Aging and Independent Living |
| DCF | Department for Children and Families |
| DDAS | Division of Disability and Aging Services |
| DBVI | Division for the Blind and Visually Impaired |
| DDSD | Division of Developmental Services Division |
| DRHO | Designated Regional Housing Organization |
| DLP | Division of Licensing and Protection |
| DMH | Department of Mental Health |
| DVHA | Department of Vermont Health Access |
| DVR | Division of Vocational Rehabilitation |
| E & D | Elderly and Disabled |
| ELP | Elder Law Project |
| ERC | Enhanced Residential Care |
| FAST | Finance Abuse Specialist Team |
| HASS | Housing and Supportive Services Grant Program |
| HCBS | Home- and Community-Based Services |
| HHA | Home Health Agency |
| IFF | Intrastate Funding Formula |
| I/R/A | Information/Referral/Assistance |
| LTC | Long Term Care |
| LTCOP | Long Term Care Ombudsman Program |
| LTSS | Long Term Support Services |
| MAP | Medicare Advocacy Project |

| | |
|---|---|
| MFP | Money Follows the Person |
| NEVAAA | Northeastern Vermont Area Agency On Aging |
| NFCSP | National Family Caregiver Support Program |
| NSIP | Nutrition Services Incentive Program |
| OAA | Older Americans Act |
| OPG | Office of Public Guardian |
| PACE | Program for All-inclusive Care for The Elderly |
| PSA | Planning Service Area |
| RBA | Results Based Accountability |
| RCH | Residential Care Homes |
| RSVP | Retired Seniors Volunteer Program |
| SASH | Seniors Aging Safely at Home Pilot |
| SLP | Senior Law Project |
| SCSEP | Senior Community Service Employment Program |
| SMPP | Senior Medicare Patrol Project |
| SHIP | State Health Insurance Assistance Program |
| SLTCOP | State Long Term Care Ombudsman Project |
| SNAP | 3Square Vermont |
| SPA | State Plan on Aging |
| SUAD | State Unite on Aging and Disabilities |
| SVCOA | Southwestern Vermont Council On Aging |
| TBI | Traumatic Brain Injury |
| VACCD | Vermont Agency for Commerce and Community Development |
| VAHHA | Vermont Assembly of Home Health Agencies |
| VCIL | Vermont Center for Independent Living |
| VDH | Vermont Department of Health |
| VDHA | Vermont Department of Health Access |
| VDOL | Vermont Department of Labor |
| VHFA | Vermont Housing Finance Agency |
| VIP | Veterans Independence Program |
| VHCIP | Vermont Health Care Integration Project |
| VLTCOP | Vermont Long Term Care Ombudsman Project |
| VOP | Vermont Ombudsman Project |